A position in the making: A Bourdieusian analysis of how RN prescribing influences collaborative team practice in New Zealand

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Abstract

Background. In 2016, New Zealand introduced legislation enabling suitably qualified registered nurses the authority to prescribe from a limited formulary under the supervision of an authorised prescriber (doctor or nurse practitioner). Registered nurse prescribing is well established internationally and has been shown to enable the provision of quality, safe, and efficient health care. The Nursing Council of New Zealand stipulates that designated registered nurse prescribers are required to work collaboratively within the health care team. This study explored how registered nurse prescribers influence collaborative team practice. The research aimed to understand how registered nurse prescribers interact with other members of the health care team and to identify the social processes at play.

Method. Bourdieu's 'Theory of Practice' provided the methodological framework to explore health care teams as competitive social spaces where health professionals vie to establish social position and authority. Three health care teams, representing primary health and specialty practice, were recruited using purposive and snowball sampling. Individual participants included registered nurse prescribers, doctors, pharmacists, non-prescribing nurses, and a nurse practitioner. Data were collected through individual interviews and team meeting observation and analysed using reflexive thematic analysis informed by Bourdieu's theoretical concepts.

Findings. Three themes were identified. The first theme, 'social topography', positions team members in a social space, relevant to others, and according to their endowment of various forms of capital. A pervasive system of classification by professional discipline influences this established social order. The second theme is 'working with a registered nurse prescriber'. Classification by discipline drives the way the teams work, informing the objective structures including the division of labour and the allocation of time and physical space. Team members internalise their experience of the objective organisational structures of the team. Registered nurse prescribers develop an embodied sense of opportunity which either limits or enables their ability to work collaboratively. The final theme, 'patterns of communication', addresses the way the team communicates including opportunities for shared clinical decision making. Prescribing authority signifies a greater level of responsibility for registered nurse prescribers, and they rely on their relationships with authorised prescribers to assist them to gain knowledge, confidence, and establish their new prescribing role. The patterns of communication evident in each team reflect the power dynamics at play and demonstrate authorised prescribers to hold a position of symbolic dominance over decision making.

Conclusion. The propensity for the registered nurse prescriber to both realise the full potential of their prescriptive authority and to influence collaborative practice is determined by the organisational structure of the team and the relationships shared with authorised prescribers. The findings of this study build on an emerging body of research regarding the collaborative model of designated registered nurse prescribing in New Zealand. This research offers a unique and original contribution regarding how registered nurse prescribers work with others and influence collaborative team practice. These findings have relevance to those concerned with enabling and promoting registered nurse prescribing including postgraduate educators, health policy makers, and health care teams.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:
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Date: 23/05/2022

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Ethical Approval

Ethical approval to conduct the research reported in this thesis was granted by Auckland University of technology Ethics Committee (AUTEC) on 23 March 2018 (Reference number 18/39). The ethics approval letter is included as Appendix B.

Chapter One: Introduction

Globally, nurse prescribing is well established and promoted as an effective strategy for enabling accessible, quality health care that meets the needs of ageing populations burdened by chronic disease. The past three decades have seen steady growth in the number of countries adopting nurse prescribing. In New Zealand (NZ), the implementation of prescribing authority for nurses has been relatively recent in comparison to other developed countries. The extension of designated prescribing authority to registered nurses (RNs) supports the NZ Health Strategy (NZHS) realising its goal of providing health care that is readily accessible, community centred, equitable, and maximises the contribution of the health care team (Ministry of Health, 2016a).

This research focuses on designated RN prescribing in NZ, as opposed to nurse practitioners (NPs) who are registered under an advanced scope of practice, hold a master's degree, and are authorised prescribers. As authorised prescribers, NPs can prescribe any medications independently within their area of competence. Legislation enabling designated RN prescribing came into place in NZ in September 2016. Currently there are two levels of designated RN prescribing authority—RNs prescribing in primary health and specialty teams, and RNs prescribing in community health. This research pertains to the former group—RNs prescribing in primary health and specialty teams. RNs applying to the Nursing Council of New Zealand (NCNZ) for prescribing authority in primary health and specialty teams must have a minimum of three years of clinical experience in the area they wish to prescribe, hold a NCNZ approved post graduate diploma in RN prescribing, and work in a collaborative team (NCNZ, 2021c).

In NZ, RNs prescribing in primary health and specialty teams are required to work in a collaborative multidisciplinary environment and have an authorised prescriber (doctor or NP) available for consultation (NCNZ, 2021c). Collaborative interprofessional practice is internationally regarded as the gold standard of health care, promoting efficient, safe, accessible health care that maximises the contribution and job satisfaction of health professionals (World Health Organization [WHO], 2010; World Health Professions Alliance, 2019). Due to the relatively recent adoption of RN prescribing in NZ, there is limited published research in the area and none that specifically explores how RN prescribers work collaboratively in health care teams. This research adopts a critical approach informed by Bourdieu's 'Theory

of Practice' to gain an appreciation of how RN prescribers influence collaborative team practice.

Overview of Chapter

This first chapter begins with an explanation of how I became interested in RN prescribing and collaborative team practice. Following, RN prescribing is located within the context and history of advanced nursing practice in NZ. Collaborative practice, as a requirement of designated RN prescribing, is introduced, and key related terms defined. Important NZ government policy aligning with RN prescribing is briefly summarised. Finally, the research question and aims are presented, followed by a summary of the chapters included in the thesis.

My Motivation for Completing This Research

My interest in advanced nursing practice and collaborative teamwork began in the late 1990s when I had the privilege of leading a team, as a clinical charge nurse, to establish a cardiac and respiratory rehabilitation inpatient unit. At the time, the team was referred to as multidisciplinary and included nurses, doctors, pharmacists, physiotherapists, occupational therapists, social workers, dieticians, and psychologists. The team's goal was to collectively encourage and maintain independence while supporting people to better manage and take control of their chronic health conditions. The task of creating an entirely new model of care was exciting and liberating, and we soon earned ourselves a reputation for challenging some of the long-standing habitual practices associated with inpatient medical care.

With the aim of providing care centred on the patient's needs, rather than the needs of the team, we worked hard to encourage independence. We attempted to remove power laden symbolic barriers between the staff and the patients by choosing not to wear uniforms. Those patients who were well enough maintained their normal daily routine by preparing their breakfast in the communal kitchen and getting dressed, out of their pyjamas, during the day. In order to avoid exhausting the patients with individual discipline specific assessments, we developed a multidisciplinary assessment form. The team recognised that the patients had valuable knowledge about living with chronic illness; thus, we facilitated group education sessions enabling the patients to share their management strategies and personal experiences. The nurses presented case reviews and lead team meetings; a practice which recognised their integral knowledge of the patient's needs. The team were united in their approach and motivated to enhance the quality of life of

the patients by enabling them to self-manage at home and avoid unnecessary hospitalisation.

The time I spent working with this team was the most rewarding of my nursing career and the most challenging. While the idea of working collaboratively, placing the patient at the centre of care, seemed quite straight forward and practical, the reality of changing the way people worked was far from simple. There were team members who embraced working in a different way and there were others who resisted, complained, and even resigned. I learned more about my colleagues, including those from other disciplines, than I knew before. I gained an appreciation of what professional identity means to individuals, and how hard it can be for some to try new ways of working. I also learned what it means to be trusted as a leader.

In 2002, having completed my master's degree and ready to start a family, I sought a more flexible position and a new challenge and moved into nursing education. I have spent the latter half of my career teaching pharmacology in undergraduate, graduate, and postgraduate programmes. I coordinate both the RN prescribing and NP education pathways at Ara Institute of Canterbury, as well as leading the practicum papers for these programmes. My interest in RN prescribing began in 2013 when I was asked to contribute to a submission to the NCNZ's consultation document regarding RN prescribing.

Contributing to the NCNZ consultation process was my first introduction to the potential of RN prescribing and I was immediately intrigued. With the understanding that RN prescribing authority was on the horizon in NZ, I was inspired to further my knowledge in the hope that I would, in the future, contribute to the educational preparation of these nurses. Using a well overdue sabbatical, I set off on a four-month study tour of the United Kingdom (UK) visiting universities and meeting with educators of non-medical prescribing courses in order to broaden my understanding.

While in the UK, I visited several universities, observed classes, and met with both RN prescribers, educators, and several inspirational nurse scholars. I was intrigued by the two models of nurse prescribing offered at the time and motivated by the well-established and integrated approach to nurse prescribing. I returned to NZ at the end of 2015, and the following year, in 2016, changes were made to the NZ Medicines Act (1981) which enabled medication prescribing rights for RNs. Since this time, I have been integrally involved in planning and delivery of post graduate education for RNs preparing to apply for designated RN prescribing authority at Ara. In 2016, I enrolled in my first paper in the Doctor of Health Science at Auckland University of Technology (AUT). Engagement in a professional

doctorate has enabled me to apply my research to nursing practice with the intention of producing findings that will both inform and lead change in advanced nursing practice and education in the future.

The model of RN prescribing introduced in NZ shares some features of international models; however, the requirement for RN prescribers to work in a collaborative team is unique. Noting a lack of clarity about what working collaboratively actually means, I set about designing a research project exploring the way RN prescribers work in and influence collaborative health care team practice.

The Context

Collaborative Practice

This research aimed to gain an appreciation of how RN prescribers influence collaborative team practice. The term 'collaborative team' has been used here deliberately to replicate the terminology used by the NCNZ (2021c) in their guidelines addressing designated RN prescribing. The NCNZ states that designated RN prescribers are required to work in a collaborative healthcare team that includes an authorised prescriber (doctor or NP), and cite the College of Registered Nurses of British Columbia's (2014, as cited in NCNZ, 2021c) definition of collaboration suggesting it is "joint communication and decision-making with the expressed goal of working together toward identified health outcomes while respecting the unique qualities and abilities of each member of the group or team" (p. 24).

The NCNZ (2021c) extend their description of the collaborative team environment suggesting in one document that it should be both "multidisciplinary" (pp. 9, 25) and "interdisciplinary" (p. 5). The term 'interdisciplinary' is used just once, with the authors favouring the term 'multidisciplinary' to describe the team. The term 'multidisciplinary' is not specifically defined; however, the more general term 'team-based health care' is referred to as:

> The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers - to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care. (Mitchell et al., 2012 as cited in NCNZ, 2021c, p. 5)

The NCNZ (2016, 2021c) guidelines and the designated RN prescribing competencies use the terms "collaborative team" and "multidisciplinary team" interchangeably. This inconsistency suggests that because there are multiple disciplines in a team, they will work in a collaborative manner. Inconsistency and ambiguity in the language used to describe health care teams in published literature

is not unusual. The terms multidisciplinary, interdisciplinary and interprofessional are often used interchangeably and without adequate definition (Flores-Sandoval et al., 2021). Each term characterises the way that health care teams work together. Key features differentiating these terms relate to the role of the patient or client and the degree of partnership and cohesion occurring between health care professionals.

The term ‘multidisciplinary’ (as suggested by the prefix, multi-) means that several disciplines are involved in patient care. Originating in the 1980s, the term multidisciplinary is used to refer to a team structure where each health care provider performs an independent assessment and implements a plan of care in parallel, but not in partnership, with other members of the team (Forman et al., 2015; Orchard & Bainbridge, 2015). In this way, the multidisciplinary team works in professional silos addressing discipline specific problems and only coming together when a problem or issue arises. The focus of a multidisciplinary approach is on the role of the members of the health care team, rather than the patient or client.

The 21st century has seen a deliberate shift toward an interprofessional way of working together as a way of responding to unprecedented demand on health care services. Advances in medical technology, extended life expectancy, and the increased prevalence of chronic disease have put pressure on healthcare providers necessitating a more coordinated approach to care delivery (Frenk et al., 2010). Interprofessional practice is promoted as a means to address patient care while maximising team efficiency in times of a global shortage of health care professionals (WHO, 2010).

The WHO (2010) suggested collaborative practice “occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings” (p. 13). This conceptualisation positions the patient or client as the central focus and requires health care professionals to work together rather than in silos. The terms interdisciplinary and interprofessional are also used interchangeably in the literature. The most widely stated difference between the terms being the distinction between the word’s profession and discipline. Interprofessional is suggested to be more appropriate in the context of a health care team due to the word professional being more practically applied than a discipline which is considered more theoretical (Flores-Sandoval et al., 2021).

Advanced Nursing Practice in New Zealand

The earliest official dialogue regarding the adoption of nurse prescribing in NZ can be traced back to the early 1990s and coincides with radical reforms to the

NZ health system, along with the development of advanced roles in nursing practice. At this time, there was increasing concern regarding inefficiencies in the delivery of primary health care and the growing demand on health care services caused by chronic disease (Jacobs & Boddy, 2008). In 1994, the Minister of Health commissioned a discussion paper on the potential extension of limited prescribing rights for health care professionals. The paper highlighted a myriad of provisions and considerations but, in principle, concluded by supporting the extension of prescribing rights on the grounds this would enhance access to quality health care (Shaw, 1994). Several years later, in 1998, the Ministerial Taskforce on Nursing was established to identify the barriers to nurses achieving their full potential in contributing to optimal and innovative health care provision in NZ (Ministry of Health, 1998).

The report from the Ministerial Taskforce on Nursing made 37 recommendations including expanding scopes of practice and strengthening postgraduate education for nurses (Ministry of Health, 1998). These recommendations formed the foundation for the NP scope of practice in NZ (Jacobs & Boddy, 2008; Wilkinson, 2011). Amendments to the Medicines Act were made in 1999 and the NCNZ, directed by the Minister of Health, developed the educational framework and competencies for the first NZ NP scope of practice (Ministry of Health, 2022, March 6). The NCNZ is the statutory body under the Health Practitioners Competence Assurance (HPCA) Act (2003) responsible for registering all nurses in NZ. In their regulatory capacity, the NCNZ sets the educational and competence standards for all nursing scopes and levels of nurse prescribing.

Nurse Practitioner Scope of Practice

In 2001, the NP role was officially introduced as a distinct scope on the NCNZ register and, soon after, the first NP in NZ was registered as a neonatal NP (Gagan et al., 2014). Recognised as clinical experts and holding a master's degree, NPs are required to demonstrate advanced knowledge and skills, and work both independently and collaboratively (Gagan et al., 2014). It took a further three years, until the legislation was changed in 2005 for NPs to have the option of applying for designated prescribing authority. At this time, as designated NP prescribers, these nurses were limited to a schedule of medications from which they could prescribe. Existing NPs who wished to prescribe were required to complete further study and, once approved, could prescribe in the areas of aged care and child family health (Lim et al., 2007). These areas were identified by the government as public health priorities at the time.

Later, in 2005, the prescribing role was broadened, providing designated prescribing rights for approved NPs working in areas other than child-family health and aged care (Lim et al., 2007). In July 2014, further amendments to the Medicines Act (1981) were introduced enabling NPs to hold authorised prescribing rights, meaning NPs could now prescribe independently from the full medicines schedule. NPs registering after July 2014 are registered under a mandatory prescribing scope. The NCNZ will no longer register NPs in a non-prescribing capacity (Wilkinson, 2014).

Standing Orders for Administering Medication

In 2002, in response to a shortage of doctors, particularly in the rural and remote areas of the country, the Ministry of Health adapted legislation (Medicines Regulations-Standing Orders 2002) to allow nurses to administer medications in the absence of a prescriber or a prescription. A standing order is a written instruction outlining the specific medication that can be administered under clearly stipulated circumstances. Doctors, dentists, optometrists, and NPs are authorised to issue a standing order (Ministry of Health, 2016b). Originally designed to be used in emergency situations, standing orders soon became common practice and are used to enable patients' access to a large range of medications both in primary and secondary care (Wilkinson, 2015). The increased reliance on standing orders in primary health care areas, and specifically in diabetes care, was one of the catalysts for the development of the diabetes nurse specialist prescribing project.

Diabetes Nurse Specialist Prescribing Project

Following on from NPs, the next group of nurses to gain prescribing authority in NZ were specialist diabetes nurses (Lim et al., 2014). In 2011, Health Workforce NZ commissioned the New Zealand Society for the Study of Diabetes (NZSSD) alongside the Nursing Innovations Team of the Ministry of Health to conduct a diabetes nurse prescribing demonstration project (Willkinson et al., 2011). This six-week pilot involved 12 experienced diabetes nurse specialists prescribing a limited range of medications to patients with diabetes across four clinical sites. Evaluations of this trial found nurse prescribing to be a safe and beneficial approach to enhancing health care delivery (Budge & Snell, 2013; Wilkinson et al., 2011). A staged roll out followed, expanding prescribing rights to other diabetes nurses (Philips & Wilkinson, 2015).

Registered Nurse Prescribing in Primary Health and Specialty Teams

Following positive findings of the evaluation of the diabetes nurse prescribing project, in 2013 the NCNZ consulted extensively on the implementation of two

frameworks for RN prescribing. These were specialist nurse prescribing and community nurse prescribing (NCNZ, 2014). The NCNZ reported strong support on the proposal for specialist prescribing and forwarded an application for the extension of prescribing authority for this group to the Minister of Health. On September 20, 2016, changes to the Medicines Act (1981), specifically the Medicines (Designated Prescriber-Registered Nurses) Regulation 2016, enabled the NCNZ to authorise suitably qualified RNs practising in primary health and specialty teams with designated prescribing rights.

Nurses applying for prescribing authority must have completed a minimum of three years of experience in the area in which they intend prescribing and have completed a NCNZ approved post graduate diploma (NCNZ, 2021c). Once endorsed, designated RN prescribers are required to work in a 'collaborative team' and may prescribe specific medications from a published formulary. Table 1, below, illustrates the parameters of designated RN prescribing in comparison to NPs and community nurse prescribers. In 2017, the previous Medicines (Designated Prescriber-Registered Nurses Practising in Diabetes Health) Regulations 2011 were revoked and all diabetes RN prescribers are now regulated by the designated nurse prescriber regulations with a medication list limited to diabetes and related cardiovascular conditions.

Registered Nurse Prescribing in Community Health

In 2019, the Minister of Health approved a managed roll out of RN prescribing in community health settings. Under the Medicines (Designated Prescriber-Registered Nurses) Regulation 2016, the NCNZ may authorise RNs who have completed the required training to prescribe specified prescription medicines in community settings (NCNZ, 2019). Applicants must have had three years of clinical experience, one of which is in the area in which they will be prescribing. Intended as an alternative to administering under standing orders, this level of prescribing is more limited than the previously discussed model and designed to meet the needs of normally healthy people with minor illnesses only. A post graduate qualification is not required; rather, these nurses are required to complete a NCNZ approved 'work-based education programme' delivered by the employing health care provider (NCNZ, 2021b).

Table 1

The three levels of nurse prescribing in New Zealand

Levels of Nurse Prescribing Authority in NZ			
Prescriber title	NP	RN prescribing in primary health and specialty teams	RN prescribing in community health
Prescribing authority	Authorised	Designated	Designated
Qualification	Clinical master's degree in nursing	NCNZ approved post graduate diploma	NCNZ approved work-based recertification programme
Scope of practice	Nurse practitioner May work autonomously	Registered nurse Must work in a collaborative team with an authorised prescriber available	Registered nurse Must work with/ meet regularly with a collaborative team and have a authorised prescriber available
Medications	Prescribe any medications	Prescribe from medicines list for RN prescribing in primary health and specialty teams	Prescribe from medicines list for RN prescribing in community health (specific medications negotiated by the RN prescriber and employer/ mentor)
Numbers of nurses authorised to prescribe as at March 31, 2021	533	301 in primary health and specialty teams 58 diabetes nurse prescribers	83

(NCNZ, 2021a, 2021b, 2021c)

Registered Nurse Prescribing in the Context of New Zealand Health Policy

The NZHS (2016) identified the demands facing the NZ health system over the 10 years since it was published. Among the most demanding challenges identified in the NZHS were the aging population and the associated impact of chronic health conditions. The NZHS established key priorities for health care based on the aforementioned demands, current trends, and identified health priorities. The strategy includes five key themes.

The first strategic theme is to be ‘people powered’, offering choice to health consumers in terms of who delivers their health care, where it is delivered and how it is delivered. The second theme, ‘closer to home’, focuses on providing health care in a convenient location close to the people who need it. ‘Value and high performance’ is the third theme, and promotes sustainable quality health care. The fourth theme, ‘one team’, focuses on maximising the strengths of the health care team. The strategy promotes minimising the fragmentation of care by integrating service delivery throughout the patient’s journey. The final theme, ‘smart system’, encourages innovative technology to extend and support both health care delivery and the information storage and sharing systems that sit alongside it (Ministry of Health, 2016a).

Not long after the NZHS was revised, the NZ Health and Disability System Review was commissioned. The findings of the review identified the need for significant health reforms to strengthen the NZ health system ensuring more equitable health outcomes and access for all New Zealanders (Health and Disability System Review, 2020). In addition to major reforms of leadership structure and the creation of a Māori Health Authority, significant changes to healthcare workforce planning and development have been proposed.

The NZHS review noted that NZ shares the same challenges experienced internationally, including a health workforce under pressure and in short supply. The review promotes significant change to the current model of health care delivery. Interprofessional practice is encouraged whereby health professionals better understand and appreciate the contribution of colleagues from other disciplines and focus on meeting the needs of the patients. The review promotes a move away from traditional models of care delivery that have been medically focused to more innovative and integrative systems (Health and Disability System Review, 2020). The NZ health system is currently in a transition phase, moving toward major health reforms designed to change the way health services are structured.

The inclusion of RN prescribers in primary health and specialty teams aligns with the recommendations of both the NZHS (2016) and the NZ Health and Disability (2020) review. RN prescribing enables a more flexible nursing workforce working to their full potential within the RN scope to meet the needs of the community. RNs working in primary health care and specialty practice as designated prescribers can readily provide safe and timely access to essential medications for people who may not have previously been able to access these services.

Significance of this Research

In comparison to the international experience, RN prescribing in NZ is in its infancy. The collaborative model of designated RN prescribing introduced in NZ is unique, differing from the nurse prescribing models operating in other countries. Furthermore, the context of the NZ health care system differs to international models. Little is known about how RN prescribers in NZ work in and influence collaborative practice in teams.

It is imperative for health care professionals, employers, educators, and policy makers to understand how RN prescribers work in and influence collaborative teams. The findings of this research will guide future health care team practice in areas where RN prescribers are employed. In addition, the findings of this research are vital for informing and enhancing the future education of designated RN prescribers and the other health care professionals with whom they work.

Research Question and Aims

The research question informing this study is, how do RN prescribers influence collaborative team practice in NZ? The research aims to understand:

- How RN prescribers interact with other members of the health care team
- What social processes are at play within each health care team

This study engages Bourdieu's 'Theory of Practice', as the methodological framework to conduct the research. The outcomes of this research will help inform change in both advanced nursing practice as well as post graduate education preparing RNs to prescribe.

Overview of Chapters

This thesis is presented in eight chapters.

Chapter one: Introduction

Chapter one has outlined my motivation to conduct the research as a longstanding interest in both advanced nursing practice and collaborative team practice. A brief summary of advanced nursing practice in NZ and specifically designated RN prescribing was provided. Collaborative practice was defined in relation to the NCNZ's guidelines for designated RN prescribing and within the context of interprofessional practice. Finally, the significance, research question, and aims of the research were identified.

Chapter two: Literature review

The literature review presents a summary of the empirical literature published about RN prescribing and collaborative team practice both internationally and in New Zealand.

Chapters three: Methodology

Chapter three addresses the paradigmatic, epistemological, ontological, and methodological assumptions underlying the research. Bourdieu's 'Theory of Practice' is introduced as the methodological approach used to guide the study.

Chapter four: Methods

Chapter four discusses how ethical and cultural considerations were addressed. The processes of recruitment, data collection, and data analysis are described. Finally, this chapter discusses the strategies adopted to ensure the findings are trustworthy.

Chapters five, six, and seven: Research findings

Chapters five, six, and seven present the findings from the three teams included in the study. Three main themes of 'social topography', 'working with a RN prescriber', and 'patterns of communication' are presented across the three chapters, along with subthemes pertinent to each individual team.

Chapter eight: Discussion

This final chapter considers the research findings within the context of previous research. Recommendations from the research are discussed for education providers, health policy makers, and health care teams. Suggestions are made for future research. The chapter concludes by addressing the strengths and limitations of the study, before providing both a summary of the research and a concluding statement.

Summary

RNs have been prescribing in primary health and specialty teams in New Zealand since 2016. The NCNZ require these nurses to work in collaborative multidisciplinary teams. To date, there is no research conducted in NZ exploring the impact of RN prescribing on collaborative team practice. The findings from this research will illustrate the way that designated RN prescribers influence collaborative team practice. The findings will be valuable for informing both practice and education policy as new models of care are introduced to meet the changing demands on the NZ health care system. The next chapter will critically engage with existing literature regarding RN prescribing and collaborative team practice.

Chapter Two: Literature Review

Chapter one provided an introduction to RN prescribing. The collaborative nurse prescribing model implemented in NZ has been described and my interest and motivation for completing this research discussed. This chapter presents a critical review of recently published literature regarding RN prescribing and collaborative team practice. The aim of a literature review is to provide a critical synthesis of existing knowledge in order to highlight gaps in understanding and justify further research to be conducted in the area (Torraco, 2016). This chapter begins with a brief discussion of pertinent terminology and a description of the search strategy used to identify relevant empirical research. Next, the findings of the review are presented under the following themes: international context of nurse prescribing; enhanced satisfaction and autonomy for nurses; challenges to professional boundaries; support; supervision and mentorship from doctors; and, finally, recognition and remuneration. The chapter concludes with an explanation of how the findings from the literature review have informed the current study.

Terminology

The central topics of interest in this literature review are RN prescribing and collaborative practice within the NZ context. The literature reveals disparities in the terminology used to refer to nurse prescribing between countries. The generic term ‘non-medical’ prescriber is used internationally to refer to health care professionals who prescribe but who sit outside the medical profession; for example, nurses, pharmacists, midwives, podiatrists, and physiotherapists. Although some studies refer to findings by individual discipline, this occurs inconsistently and in many studies findings are generalised to include prescribers from multiple disciplines (Graham-Clarke et al., 2018). Only studies that separate nurse prescribers from other disciplines have been included in this review. When conducting the review, careful consideration was given to the nurse prescribing regulations and scope in the country in which the research was conducted in order to accurately apply the findings to the NZ context.

This research is concerned exclusively with RN prescribers. The term ‘RN prescriber’ refers to a registered nurse who has specialised knowledge and has met specific regulatory requirements to prescribe. In NZ, the scope of the RN prescriber is separate from that of a NP. As in NZ, internationally a NP is a master’s qualified expert nurse who practises under a separate scope and is considered an advanced practice nurse (APN) (International Council of Nurses, 2020). In countries that

include a NP scope, the majority are granted prescribing authority. While variation exists in most countries, NPs prescribe in a more extensive and independent manner than RN prescribers. For the purposes of this literature review, the prescribing role of the NP is considered separate from that of a RN prescriber and only studies pertaining to RN prescribing are included.

Search Strategy

The search strategy utilised for this literature review was developed with the assistance of a postgraduate liaison librarian at AUT. In order to locate relevant literature, the CINAHL, Medline, and Scopus electronic databases were searched. The following search terms were used and repeated across the databases: (nurse OR nurses OR "nursing staff" OR "non-medical" OR nonmedical) W/5 (prescrib*) AND (collaborative OR interprofessional OR inter-professional OR multidisciplinary OR interdisciplinary OR "team practic*"). Inclusion criteria for the literature search constituted: peer reviewed research and systematic literature reviews; articles published in English; date limits from January 2010 to December 2021.

The searches conducted at initiation of the research project resulted in 860 articles; the repeated articles were removed. The remaining titles, abstracts, and, in some instances, the full paper were screened. Publications that did not refer to prescribing RNs (excluding NPs) and relate to team practice were removed. At the completion of this process 65 articles remained. In addition, the reference lists of selected articles were scrutinised and, if relevant, additional articles were included. The literature search was repeated on several occasions throughout the research process to identify subsequent publications.

International Context of Nurse Prescribing

Although relatively new to NZ, RN prescribing is well established internationally (Kroezen et al., 2012; Maier, 2019). Over the past decade, the number of countries including nurse prescribers in the workforce has steadily grown, with as many as 14 countries adopting prescribing authority for nurses between 2010 and 2015 alone (Maier & Aiken, 2016). Ageing populations, the increasing prevalence of chronic disease, coupled with international health workforce shortages have seen global health systems under pressure. The reasons for extending prescribing rights to nurses address these concerns aiming to enhance the provision of quality care, increase access to medications, and optimise the skills of all health care professionals (Kroezen et al., 2012; Magowan, 2020; Maier, 2019). The benefits of RN prescribing are reported to include improved access to medications

and quality patient care, improved utilisation and recognition of nurses' skills, better use of doctor's time, and improved teamwork (Coull et al., 2013; Creedon et al., 2015; Drennan et al., 2009).

Nurse prescribing has been widely reported to be safe and effective (Ladd & Schober, 2018). A systematic review of the literature (N=35) in 2014 noted nurse prescribing to result in positive patient outcomes and to be comparable to physician prescribing (Gielen et al., 2014). Later, in 2016, a subsequent Cochrane review (N=46) supported these findings and suggested that prescribing pharmacists and nurses provided care that resulted in patient outcomes comparable to doctors (Weeks et al., 2016).

Internationally, there is considerable variance in the way RNs prescribe—this being dependent on the regulatory authority in each country (Kroezen et al., 2012; Maier, 2019). Significant discrepancy exists in terms of the education requirements for nurses to achieve prescribing authority. In some countries, prescribing education is provided at graduate level; and in others, at postgraduate level. Another variable is the degree of medical supervision required, and the restrictions placed on prescribing in relation to medication formulary and patient population. Following is a brief overview of the models of nurse prescribing adopted internationally including Europe, the UK, United States of America, Canada, and Australia.

Europe

A large cross country comparative analysis conducted in 2019 revealed that 13 European countries have adopted laws on nurse prescribing including: the UK, Ireland, Netherlands, Cyprus, Denmark, Estonia, Finland, France, Norway, Poland, Spain, Sweden, and Switzerland (Maier, 2019). This survey noted variation in the qualifications and educational preparation of nurses, with some being master's prepared. This suggests that the model of nurses prescribing in some of these countries is more comparable to the NZ NP scope of practice rather than RN prescribing.

United Kingdom

The UK was one of the first countries in the world to legislate for and implement non-medical and nurse prescribing (Maier, 2019; Snell et al., 2021). The earliest nurse prescribers were district nurses and health visitors who commenced prescribing from a limited formulary in the mid-1990s (Coull et al., 2013). The Royal College of Nursing (2014) suggested that nurse prescribing is now considered a mainstream qualification, with over 19,000 nurses prescribing across the UK in 2014. Health legislation and policy reforms have evolved to such a degree that, in

comparison to other countries, the UK is considered to have the most extensive legislation enabling RN prescribing (Kooienga & Wilkinson, 2017).

Currently there are two pathways by which RNs can achieve prescribing rights. The first is for 'community practitioner nurse prescribers', who are district nurses, public health nurses, and school nurses who have completed a community practitioner nurse prescribing course and prescribe from a limited formulary (Nurse Prescribers Formulary for Community Practitioners). The second pathway requires RNs to complete an independent/supplementary prescriber preparation programme which will enable them to prescribe as both an independent and supplementary prescriber (Nursing and Midwifery Council, 2018).

Independent nurse prescribers are authorised to prescribe from the entire British National Formulary (BNF) (except for some controlled drugs), within their area of competence (Nursing and Midwifery Council, 2018). As a supplementary prescriber, the RN prescribes in accordance with an agreed Clinical Management Plan (CMP) which is written by a doctor who is responsible for establishing the diagnosis (Bowskill et al., 2013). As a supplementary prescriber, the RN may prescribe from the entire BNF, in the same way as an independent prescriber, if the medication is listed on the CMP.

Ireland

The Republic of Ireland has included RNs on a prescribing register since 2007 (Wilson et al., 2018). Once endorsed, RN prescribers are required to sign a collaborative practice agreement (CPA) with their employer and a medical practitioner stipulating the medications they are authorised to prescribe (Lennon & Fallon, 2018). This highly regulated and controlled model of prescribing in many ways resembles the UK supplementary prescribing model.

The United States of America

In the United States of America, Advanced Practice Registered Nurses (APRNs) are the only nurses currently authorised to prescribe medications. An APRN is an experienced nurse holding a minimum of a master's degree and includes NPs. Prescribing authority was first granted to an APRN in Idaho state in 1971 with the number of states granting authority increasing significantly during the 1980s and 1990s (Kaplan & Brown, 2021). There are a variety of restrictions placed on APRNs depending on in which state they practice (Kaplan & Brown, 2021; Kooienga & Wilkinson, 2017).

Canada

Canada was an early pioneer of advanced nursing practice, introducing NP education in 1975. Several jurisdictions throughout Canada have since implemented or are planning the implementation of RN prescribing (Moody et al., 2020). The decentralised model of health care administration has meant that different models of RN prescribing have been introduced in the various provinces and territories (Canadian Nurses Association, 2015). In response, the Canadian Nurses Association have developed a pan-Canadian framework for RN prescribing in Canada (Canadian Nurses Association, 2015). At the time of writing, most Canadian provinces appear to be adopting a supplementary RN prescribing model including the use of clinical decision support tools and a limited formulary.

Australia

NPs have had prescriptive authority in some states of Australia since the late 1990s (Cashin et al., 2014; Raven, 2012). With the exception of a small number of nurses working in rural and isolated practice endorsed to supply medications, RN prescribing has not been implemented nationally. In 2018, The Nursing and Midwifery Board of Australia (NMBA) presented a proposal for consultation on prescribing endorsement for RNs. If implemented, the proposed model for endorsement will enable suitably qualified RNs to prescribe under supervision. The model is referred to as ‘prescribing in partnership’ and appears similar to the collaborative model implemented in NZ. Public consultation on this proposal closed in September 2018 and, at the time of writing, neither the analysis of the submissions nor the outcome of the consultation process had been made publicly available.

Enhanced Satisfaction and Autonomy for Nurse Prescribers

A number of studies undertaken overseas have investigated the impact on and experiences of RN prescribers. There appears to be a general consensus that prescribing nurses have a positive view of prescribing, welcoming the opportunity to extend their practice. Several studies have noted nurse prescribers report feeling increased satisfaction in their work, arising from the opportunity to be more autonomous in meeting patients’ needs, rather than relying on a doctor to write a prescription when required (Carey et al., 2014; Casey et al., 2020; Connor & McHugh, 2019; Cousins & Donnell, 2012; Lennon & Fallon, 2018). Having noted enhanced job satisfaction, previous studies have also recognised the additional demands and stressors associated with the nurse prescribing role including

increased work load, lack of time to complete the role, undue pressure to prescribe, and lack of financial remuneration (Cousins & Donnell, 2012).

The experience of NZ nurses is consistent with their international colleagues, with nurses reporting enhanced satisfaction in their work due to the empowerment prescribing authority offers them in providing comprehensive care (Budge & Snell, 2013; Pearson et al., 2020; Snell et al., 2021; Willkinson et al., 2011). A recent qualitative study reported on the experiences of 16 RN prescribers from both the North and South Islands of NZ (Pearson et al., 2020). The nurses noted enhanced work satisfaction in being able to work to what they considered the top of their RN scope of practice. RN prescribing was noted to save both the time of the nurses and of the authorised prescribers as they no longer needed to locate a doctor or NP to prescribe medications. As RN prescribers, the participants felt they were better prepared to conduct comprehensive patient assessments and plan holistic care, as well as to share their enhanced knowledge with both their patients and colleagues. As noted overseas, the RN prescribers in this study also commented on the associated responsibility and time demands of prescribing. The RN prescribers expressed frustration at the lack of recognition and financial remuneration they received for the increased responsibility of prescribing (Pearson et al., 2020).

Challenges to Professional Boundaries

Prior to the introduction of non-medical prescribing, the role of prescribing medications sat solely within the domain of the medical profession. The extension of prescribing authority to non-medical health care professionals, including nurses, has challenged entrenched professional boundaries. Nurses around the world have reportedly faced opposition from the medical profession as they have advocated for the adoption of prescribing authority (Kroezen et al., 2013; Lim et al., 2014). A range of arguments have been used to support this medical opposition including the claim that nurse prescribing causes risk to public safety and suggestion that nurses lack the required education and diagnostic skills to prescribe (Kroezen et al., 2012).

The situation in NZ has been consistent with the global experience, with nurse prescribing facing medical opposition from the outset (Philips & Wilkinson, 2015; Wilkinson, 2011). The NZ Medical Association, in 1998, vehemently opposed the idea of NPs prescribing, claiming potential risk to patient safety (Jacobs & Boddy, 2008). Moller and Begg (2005) published a contentious article suggesting that independent nurse prescribing was “a threat to the standard of healthcare in New Zealand” (p. 1) and citing nurses lack of diagnostic skill as a key concern.

Medical organisations in NZ have consistently offered their preference for nurses to prescribe in a dependent relationship alongside doctors (Wilkinson, 2011).

Irrespective of initial medical opposition, the number of countries adopting non-medical prescribing authority has steadily increased over the past decade (Maier, 2019). While initially there was strong medical opposition to RN prescribing, it appears there is a growing sense of acceptance of the role (Connor & McHugh, 2019; Coull et al., 2013; Graham-Clarke et al., 2018; Kroezen et al., 2014). A review of literature published between 1997 and 2007 of nurse and pharmacist supplementary prescribing in the UK (N=35) noted the medical profession to be uninformed about nurse prescribing, concerned about the erosion of their professional role and about safety implications (Cooper et al., 2008). However, a subsequent systematic review (N=42) published a decade later showed a different picture. This later review, exploring the facilitators and barriers to non-medical prescribing, included studies conducted between 2007 and 2012 and noted that medical professionals were generally accepting of non-medical prescribing (including nurse prescribing) (Graham-Clarke et al., 2018).

The previously cited findings suggest that over time, with exposure and experience of working with non-medical prescribers, the medical profession have become more accepting. However, some argue that rather than accepting nurse prescribing, when faced with pressure to share prescribing authority, the medical profession has manipulated the regulation of non-medical prescribing to suit their purposes. In tempering their stance of complete opposition, the medical profession has relinquished aspects of the role and promoted dependent prescribing models whereby they maintain a degree of control over patient care and nursing practice (Kroezen et al., 2013; Pritchard, 2017).

Dependent Models of Nurse Prescribing and Medical Control

A large international study that surveyed regulatory bodies and nursing/medical professional associations in 10 countries noted that, with the exception of independent nurse prescribing in the UK, nurse prescribing is largely executed under the auspices of medical supervision and control (Kroezen et al., 2012). The term ‘dependent model’ is used to refer to prescribing authority where the prescriber is reliant, in some capacity, on medical supervision to carry out their prescribing role (Cooper et al., 2008). As already mentioned, the supplementary prescriber model in the UK and the Irish model where nurses prescribe from a collaborative practice agreement are both examples of dependent prescribing.

Dependent prescribing models have been noted to restrict nurse prescribing, limiting the nurse's autonomy and ability to be optimally effective in the role (Courtenay et al., 2012; Stenner et al., 2010). Stenner et al. (2010) noted that the supplementary model of prescribing in the area of diabetes care was overly restrictive and a barrier to prescribing. A similar pattern was noted in a large online questionnaire of 880 non-medical prescribers within one health authority in the UK (Courtenay et al., 2012). This study noted supplementary prescribers to be considerably less likely to prescribe in comparison to independent prescribers due to the restrictions and supervision requirements imposed, leading the authors to question the continuation of the supplementary prescribing authority. In Ireland, a CPA between the nurse, employer, and doctor dictates the medications a nurse prescriber may prescribe. Casey et al. (2020) noted in an Irish study that nurse prescribers felt their ability to fully meet their patients' needs were limited by the CPA.

Several studies conducted in the UK have interpreted the perceived barriers of the supplementary prescribing model as due to the medical profession's position of dominance over nurses and pharmacists who prescribe (Bowskill et al., 2013; Cooper et al., 2012; Dobel-Ober et al., 2013). Creedon et al. (2015), in a literature review, noted that "protocols and formularies for prescribing developed and approved by medical staff restricts the process and places nurse prescribers in a subordinate position to the medical staff" (p. 881). Fisher (2009, 2010) investigated relationships between doctors, pharmacists, staff nurses, and prescribing district nurses using interviews to collect data and employing an ethnographic methodology. The principles of Weber and Foucault's theories were used to analyse the data involving issues of bureaucracy, domination, and power. The key finding from this research project suggested that, in some cases, relationships between nurse prescribers and doctors were hampered by a "struggle for dominance and control" undermining the potential for a collaborative relationship (Fisher, 2010, p. 584). A noted limitation of this research was that due to access difficulties only one GP was interviewed. This limitation suggests that the findings do not adequately reflect the GPs' perspective and care should be taken with applying the findings.

New Zealand's Collaborative Model of Registered Nurse Prescribing

The designated RN prescribing model introduced in NZ requires the RN prescriber to prescribe within a collaborative team with an authorised prescriber available to consult if required. This model does not enable the degree of autonomy that the independent model does in that a limited formulary is stipulated. However,

the collaborative model does not limit RN prescribers by imposing an individualised prescribing agreement or patient specific plan, this allows them more autonomy than the dependent model used in the UK. To date, there is limited research published in NZ that explores strengths and weaknesses of the collaborative model.

Two studies have been completed in NZ that explore how RNs prescribe in practice. The first is a descriptive study reporting on the prescribing practice of 11 RN prescribers working in both specialty teams and primary healthcare in one district health board (DHB) (McGinty et al., 2020). The RN prescribers in this study were found to be prescribing for patients with an extensive breadth of conditions, including chronic disease, acute presentations, as well as patients with new diagnoses. The nurses were prescribing broadly, particularly those working in primary care, including medications from 15 of the 20 therapeutic groups recorded on the approved medication list for designated RN prescribers. The study noted that on 30 occasions the RN prescribers had to ask an authorised prescriber to write a prescription due to it not being included on the designated RN prescriber's medication list. While some of these medications were considered out of scope for an RN prescriber, others were commonly used medications added to the NZ pharmaceutical schedule subsequent to the publication of the nurse prescribers list. The authors concluded that the RN prescribing list is outdated and due for review (McGinty et al., 2020). Subsequent to this article being published, in March 2022, the NCNZ (2022) have updated the medicine list for RNs prescribing in primary health and specialty teams.

The second NZ study exploring how RNs prescribe is a small qualitative research project exploring the antibiotic prescribing practices of six RN prescribers (Lim et al., 2020). This study noted RN prescribers to be safe and well informed in relation to judicious prescribing of antimicrobial therapy. In contrast to the findings of McGinty et al. (2020), this study did not refer to the RN prescriber medication list as limiting the prescriber's choice of antibiotic. Neither did this article make mention of the collaborative relationship shared between the RN prescriber and authorised prescriber or other members of the healthcare team.

Support

The need for nurse prescribers to have support from the people they work with and from the organisation employing them is noted repeatedly in international and NZ research. Supportive relationships are described by nurse prescribers as being both enabling to their prescribing practice when they exist and a barrier when they do not (Casey et al., 2020; Jones et al., 2011; McHugh et al., 2020; Snell et al.,

2021; Stenner et al., 2010). Many of the studies reviewed refer to this necessary support as coming from generic groups such as peers, colleagues, members of the multidisciplinary team, or other health care professionals without identifying the discipline of the supporters (Casey et al., 2020; Jones et al., 2011; Lennon & Fallon, 2018; McHugh et al., 2020; Stenner et al., 2010). In the studies that did identify the discipline of the supporters, most suggested that nurse prescribers were more reliant on the medical profession for ongoing support than any other professional group. This is an expected finding given in most countries the regulations informing nurse prescribing mandate an element of medical mentorship or supervision.

As discussed, there are a large number of studies that highlight support from others as enabling nurse prescribing but relatively few that provide detail about what the required support consists of. Two key themes were apparent in the literature in relation to the need for supportive relationships. These were risk and knowledge sharing.

Risk

The act of prescribing medication, regardless of profession, carries a high degree of responsibility and associated clinical risk. Nurses report feeling vulnerable when prescribing with several studies demonstrating this as a deterrent to integrating prescribing in nursing practice (Bowskill et al., 2013; Maddox et al., 2016; Ross & Kettles, 2012). One study specifically addressed trust as an important characteristic of a supportive working relationship. Bowskill et al. (2013) interviewed 26 supplementary and independent nurse prescribers in the UK to understand how nurse prescribers integrate prescribing in practice. The researchers noted that previously established relationships, particularly between the prescribing nurses and doctors, were important in aiding the integration of the nurse prescribing role. This study found that if nurses do not feel trusted, they are not prepared to take on the responsibility and perceived risk of prescribing (Bowskill et al., 2013). Nurses were seen to actively work on establishing and maintaining trust with doctors by requesting permission to prescribe or asking for the doctor to check their prescribing. These “permission-seeking” and “doctor-checking” (Bowskill et al., 2013, p. 2083) activities were noted particularly in the first 18 months of the nurses’ prescribing experience and were seen as assisting with establishing the competence of the nurse prescriber and reducing the risk of error. This study determined that participants felt safe to prescribe when their prescribing role was firmly established and agreed upon by others, including doctors.

Knowledge Sharing

Nurse prescribers extend their knowledge, build confidence and prescribing competence when they have other prescribers, in particular doctors, from whom to seek guidance (Maddox et al., 2016; Stenner et al., 2010). Opportunities for impromptu, informal communication regarding prescribing practice have been noted as valuable for nurse prescribers (Coull et al., 2013; McHugh et al., 2020; Stenner et al., 2010). Prescribing nurses who find themselves working in isolation and without a doctor to discuss their prescribing decisions, lacked confidence and were less likely to prescribe in these circumstances (Maddox et al., 2016).

Supervision and Mentorship From Doctors

This literature review revealed research conducted both in the UK and NZ suggesting prospective nurse prescribers have reservations about the support they will receive from medical colleagues when they begin to prescribe. A study conducted in Northern Ireland interviewed 45 nurses during their training to become supplementary prescribers (Hales et al., 2010). Supplementary nurse prescribers are reliant on the development of a CMP with a doctor in order to prescribe. The findings of this study suggested nurses resented the supplementary model of nurse prescribing due to their ability to prescribe being reliant on medical discretion. These nurses anticipated that the degree to which they would be able to prescribe effectively and autonomously would be largely influenced by a range of factors including: the economic imperatives in general practice leading to GP control over nurse prescribing; time constraints in hospitals leading to doctors simply signing off on CMPs rather than collaboratively negotiating them; and their perceived sense of risk in the face of what they deemed to be the overly punitive regulation of the nursing profession. The collective view of prospective nurse prescribers in this study was that doctors would maintain a dominant role (Hales et al., 2010).

The collaborative nurse prescribing model adopted in NZ differs from the aforementioned supplementary model in Northern Ireland; however, in both cases nurses are reliant on the support of other prescribers. All RNs in NZ seeking RN prescribing endorsement require formal mentorship from an authorised prescriber (doctor or NP) while completing their prescribing practicum. In addition, after achieving designated prescribing endorsement from the NCNZ, they are required to be supervised by an authorised prescriber for their first year of prescribing practice (NCNZ, 2021c). Several studies conducted in NZ have raised concerns regarding the availability of authorised prescribing mentors. In the wake of the successful diabetes prescribing trial, research was conducted to assess the appetite of

diabetes nurse specialists to become prescribers (Philips & Wilkinson, 2015). This self-report survey (N=92) conducted in 2012 identified that non-prescribing nurses were supportive of nurse prescribers and almost 73% of participants showed interest in becoming a prescriber themselves. Unspecified concerns were raised from a small number of nurses regarding “support from GPs for prescribing” (n=8) and access to medical supervisors (n=5) (Philips & Wilkinson, 2015, p. 12). Findings from a later self-report study (N=305) conducted in 2013 to gauge the interest of primary health care nurses in the NCNZ’s proposals for designated nurse prescribing also demonstrated a positive attitude from nurses regarding prescribing, with 82% expressing interest (Wilkinson, 2015). This study concurred with previous findings and suggested nurses had doubts about the support they would receive from their GP employers. The reasons stated for this uncertainty included the cost to the GP practice of the nurses’ education, and the impact of nurse prescribing on the profitability of the business (Wilkinson, 2015).

Both aforementioned NZ studies were conducted in the area of diabetes prior to 2014 when legislation changes were introduced in NZ changing the prescribing status of NPs from designated to authorised. Since this time, NPs have been able to mentor RN prescribing students and designated RN prescribers in their first year of practice. There has been no research published that specifically explores the availability or impact of NPs mentoring RN prescribers in comparison to GPs and other doctors.

A more recent study addressing nurse prescribers’ perceptions of the role in NZ was conducted in 2019 (Pearson et al., 2020). The findings from this small study (N=16) supported previous findings suggesting mentor support, from both doctors and NPs, is imperative and voicing concern that as more nurses pursue prescribing, endorsement supervisors will become harder to find. One final study, a collaborative project comparing practices, barriers, and facilitators in nurse prescribing between the UK and NZ addressed mentorship and support (Snell et al., 2021). The researchers noted “access to colleagues for mentorship and support as being the major facilitator of their prescribing practice” (Snell et al., 2021, p. 6). Unfortunately, aside from interview excerpts that mentioned a range of disciplines (GPs, hospice doctors, pharmacists, clinical nurse leads in the UK, and doctors and nursing mentors in NZ) no specific detail was provided as to who provided the support or the nature of the support.

Recognition and Remuneration

The final theme to be discussed in this literature review is the role of the organisation in supporting the nurse prescriber. Previous studies have emphasised the importance of an organisational infrastructure that supports RN prescribing. Recognition and valuing of the nurse prescribing role have been identified as important variables contributing to the retention of nurse prescribers. A large Scottish study implementing a mixed method design identified that 60% of mental health nurse prescribers recruited were not actually prescribing (Ross & Kettles, 2012). This study attributed lack of recognition, in terms of both remuneration and status, as contributing factors. Lack of recognition, in the form of remuneration, has also been identified as a barrier to nurse prescribing in several other UK studies (Casey et al., 2020; Earle et al., 2011a).

A lack of understanding and appreciation of the role and remit of the nurse prescribing role has been widely reported as a barrier to the implementation of nurse prescribing (Earle et al., 2011b; Lennon & Fallon, 2018; Pritchard, 2018; Ross & Kettles, 2012). Nurse prescribers reported feeling undervalued and frustrated when their extended knowledge and prescribing ability is not recognised by other team members (Casey et al., 2020; Connor & McHugh, 2019; Lennon & Fallon, 2018). While no one study has focused solely on the understanding team members have of the prescribing nurse's role, several studies have noted both members of the health care team and managers to be poorly informed. Uncertainty about the nurse prescribing role and related legal restrictions and regulations can lead to nurses feeling pressured to prescribe outside of their scope (Connor & McHugh, 2019; Lennon & Fallon, 2018). Furthermore, nurse prescribers feel burdened by the need to educate colleagues about their prescribing role and the regulatory conditions involved (Lennon & Fallon, 2018).

The importance of organisational readiness in implementing RN prescribing has also been noted in several NZ studies. Pearson et al. (2020) identified a lack of role recognition and remuneration resulted in nurses feeling frustrated and undervalued (Pearson et al., 2020). In another recent NZ study, the researcher mapped her journey to becoming a designated RN prescriber and implementing the role in specialty practice (Hutchinson Daniel et al., 2020). As a pioneer of the RN prescribing role in her clinical area, the lead researcher reflected a long and frustrating journey plagued by a lack of local policy and organisational readiness.

Justification for This Research

The collaborative model of RN prescribing implemented in NZ is unique and differs from all other international models. The NZ model is not considered 'independent' in that RN prescribers are required to work in collaborative teams with access to authorised prescribers. Neither is the NZ model considered 'dependent' in that NZ RN prescribers are not required to prescribe according to a medically approved management plan. The other important factor that distinguishes the NZ collaborative model of RN prescribing from international models is the potential relationship between a RN prescriber and a NP as mentor and collaborative practice partner.

Due to the recent implementation of RN prescribing in primary health and specialty practice, research exploring RN prescribing in NZ is limited. Previous research has focused on the experiences of RN prescribers, their prescribing practice, as well as evaluation of the diabetes prescribing project. However, to date, there is no published research that explores how RN prescribers work in teams and influence team practice in the NZ context. Recognising the dearth of published studies in this area and the need to know more about the unique collaborative model of RN prescribing operating in NZ, this study seeks to gain an appreciation of how RN prescribers influence collaborative team practice.

Summary

There is a large body of international research that addresses nurse prescribing; however, very little has focused specifically on the relationships these nurses share with other professionals in the health care team. This literature review explored a vast number of studies in order to explicate findings relating to how nurse prescribers work in teams.

The first theme in this literature review demonstrated the rising numbers of countries implementing nurse prescribing. The benefits of nurse prescribing have been well documented as enhancing quality, timely, and accessible health care both abroad and in NZ. A range of prescribing models were described, differing in terms of the degree of medical supervision required as well as the limitations surrounding the medications that can be prescribed. Models ranged from 'independent', where few limitations are imposed to 'dependent' where the nurse must prescribe according to an individualised management plan written by a doctor which stipulates which medications can be prescribed.

Historically, the task of prescribing sat within the medical domain. In most countries the introduction of non-medical prescribing has faced opposition from the

medical profession. Possibly due to medical opposition to independent non-medical prescribing, nurses currently prescribe under a dependent model in many countries. Several studies have suggested that dependent models are overly restrictive and discourage nurses from prescribing. The collaborative model of nurse prescribing introduced in NZ differs from both the independent and dependent models. There is little research to date that explores nurse prescribing practice in NZ. However, there is some suggestion that the RN prescriber medication list is overly restrictive.

The need for support from other health care professionals was a recurrent and pervasive theme in this literature review. Yet, few studies have explicated from which disciplinary group this support comes. Detail on the exact nature of support is scant with some suggestion that this support provides essential opportunities for learning and building trust and confidence in prescribing practice. Dependent prescribing models raise concerns for nurses in terms of being able to readily access medical supervision. Research conducted in NZ also suggests that as the demand for nurse prescribers increases, nurses will have more difficulty in accessing a mentor. The final theme explored the importance of recognition and role appreciation in supporting nurse prescribing.

This review of the literature supports the use of a relational research approach that incorporates aspects relating to both personal experience and social context. The following chapter presents the theoretical and methodological assumptions underpinning this research.

Chapter Three: Methodology

The previous chapter provided a review of the existing literature. Due to the relatively recent introduction of RN prescribing in NZ, little research has been conducted in the area and none that specifically addresses the way that RN prescribers work with others in health care teams. This chapter addresses the theoretical and methodological assumptions underlying the research. The chapter begins by revisiting the research question and aims, and includes justification of the decision to apply a critical research methodology. Next, the transformative paradigm, as the overarching research approach, is presented, followed by the epistemological, ontological, and axiological assumptions that underpin it. Finally, Bourdieu's 'Theory of Practice' is introduced as the methodological approach guiding the study.

The Research Question and Aims

The research question informing this study is, how do RN prescribers influence collaborative team practice in NZ? The research aims to understand:

- How RN prescribers interact with other members of the health care team
- What social processes are at play within each health care team

The primary interest of this research lies in appreciating the social processes that impact health care team practice. The intent is that the findings from the research will be practically applied in future health care policy, practice, and education. As the primary researcher, I believe that all human relationships are influenced by the presence and inequity of power. This world view, coupled with the practical intent of the research and findings of the literature review, led me to conduct this research within a transformative paradigm.

The Transformative Research Paradigm

The term paradigm, in a research context, refers to "a set of assumptions, concepts, values and practices that constitutes a way of viewing reality" (McGregor & Murnane, 2010, p. 419). Often referred to as a 'worldview', the values and beliefs of the researcher influence the way they construct their research question and the manner in which they implement the study (Kivunja & Kuyini, 2017). The research paradigm can be likened to a bridge enabling the researcher to navigate a passage between the research question and the answer (Weaver & Olson, 2006).

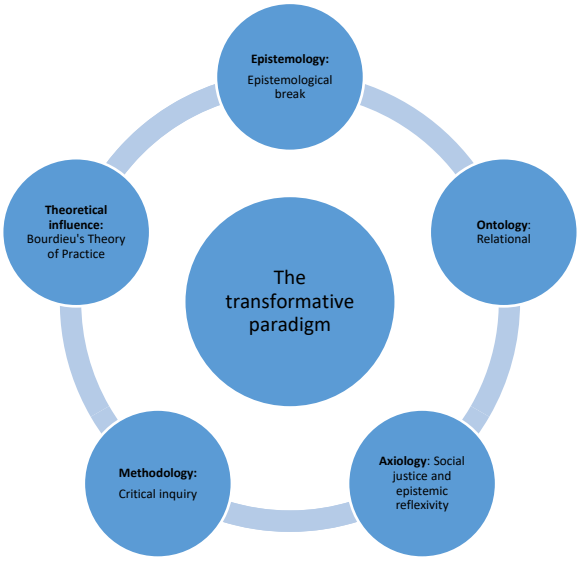
This research is firmly grounded in the belief that social hierarchy exists in all human relationships. Within any group of people—family, sports club, or health care team—social stratification is unavoidable and results in the disparate and inequitable distribution of power. Changes in roles and responsibilities within a social group will, therefore, result in disruption to the existing order potentiating transformation of the balance of power. This standpoint is recognised in the transformative paradigm, which acknowledges the pervasive effects of power inequity in interpersonal relationships (Mertens, 2010).

The transformative paradigm encompasses research perspectives that address power imbalance with the aim of potentiating positive social change (Mertens, 1999). This research is conducted with the intention of both gaining an appreciation of the social stratification existing in health care teams and grasping the impact of the inclusion of a new role, a RN prescriber. This research meets the requirements of a professional doctorate in health science, in that it is grounded in clinical practice and its purpose is inherently practical. The findings will be transformative when applied, enabling change to health care policy, practice, and education.

Denzin and Lincoln (2005) suggested that a paradigm is constructed of four elements: epistemology, ontology, axiology, and methodology. Figure 1 illustrates the elements contributing to the transformative paradigm. Explication of each of these constitutive elements follows, demonstrating congruence between the researcher's personal values and the methodology chosen to answer the research question.

Figure 1

Outline of the elements contributing to the transformative research paradigm



Epistemology: Epistemological Break Between Objectivism and Subjectivism

Epistemology is defined as “a way of understanding and explaining how we know what we know” (Crotty, 1998, p. 3). Traditionally, research approaches have been classified as looking at the social world in either an objective or subjective manner. Research conducted objectively aligns with the positivist tradition of science which asserts that reality can be measured and is, therefore, devoid of potential for subjective interpretation (Gray, 2004). In contrast, interpretive research methodologies lie at the other end of the epistemological spectrum and are based on subjectivism with the understanding that there are endless ways of seeing the world which are constructed by the individual (Moses & Knutsen, 2012). The epistemological position informing this research deviates from either a purely objective or subjective appreciation of knowing by employing a unique perspective informed by Pierre Bourdieu.

Bourdieu’s views on epistemology were heavily influenced by the two opposing schools of philosophy—existentialism and structuralism (Bourdieu, 1977a; Swartz, 1997). In his early career, as an ethnographic researcher, Bourdieu employed a structuralist approach. However, over time he grew to reject this approach on the grounds that structuralism wrongly ignored the subjective experience of the individual (Griller, 1996; Swartz, 1997). Yet, he also rejected the subjectivism of existentialism in its suggestion that reality is best understood through consciousness and personal experience. Bourdieu proposed an ‘epistemological break’ from objective/subjective dualism integrating both subjectivism and objectivism in his epistemological position.

The ‘epistemological break’ offers an alternative way of seeing the world through what has been referred to as a “double focused analytic” lens (Bourdieu & Wacquant, 1992, p. 7). The key premise identifies human behaviour is best understood by considering both the participants’ lived experience and conscious perception and the social, temporal, and historical space in which they exist (Bourdieu & Thompson, 1992; Swartz, 1997). Bourdieu used the concepts of habitus and field to assist him to integrate both an objective and subjective perspective to research. These concepts will be discussed later in this chapter.

Ontology: Relational

The epistemological position supporting this research has been accounted for as reflexive, involving an epistemological break between objectivism and subjectivism. Now the ontological positioning of this research will be outlined. Ontology is concerned with the “philosophical study of the nature of existence or

reality" (Kivunja & Kuyini, 2017, p. 27). In keeping with the previously stated epistemological position, this research is informed by an ontological position of relationism, meaning that an individual's social reality cannot be separated from the social context they inhabit. In adopting a relational perspective, the researcher appreciates the dynamic interplay between individual perceptions of their circumstances and the objective structures and social influences that impact them (Mauthner & Doucet, 2003). With this view, reality is influenced by multiple social contexts including political, social, cultural, religious, and gender.

Axiology: Social Justice and Epistemic Reflexivity

Axiology refers to the role of values in guiding the research process (Given, 2008). According to Bourdieu (1993), sociology is "a science that makes trouble" (p. 8) because it exposes power differentials and competition in social relationships. In keeping with this axiological imperative, this study commits to revealing hidden and potentially confronting social forces at play within health care teams as an axiological imperative.

A second value guiding this research is to adopt a non-discriminatory approach to all participants; and, in doing so, fully appreciate the contribution of all members of the health care teams included in the study. This imperative is demonstrated and maintained through the relationship the researcher shares with the participants and their data. I was cognisant of the potential for my values, social background, and experience to influence the research process and data analysis. In order to mitigate this risk, I adopted Bourdieu's approach of epistemic reflexivity.

Epistemic reflexivity, also referred to as 'participant objectivation', is intended to minimise the risk of the researcher inadvertently influencing the research process (Bourdieu & Wacquant, 1992; Swartz, 1997). Recognising that power differentials define and influence all human relationships, there is a pervasive potential for the researcher to inadvertently marginalise or dominate participants by inflicting their own values. A reflexive position promotes an open and honest approach on behalf of the researcher, lessening the risk of inaccurate theorisation and domination of the process (Bourdieu & Wacquant, 1992).

Methodology: Critical Inquiry

The research methodology justifies how the researcher approaches and plans the research and is informed by their epistemological and ontological beliefs. In designing this study, I sought an approach that would assist in appreciating the social processes at play in health care teams. A critical approach was deemed most fitting, providing an opportunity to explore the power differentials at play and the

impact these disparities present in practice. Research informed by critical inquiry addresses power relations and issues of justice, and is intended to be transformative enabling emancipatory change (Koro-Ljungberg & Cannella, 2017).

'Critical inquiry' is an umbrella term referring to an overall research approach whereby a diverse range of strategies may be included. Bourdieu's 'Theory of Practice' shares many of the underpinning tenets of critical inquiry. These 'critical' characteristics include concerns regarding perceived social injustices, marginalisation, and power differentials. As the methodology employed in this study, Bourdieu's (1977a) 'Theory of Practice' offers a lens for understanding the way in which social inequality is reproduced over time. Research informed by Bourdieu's 'Theory of Practice' places power imbalance at the centre of the inquiry; therefore offering "a critical not just a neutral, understanding of social life" (Postone et al., 1995, p. 10). Ultimately, critical inquiry pushes the researcher beyond mere description toward critique and ultimately social change.

Bourdieu's 'Theory of Practice'

Bourdieu adopted inspiration from, and his work was heavily influenced by, a range of philosophical traditions. A brief history of Bourdieu's origins and sociological influences will now be introduced.

History and Influences

Pierre Bourdieu (1930-2002) was born and raised in south-western France, where he was recognised as an intellectually gifted and highly motivated student (Swartz, 1997). He studied in Paris and after graduating taught philosophy (Swartz, 1997). In 1955, Bourdieu was conscripted to serve in the Algerian war of independence (Gray, 2004). Following the war, Bourdieu remained in Algeria attending university and commencing his anthropological studies of the displaced traditional Algerian peasants. This early research formed the basis for his first publication *Sociologie de l'Algerie* in 1958 (Swartz, 1997). On returning to France, Bourdieu was appointed Director of Studies at the École Pratique des Hautes Études and later, in 1981, the Chair of Sociology at the Collège de France (Swartz, 1997). He published prolifically on a wide range of subjects including art, writing, education, language, social class, and politics. Bourdieu was a highly regarded academic and an influential researcher.

In addition to the aforementioned philosophical influences of existentialism and structuralism, Bourdieu's social theory is thought to have been heavily influenced by the work of three revered sociologists—Marx, Durkheim, and Weber

(Harker et al., 2003; Swartz, 1997). Although he did not consider himself a Marxist, Bourdieu is reputed to have been heavily influenced by Marx's notions of power and the way that unequal distribution results in class conflict and social inequality. In addition to Marx's influence, Bourdieu drew on both Weber's ideas around the sociology of religion and Durkheim's early work on social interactionism (Swartz, 1997). Bourdieu (1993) acknowledged the contribution made by each of these sociologists, who he referred to as his "predecessors" (p. 10), integrating offerings from each without prescribing fixedly to either.

Key Concepts

The concepts of agency and structure refer to "the relationship between individual action and social structure" (Swartz, 1997, p. 8). Bourdieu opposed the separation of structure from agency. His ontological premise was that human action is motivated by both conscious intention and the influence of society (Bourdieu, 1990a; Swartz, 1997). In order to address this premise, Bourdieu (2020) promoted a way of looking at the world that incorporated both the individual's perceptions and the influence of the societal structures around them. He proposed "a structural theory of practice that connects action to culture, structure and power" (Swartz, 1997, p. 9).

The purpose of any research endeavour guided by Bourdieu is to form an understanding of the social world of interest, Bourdieu referred to this as "construction of the object" (Bourdieu & Wacquant, 1992, p. 224). In order to assist with this act of construction, Bourdieu created what he referred to as 'thinking tools' to enable him to understand the relationship between objective structures and human relationships within these structures (Wacquant, 2018). Bourdieu's foundational 'thinking tools' include the concepts of habitus, field, and capital. Bourdieu was emphatic that these concepts are considered tools put to work in the practical construction of understanding as opposed to theoretical concepts used for mere theorising (Bourdieu & Wacquant, 1992). Application of Bourdieu's tools to research enables the researcher to combine theory with methodology in an applied and practical manner. Each of Bourdieu's foundational concepts will now be explained, commencing with habitus.

Habitus

Bourdieu (2020) purported that social existence manifests in two forms: firstly, in objective structures in "mechanisms and things" and secondly, in subjective structures "in bodies" as the habitus (p. 28). This way of conceptualising the social world enabled Bourdieu to operationalise his rejection of the dualism between

subjectivism and objectivism and the individual and society. The concept of habitus demonstrates that, from Bourdieu's perspective, individuals are socialised beings who are integrated and inseparable from society.

Habitus is expressed as an evolving "system of dispositions" (Bourdieu, 2020, p. 29) generated from past experience. Dispositions of the habitus manifest in every action of being including, but not limited to, patterns of cognition, language, communication, physical action, tastes, and values. Bourdieu (1984) described habitus as functioning "below the level of consciousness and language" (p. 468) guiding action in a practical and productive way. So the habitus is a "present past" (Bourdieu, 1990b, p. 54) in that it shapes the way we perceive and respond to the social world in the future. In appreciating habitus as an "incorporated social" entity (Bourdieu, 2020, p. 29), Bourdieu suggested that those who have shared similar life experiences may have, to a degree, a shared group or class habitus.

When a group has been exposed to similar social influences they likely share common dispositions (Bourdieu, 1977a; Bourdieu, 2020). In the context of this research, health professionals from the same discipline, who have experienced similar social conditions such as education and work experience will have, to some extent, a shared group habitus. This research is conducted with the assumption that health care professionals from various disciplines approach their practice in a way that is, in part, conditioned by the group habitus to which they belong. The group habitus shapes the way the individuals interpret experiences, communicate and interact within the healthcare team.

Habitus, according to Bourdieu (1977a) is a "structuring structure" (p. 72). This means that the dispositions of the habitus generate social action, or what Bourdieu referred to as 'practice'. Furthermore, habitus is generated by practice. In Bourdieu's words, it is a "structured structure" (p. 72). This explains the interdependent and dualistic relationship between practice and habitus. In Bourdieu's 'Theory of Practice', the social space where habitus is structured by practice and, in turn, generates practice, is referred to as the field.

Field

Bourdieu (2020) used the word 'field' to refer to the social context of interest to the researcher. Within any field the agents that inhabit it are located in a social position. Commensurate with the ontological imperative of relationism, an agent's social position in a field can only be considered in relation to the position of others. This position is generated and influenced by the availability of both tangible and intangible resources referred to as capital. Tension and struggles manifest as

agents contest and compete for position (Bourdieu, 2020). In this way, Bourdieu further defined a field as a field of forces and a “space of conflict and competition” (Bourdieu & Wacquant, 1992, p. 17).

The intention of this research is to understand how RN prescribers influence collaborative team practice; therefore, the field of interest is the health care team in which the RN prescriber works. This research seeks to understand the ways in which members of the health care team interact and the social processes at play within each health care team. The three healthcare teams included in the study are considered as three unique fields situated within the broader field of health care in NZ. Health care teams are understood as specialised social spaces bounded and recognisable by their location within the broader context of health care provision in NZ; their specific purpose (delivery of a specific type of health care); inclusion of members from specific professional disciplines who may share a group habitus; and the existence of socially and historically constructed customs and norms.

Doxa

Agents become accustomed to the conditions of the fields they occupy. When the habitus is aligned with the conditions of the field, the agents share what Bourdieu referred to as a doxic understanding. Doxa is a pre-reflexive state informing an appreciation of social position, and shaping the way people react and comply with the rules and norms of a field (Bourdieu & Wacquant, 1992). Bourdieu (1977a) used the concept of doxa to explain the adherence people have to the conditions in which they find themselves and the way in which they take these for granted and accept them as the “natural world” (p. 164).

Capital

Capital refers to the personal resources possessed by agents that determine their ability to succeed in the various cultural fields they inhabit (Bourdieu, 1986). Field and capital are inseparable and interdependent concepts in that, “capital is both what is engendered in the field and what is at stake in the field” (Bourdieu, 2020, pp. 224-225). Capital is field specific, meaning that various forms of capital will be valued in different ways depending on the field being studied. Furthermore, capital will always be distributed unequally. It is this disproportionate distribution of capital that provides the social energy driving agents to compete or, as Bourdieu (2020) suggested, “struggle” to appropriate and maintain their stocks of capital.

Bourdieu identified four different forms of capital: economic, cultural, social, and symbolic. Economic capital “is immediately and directly convertible into money” (Bourdieu, 1986, p. 243) and refers to access to financial wealth and the benefits

that this incurs. Cultural capital exists in three states: institutionalised, objectified, and embodied (Bourdieu, 1986; Swartz, 1997). Institutionalised cultural capital is capital apparent as educational qualifications or credentials such as titles. Objectified cultural capital includes material objects and personal possessions. Finally, embodied cultural capital refers to capital that is incorporated into one's culture. Mannerisms, ways of dressing, taste in fashion or food are all forms of embodied capital. Linguistic capital is an important sub form of embodied cultural capital that is applied in this research. Linguistic capital refers to an individual's communication skills including their use of language and ability to command an audience (Bourdieu & Thompson, 1992).

The third form of capital, social capital, applies to the many potential benefits attained through social connections (Bourdieu, 2020). Depending on the situation, social capital can have a "multiplying effect" (Bourdieu, 2020, p. 228) on all other forms of capital in that social connection increases one's chance of appropriating other resources. Finally, symbolic capital is any form of capital that is recognised or authenticated as being evident and valued by other agents in the field (Bourdieu, 1985). Having symbolic capital equates to being held in high regard and having a prestigious reputation (Bourdieu, 1985). The form and volume of capital possessed influences one's position in the field and their success in the struggle for a favourable position. Bourdieu (1986) associated the possession of capital as holding power, suggesting that capital evokes power.

Symbolic Violence and Misrecognition

Central to Bourdieu's 'Theory of Practice' is the premise that social inequality exists in every field and is generated through the disparate distribution of different forms of capital which can evoke different types of power. Social stratification is, therefore, based on the inequitable possession of capital and the presence of power imbalance. Through this power imbalance a dominant and dominated relationship is revealed and a struggle for position and authority within the field ensues (Bourdieu, 1977a).

Bourdieu (1977a) suggested that an agent's response to power imbalance depends on their situation and whether they are located in an advantaged position (dominant) or a disadvantaged position (dominated). The dominant group seek to maintain the familiar social order by employing symbolic forms of manipulation to assert their authority and social position. This nonphysical form of manipulation is what Bourdieu referred to as symbolic violence. In the words of Bourdieu (2001), symbolic violence is: "a gentle violence, imperceptible and invisible even to its

victims, exerted for the most part through the purely symbolic channels of communication and cognition (more precisely, misrecognition), recognition or even feeling" (pp. 1-2).

Symbolic violence is not recognised by those involved as an intentional harmful act. This deception is achieved through an unconscious form of manipulation, referred to as misrecognition. Misrecognition plays out in situations where an action is not recognised for what it is; instead, it is attributed another meaning. Acts of misrecognition are practical and serve the purpose of making situations appear natural and anticipated or unremarkable. Social inequality, through a Bourdieusian lens, is perpetuated and essentially reproduced through symbolic violence and acts of misrecognition.

Reproduction lies at the heart of Bourdieu's 'Theory of Practice'. Reproduction explains the way hierarchy and social inequality persist in fields with the unconscious acceptance of those who inhabit them. Reproduction results from the competition arising from divergent forms and volumes of capital. Competition and struggle to establish and retain capital results in the perpetuation (reproduction) of the existing social order (Swartz, 1997).

Application of Methodology to Research

In the previous discussion I have explained how in any cultural field people (agents) are positioned in accordance with the type and volume of capital at their disposal. The way people act (practice) in any social field is dependent on the field, the embodied habitus of the occupants, and the distribution of capital in various forms. In summary, Bourdieu's (1984) concepts of habitus, field, and capital combine and interact resulting in practice. The work of the researcher is to reveal the hidden structures (habitus, capital, field) that comprise the social world and produce social action (practice). Bourdieu represented this task in the following equation: [(habitus) (capital)] + field = practice (p. 95).

Application of Bourdieu's 'Theory of Practice' to this research identifies three healthcare teams as fields and, in being such, sites of contested social positions. The research aims to locate the social position of the RN prescribers and other members of the team by identifying the forms of capital that are apparent in each team.

Rationale for Choosing the Methodology

Initial consideration was given to using case study as the methodological approach to answer this research question. Case study offers a framework for

conducting research concerning complex social phenomena within a given context (Yin, 2014). I considered adopting a multiple case study design, including several teams, as a way of understanding how RN prescribers work within the context of the teams. Yin (2014) suggested that when engaging in case study research the researcher identifies a theoretical lens to assist with conceptualising the case. To align with my personal values and my question, I sought a critical approach that accepts power is intrinsic and disparately distributed in all social arenas.

Initially, I considered applying Bhaskar's 'critical realism' as a theoretical framework. Bhaskar's philosophical approach enables exploration of the mechanisms that generate human behaviour by considering the dialectal relationship between human agency and social structure (Bhaskar, 2008). Next, I considered Bourdieu's 'Theory of Practice'. Bourdieu's theoretical concepts have been widely applied in health care research. Following careful consideration, I decided that Bourdieu's theoretical concepts were the best fit for answering my research question. Early on I proposed using case study as the research approach with Bourdieu's Theory of Practice as the theoretical lens. Following further consideration and the advice of my supervisors, I came to the realisation that Bourdieu's conceptual tools offer both the theoretical lens and practical framework as a methodology to answer the research question.

Bourdieu's 'Theory of Practice' provides an approach to explore team practice by combining both the subjective experience and perceptions of individual members of the team with the organisational structures of the health care team. The 'Theory of Practice' was generated by Bourdieu through use in research with the specific intent of being used practically to conduct research. Bourdieu (2020) emphasised that his conceptual tools be operationalised practically to guide research rather than being restricted to mere abstract theorising. Because they are grounded in research, Bourdieu's conceptual tools provide a blueprint on which to conduct research.

Summary

This chapter has outlined the transformative paradigm that the research is conducted in; as well as outlining the epistemological, ontological, and axiological underpinnings. The methodological approach of Bourdieu's 'Theory of Practice' has been outlined including the central theoretical concepts. The following chapter will describe the methods or practical steps taken and techniques utilised to conduct the research.

Chapter Four: Methods

The previous chapter addressed the paradigmatic, epistemological, and ontological assumptions informing this research. Bourdieu's 'Theory of Practice' was explicated as the methodological and theoretical approach guiding the study. This chapter outlines the research methods employed to conduct the research. The chapter begins with an explanation of how ethical and cultural considerations were addressed. Next, the recruitment process is explained, along with how data collection and data analysis were undertaken. Finally, the processes used to establish rigour throughout the research are explained.

Admission to Doctoral Degree

In accordance with AUT's academic policy, I completed a full research proposal early in my enrolment at the university. My candidature in the Doctor of Health Science was confirmed in March 2018.

Ethical Approval

Ethical approval to conduct this research was granted by the Auckland University of Technology Ethics Committee (AUTEC). Following the initial application AUTEC approved the application subject to minor amendments to the participant information letters, observation recruitment process and protocol, recruitment advertisement, and researcher safety protocol (see Appendix A). The requested amendments were made, or justification given for variance, and final ethical approval was granted on March 23, 2018 (see Appendix B)

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Te Tiriti o Waitangi

Ti Tiriti o Waitangi represents Aotearoa New Zealand's founding constitutional document. Ti Tiriti o Waitangi is an agreement between the NZ government and Māori to ensure the responsibility of the Crown to protect Māori, their rights to their ancestral lands, resources, and way of life. As a researcher, I have respected my responsibilities to Ti Tiriti o Waitangi and upheld my obligation to ensure all aspects of this study are responsive to Māori. Although this research was not specifically focused on Māori, the purposive sampling technique employed meant that participants may potentially have identified as such. Prior to gaining ethical approval I met with Annette Finlay a Māori registered nurse and Chair of Ropu Kawa Whakaruruhau Ara. I sought Annette's guidance in relation to meeting

the cultural needs of any potential Māori participants. Annette emphasised the relevance of this research for Māori health, provided advice, and offered to provide continued support and guidance should this be required. A letter of support from Annette Finlay is included in Appendix C. Annette also introduced me to a Māori pharmacist with whom I consulted. Following this consultation process, I ensured that the three principles of Te Tiriti o Waitangi—partnership, participation, protection—were considered in all stages of the research process. Ethnicity data were not collected from any of the participants recruited into this study. None of the participants voluntarily offered ethnicity information and none self-identified as Māori.

The Method

Inclusion Criteria: Identifying the Field

Bourdieu (2020) used the term ‘field’ to refer to the social space or context in which the research is set. In this study, the field is the health care team in which designated RN prescribers practise. The NCNZ (2014) stipulate the two overarching clinical areas where designated RN prescribers can practise: primary health and specialty practice. The NCNZ’s regulations also require the RN prescriber to work in a collaborative team. Therefore, I chose to recruit RN prescribers and members of their respective teams from each of these two clinical areas.

The decision to recruit both a primary health care team and a speciality practice team was intended to reflect the diverse clinical contexts in which RN prescribers practise. It was expected that the makeup of the teams, the relationships and positioning of individuals, would differ and that the type of team (primary health or specialty practice) would have a profound influence on the positioning of the RN prescriber. In keeping with Bourdieu’s methodological approach, this research focused on the relationships between members of the health care team and the social processes at play rather than on the individuals themselves.

A purposive sampling technique was used to identify the initial two clinical areas in which to conduct the research. Purposive sampling allows the researcher to gather data from sources they believe will be most enlightening to the task of answering the research question (Campbell et al., 2020). Representation was sought from both primary health care and specialty practice. Aside from the requirement for one practice setting to be primary health and the other specialty practice, the only inclusion criterion for practice setting eligibility in this study was:

- That the practice employed at least one NCNZ approved designated RN prescriber.

The inclusion criteria for participants who were invited to participate were as follows:

- At least one participant was a NCNZ approved designated RN prescriber.
- Other participants recruited into the research were members of the healthcare team identified as working with the RN prescriber and whose practise was influenced by the participation of a RN prescriber.

Recruitment of Participants

For reasons of geographical, time, and economic convenience, participants were recruited from three clinical areas within the same geographical region. Prior to recruitment I applied to the two broad health care provider organisations for permission to conduct research (locality authorisation) with health care teams included in their jurisdiction. In NZ there are 20 DHBs that are responsible for both the funding and provision of health care services in their district. Primary Health Organisations (PHO) are responsible for the provision of primary health care and are funded by DHBs. Formal locality authorisation was granted by both the DHB (Appendix D) and the PHO (Appendix E) where the participants were employed.

Locality authorisation was requested from the local DHB research office prior to recruiting the specialty practice team, which was labelled team three. The research office required me to ask the Director of Nursing (DON) of the hospital to send out information letters to RN prescribers employed there. The information letter for RN prescribers is included in Appendix F. This process differed slightly from what was proposed in the ethics application which suggested the researcher would ask the DON for the name of the clinical areas where RN prescribers were employed and would then contact these nurses using personal networks or contact details available in the public domain. Whilst the process differed from what was proposed, the nurses' confidentiality was maintained and I was not provided with any contact details. The risk of the nurses feeling any pressure to participate or coercion on the part of the DON was mitigated as their role was limited to simply forwarding the research information letter by email and the DON was not informed of who consented to be involved in the research. Four letters were sent by email and potential participants were asked to contact me in person if they wished to be involved.

One RN working in a speciality area responded by email within a day of receiving this letter. This was the only response received from the four letters that were delivered. At this point, a second sampling strategy of snowballing was

applied. Following the first interview, this RN prescriber returned to their workplace with the recruitment advertisement (Appendix G) and healthcare team information letters (Appendix H). The RN prescriber later emailed me with the email addresses of two potential participants who had identified their preference to be contacted directly by the researcher—both consented to take part in the research. The other two participants contacted me directly agreeing to participate. The following five participants were recruited in the speciality practice team:

- One designated RN prescriber
- Two medical consultants
- One non-prescribing RN
- One pharmacist

Locality authorisation was received from the PHO several weeks after receiving authorisation from the DHB. I was previously acquainted with a RN prescriber working in general practice and emailed them using an email address available in the public domain. This nurse responded by email within a day of receiving the information letter and subsequently agreed to participate in the study. Following the interview this participant returned to their workplace with information letters which were distributed to other members of the team. This action culminated in another member of this team immediately making contact with me and offering to participate in the research. The RN prescriber later provided me with the email addresses of several other members of the team who were interested in being involved and had requested to be contacted directly. Only one potential participant was emailed an information letter and did not respond. The following five participants were recruited in this primary health team which is referred to as team one:

- One designated RN prescriber
- Two GPs
- One non-prescribing RN
- One pharmacist

My original intention was to recruit just two teams; however, a third primary health team, referred to as team two, was recruited following discussion with my research supervisors. As discussed in the next section, prior to the commencement of data collection a trial interview was conducted with a NP employed in a primary health team. At this point it became evident that the inclusion of a team including a NP as an authorised prescriber would add a unique perspective and richness to the data. Following consultation with AUTEC, the NP was asked to re-sign her original

consent form notifying of her consent to include her trial interview in the research. The second general practice team was situated under the same PHO as the first and so no further locality authorisation was required. I emailed the RN prescriber working in this team using an email address available in the public domain. This nurse responded by email within a day of receiving the information letter and subsequently agreed to participate in the study. Following this interview, information letters were distributed around the team and the following five participants were recruited into the study:

- One designated RN prescriber
- One NP
- One GP
- One non-prescribing RN
- One pharmacist

Data Collection

Bourdieu recommended that the methods of data collection employed when conducting research should be selected based on both theoretical and methodological requirements (Bourdieu & Wacquant, 1992). In his own research Bourdieu was known to use both qualitative and quantitative techniques to collect data. He rejected rule bound approaches to conducting research, instead promoting the use of any technique that is practical and provides compelling evidence (Griller, 1996). The qualitative strategies of in-depth individual interviews and observation were used to collect data in this study. I abandoned an initial plan to conduct focus groups due to the challenges of bringing busy health care teams together at one time. Following the initial interviews, I had gathered a significant amount of rich data and focus group questions were not required.

Interviews.

In depth semi-structured face to face interviews were selected as the main strategy for collecting data. Interviews enable the researcher access to rich detail providing authentic insight into the meaning participants attach to experiences and social processes (Edwards & Holland, 2020). An interview schedule (Appendix I) was utilised, informed by the literature review and Bourdieu's theoretical concepts. Consistent with the relational ontological approach, the research questions were designed with the intent of uncovering the participants' experiences as they relate to the team (field). As illustrated in the following questions, the intention was to explore the meaning of the participants' interactions both with other members of the team and with the objective or organisational structures influencing the team.

- How does your role interface with the role of the RN prescriber?
- In terms of your work place and the team you work with, are there any factors that you have found particularly beneficial or constraining in terms of your prescribing practice? Can you tell me about them.

The questions on the interview schedule were open ended exploring broad topics to focus the participants and achieve consistency. In order to enable spontaneity, I adopted a flexible and reflective approach during interviews asking follow-up questions and probing into areas requiring clarification or more depth. Each interview was audio recorded.

Prior to commencing data collection, a practice interview was conducted in order to evaluate the interview schedule. I interviewed a NP who works with a RN prescriber and who consented to be interviewed. This interview was conducted under the same conditions as the final interviews and was recorded and transcribed. Following feedback from the research supervisors minor changes were made to the interview schedule to include additional topics and to adjust the wording of questions to aid in clarity.

All of the individual interviews were conducted at the initial meeting after the participant had the opportunity to ask questions and had signed the consent form (Appendix J). Participants were offered the choice of where they would like the interview to occur, and the majority chose to be interviewed in a private office at my workplace. A small number of interviews were conducted in a private office in the participant's workplace and one interview was conducted in the participant's home. I ensured my safety, when conducting this interview, by adhering to the procedures outlined in the researcher safety protocol (Appendix K). Individual interviews ranged in length from 15 minutes to 1 hour and 5 minutes. I wrote field notes shortly after each interview recording initial thoughts and observations. All of the recorded interviews were transcribed by a transcriptionist who had previously signed a confidentiality agreement (Appendix L).

Pseudonyms were allocated within the thesis to protect the identity of the participants. At the time this research was conducted, there were only a small number of RN prescribers practising in New Zealand. Therefore, any potentially identifying information relating to workplace, clinical area, and individuals has been changed within the thesis to minimise the risk of identification.

Observation of team meetings.

Bourdieu asserted that in order to fully appreciate the relational context of a field the researcher needs to observe what occurs in the field. This is because individuals are not necessarily aware of what drives their actions and/or they may

not be able to adequately explain their motivations (Bourdieu & Wacquant, 1992). Prior to commencing the research, I anticipated that each collaborative team would have regular team meetings that could be observed enabling an opportunity to see how health professionals interact in practice. However, following the interviews, it became apparent that regular meetings only occurred in team three. Two meeting observations were conducted in team three. The first was between the RN prescriber and a medical consultant; the second observation I conducted was a peer review meeting including all members of the specialty practice team. The observation protocol was informed by the literature review and by Bourdieu's concepts of habitus, capital, and field (Appendix M).

Patton's (2002) five dimensions of observational fieldwork were used to plan the observations. Each of Patton's five stages is outlined in Table 2, along with the parameters selected to guide the observation.

Table 2

The parameters informing team meeting observations

Patton's Dimensions	Researcher's Parameters for Observation
1. Role of the observer	Onlooker
2. Insider versus outsider perspective	Outsider
3. Who conducts the inquiry	The primary researcher
4. Disclosure of the observer's role to others	All participants were made fully aware that they were being observed
5. Duration of observations and fieldwork	Observation occurred for the duration of the team meetings only
6. Focus of observations	Activities and interactions between health care professionals that occur in relation to RN prescribing practice

(Patton, 2002, p. 277)

Both team observations occurred after the individual interviews which meant the participants were already acquainted with me. Prior to both observations taking place, information letters (see Appendix N) were provided and informed consent obtained from every person present in the meetings. The consent form for observations is included in Appendix O. Observations during the team meetings were made about the physical environment, people present, the agenda of the meeting, as well as what people said and the way they interacted. The meetings

were not recorded; rather, I used a field journal to write brief but comprehensive notes at the time of observation and extended on these after leaving the meeting. I also created a hand drawn sociogram during each meeting. A sociogram is a mapping tool that enables the researcher to illustrate patterns of communication in real time (Tubaro et al., 2016). Each sociogram indicated the direction of communication with lines and arrows drawn between the initiator and recipient of each conversation.

Data Analysis

Data were analysed using Bourdieu's (1997a) 'Theory of Practice' as the theoretical framework to interpret the meaning of the data and Braun and Clarke's (2006) model of reflexive thematic analysis (TA) as the analytic method used to engage with the data. When combined, these approaches offered a comprehensive approach to data analysis enabling rich and nuanced interpretation, coupled with an auditable and trustworthy analytic process.

Data analysis, informed by Bourdieu's 'Theory of Practice', is conducted by exploring the layers of interaction between the foundational principles of habitus, field, and capital (Bourdieu & Wacquant, 1992; Grenfell & Lebaron, 2014; Swartz, 1997). Bourdieu's 'Theory of Practice' and conceptual tools have been explained in detail in the previous chapter. Rather than offering techniques or processes for data analysis, Bourdieu offered a three-stage process whereby the researcher applies the aforementioned conceptual tools.

The first stage requires the researcher to "analyse the position of the field vis-à-vis the field of power" (Bourdieu & Wacquant, 1992, p. 104). This process of field analysis operationalises Bourdieu's belief that a social field does not exist alone but is influenced by layers of power each having a compounding effect on social conditions. The second stage is to "map out the objective structure of the relations between the positions occupied by the agents or institutions who compete for the legitimate form of specific authority of which this field in [*sic*] the site" (Bourdieu & Wacquant, 1992, p. 105). In this stage, the researcher locates the participants in terms of their positions of power and influence in relation to the position of others within the field (Grenfell, 2014). The third and final stage is to analyse the habitus of the individuals within the field (Bourdieu & Wacquant, 1992).

Bourdieu's three stages fundamentally informed the way I interpreted the data. However, in addition to this theoretical guidance, I sought a way of practically engaging with the data. TA is a popular analytic approach applied in qualitative

research; however, Braun and Clarke's (2006) reflexive model is unique and was selected for the following reasons.

- Reflexive TA is "theoretically flexible" (Clarke & Braun, 2018, p. 109); it does not come with a predetermined theory thereby enabling the researcher the opportunity to combine the approach with an independent theoretical framework. Reflexive TA can be used to guide both inductive and deductive analytic processes (Braun & Clarke, 2020). Deductive TA enabled me to use Bourdieu's 'Theory of Practice' as the theoretical lens through which to interpret the data.
- Reflexive TA, as the name suggests, demands researcher subjectivity requiring the researcher to be consciously involved and located in the research (Braun & Clarke, 2020). The imperative of researcher subjectivity requires the researcher to reflect on their role in the research process. This is synergistic with Bourdieu's requirement for the researcher to address the power differentials both between participants and between the participants and the researcher (Clarke & Braun, 2018). The combined approaches offer synergistic mechanisms to prevent the researcher unintentionally placing themselves in a position of power over the research process and the participants.
- Reflexive TA provides systematic guidance in the form of an auditable process. Braun and Clarke (2006) suggested a flexible six step approach to data analysis: data familiarisation; data coding; generating themes; reviewing themes; defining and naming themes; and, finally, writing up the thematic analysis.

Data Analysis Strategy.

A two staged practical strategy for data analysis was developed and is illustrated in Figure 2. The first stage includes Bourdieu's field analysis. The second stage incorporates Braun and Clarke's six step reflexive thematic analysis model with Bourdieu's 'Theory of Practice' as theoretical lens.

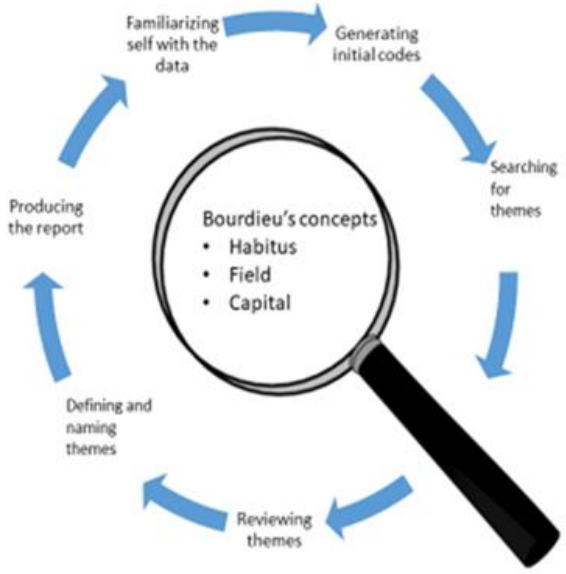
Stage One - Bourdieu's Field Analysis.

Both internal and external field analyses were performed in order to identify characteristics pertinent to each individual health care team as well as the external forces that influence each team. Internal field analysis begins with a descriptive account, providing context in order to assist with potential transferability of the findings. This process identified the characteristics of each health care team

including the type of care provided, the size, and professional make-up of the team, and funding/ governance of each team. An analysis of social topography follows determining the key members of the team who work with the RN prescriber and the type and volume of capital each member possesses. External analysis provided an understanding of where each health care team sat in relation to the broader field of power. Discussion of the external socio political, professional, and economic variables that dominate and indirectly influence the members of each health care team was included.

Figure 2

Two stage strategy of data analysis, using Braun and Clarke's model of thematic analysis and Bourdieu's 'Theory of Practice' as theoretical lens



Stage Two - Reflexive Thematic Analysis Applying Bourdieu's Conceptual Thinking Tools.

1. Data familiarisation. The first step in the process involved listening to the interview recordings to check the transcripts for accuracy. Corrections were made to incorrectly transcribed passages and notes added to explain nuances not detected by the transcriptionist such as body language and facial expression. At this point I wrote brief notes in the transcripts as I discovered aspects that stood out and interested me, and as I recognised patterns in the interviews.
2. Data coding. This stage involved repeatedly reading the transcripts, my meeting observation notes, and listening to the recordings. Patterns of

shared meaning were recorded as codes as they became apparent. I identified codes initially as single words, for example “trust” and “knowledge” and later, as my thinking developed, phrases such as “keeping others informed” and “patient ownership”. I highlighted aspects of data that resonated with Bourdieu’s conceptual tools, aligning codes with concepts; for example, the code of knowledge was aligned with cultural capital and trust with social capital. This was an iterative and evolving process. I returned to review previously coded transcripts as my list of codes developed.

3. Generating themes. At this stage I began to cluster the previously identified codes together into provisional themes. Braun and Clarke (2006) operationally define a theme as a “central organizing concept” (p. 108). Themes were actively produced, requiring me to think deeply and engage with the data looking for understanding beyond the superficial ‘taken for granted’ meaning presented in the data.
4. Reviewing themes. The themes were repeatedly reviewed over time to ensure they adequately reflected the coded data, resonated with Bourdieu’s conceptual tools, and addressed the research question.
5. Defining and naming themes. Three key themes were identified which, together, addressed the research question. In each team, sub themes were identified. Each theme and sub theme was described and supporting evidence provided in the form of excerpts from the participants interviews.
6. Writing up the TA. The TA is presented in the form of three findings chapters in this thesis. Each of these chapters tells the story of the respective team, the story is arranged according to the themes with excerpts from the interviews and observation notes for support and clarification. The final discussion chapter revisits each theme, providing a synopsis of the commonalities and differences between the three teams.

Researcher Reflexivity

In keeping with Bourdieu’s invitation for epistemic reflexivity and the call of reflexive TA to honour researcher subjectivity, I kept a reflective journal which commenced early in the planning stages of the research and was maintained throughout the process. In this journal I reflected on my own experiences as a RN, a nurse educator, and a researcher. I recorded field notes after participant interviews and observations. Journaling helped me to appreciate the impact my own experiences and position in the world have on the research process, including both data collection and analysis. Following is an extract from my reflexive journal:

> *As a nurse I identified easily with what the nurses I interviewed had to say. I felt immediately comfortable in their presence, I recognised the language they used, their sense of humour etc. When I reflect on the transcripts from interviews conducted with the nurses I sense a connection and atmosphere of comfort. Conversely, when I reflect on the interviews conducted with the doctors and the pharmacists, I note my conduct to be more stilted and awkward. I recall during these interviews feeling unjustified and uncomfortable for interrupting their working day. This was reflected in the transcripts with comments apologising for taking their time. None of this was apparent to me until after I reflected on the process. I see now that I hold the space of both researcher and nurse, I in fact share the habitus of those I am observing, in Bourdieu's words I was an "observer of a game I was still playing" (Bourdieu & Wacquant, 1992, p. 254).*

Reflexivity, in the form of journaling, offered me an opportunity to better understand my relationship with the research. Journaling enabled me to identify formative experiences in my own professional journey that have contributed to the generation of my habitus. As a result of this reflection, I better understand why I was drawn to conduct this research and appreciate the impact my habitus may have on the research processes and on the participants. Reflexive journaling has kept me focused on the participants' experiences, rather than my own; and, in doing so, enabled me to authentically answer the research question.

Trustworthiness of the Data

The trustworthiness of the data collection and analysis processes employed in this study is presented in Table 3 using Lincoln and Guba's (1985) framework for establishing rigour in qualitative research.

Summary

This chapter has outlined the practical approach undertaken to conduct the research, justifying the methods in relation to Bourdieu's methodological position. Three diverse health care teams, all including a RN prescriber, were recruited using purposive sampling. Individual participants were recruited using a snowballing technique following consent processes approved by AUTEC. Data were collected predominantly by individual interview and observation of team meetings when possible. A two staged data analysis protocol was developed incorporating both reflexive thematic analysis as a practical strategy for identifying themes and Bourdieu's 'theory of practice' as the theoretical lens. The following chapters present the research findings and interpretations.

Table 3

Trustworthiness of data collection and analysis

Criteria and Definition	Ways in Which Criteria are Addressed in the Study
Credibility: The findings of the research are an accurate representation of what the participants have shared	The research project received ethical approval from AUTEC prior to commencement and adhered to the agreed protocol as set out in the approved application. Data were collected by interview and observation (when possible) allowing a degree of data triangulation. Excerpts from the participants' transcripts were included in the write up enabling the reader to align the participants' words with my interpretation. I demonstrated methodological congruence between Bourdieu's theoretical framework and Braun and Clarke's model of reflexive TA by being transparent and detailed in my account of the way the data were analysed.
Dependability: Consistency of the findings with the data collected	I kept a journal including all research protocols, and a record of the coding process and theme development. My three research supervisors (all experienced researchers with doctoral degrees) audited the research process and a sample of data analysis providing regular peer review.
Transferability: Demonstrating that the findings may be able to be applied in another context	I provided detailed description of the health care contexts in which the research took place enabling the reader to make an informed decision regarding the extent to which the findings can be applied in another context. Purposive sampling was used to select three health care teams to include in the study based on variety in terms of health care context and health care team membership. This was done to optimise the application of the research findings to other settings. A traceable audit trail was maintained throughout the research process in the form of a research journal. Documentation in this journal included decision making and supervision discussions.
Confirmability: The findings are informed by the participants and not biased by the researcher	Bourdieu and Braun and Clarke's imperative of maintaining researcher reflexivity was adhered to. I maintained a reflexive journal throughout the research process, reflecting on both my sense of social positioning as a RN and as a researcher, as well as my epistemological assumptions.

(Amankwaa, 2016; Lainson et al., 2019; Lincoln & Guba, 1985; Merriam & Tisdell, 2015)

Chapter Five: Team One Findings

The purpose of this chapter, and the two that follow, is to present the findings from the three teams included in this study, along with my interpretations of these findings. These chapters explore the way that the RN prescribers work within their respective teams and interact with other members of the health care team. Each chapter extends on the brief introduction to the teams that was provided in chapter four. Chapters five, six, and seven begin with a brief introduction to the team including characteristics of the health care service provided, the size and makeup of the team, as well as the governance and funding structure.

The following findings chapters present the three overarching themes common to all teams. The first relates to the social topography of the team. This theme highlights the position of each member of the team related to the topographical position of other team members. The second overarching theme, working with a RN prescriber, addresses the participants' perspectives of working with a RN prescriber. The final theme, patterns of communication, addresses team specific communication. Within each team, sub themes pertinent to the specific team are presented. Figure 3, presents the themes and sub themes for team one.

Figure 3

Themes and subthemes for team one

Social Topography	Working with a RN Prescriber	Patterns of Communication
•RN prescriber •GPs •RN practice nurses	•Threatened professional autonomy: Chipping away at GP practice •Conceding aspects of care: Paraphernalia, protocols, and practicalities •Misrecognition and symbolic domination	•Establishing trust •Discretion and diplomacy: Minding your Ps and Qs

Team One – Privately Owned General Practice

Overview of the Team

This health care team (field) is situated in an urban general practice. Operating as a private health care centre, this practice falls under the umbrella of a broader field or PHO and provides primary health care services. The practice is owned by a group of GPs, some of whom work as GP partners within the practice.

In addition to the GP owners, the practice employs associate GPs, practice nurses, and a practice manager. At the time this study was conducted, the team included up to 15 GPs and an undetermined number of practice nurses including a RN endorsed by NCNZ to prescribe in diabetes. The team has expanded in recent years in response to a growing population, and is currently located across two geographical sites. All the GPs and nurses rotate working across both practice sites. In addition, a community pharmacist who regularly engages with the practice and is based at a pharmacy nearby was interviewed to gain their perspective on RN prescribing.

The general practice from which team one operates was first established in the early 1970s. Many of the GPs, both past and present, have worked in the practice for up to four decades. This model of GP owned and operated primary healthcare resembles the traditional model of general practice in NZ. This traditional model reflects a biomedical approach characterised by GPs as the primary health care provider assisted by practice nurses.

Social Topography

The health care disciplines involved in patient care on a daily basis are the RN prescriber, GPs, and RNs. Following is an account of the roles, responsibilities, and social position of each member of the team, as perceived by the participants.

RN Prescriber

At the time this research was conducted, Alice had been employed in the practice for six years and had been approved by the NCNZ to prescribe in the area of diabetes for one year. As the “diabetes nurse” in the practice, she runs a diabetes clinic one day a week, and on three other days works as a practice nurse. Alice’s role within the practice has not changed since she gained designated prescribing authority. What has changed is that Alice prescribes medications to patients both in the diabetes clinic and when working as a practice nurse.

Alice’s academic pathway leading to prescribing authority differs to the other RN prescribers included in this study in that she holds a postgraduate certificate rather than a postgraduate diploma or master’s degree. Alice conveyed a passion for learning; she started out by completing graduate level courses in diabetes before moving on to enrol in postgraduate study. During her first year of postgraduate study, Alice learned of the potential to become a RN prescriber. She completed her health assessment and pharmacology papers followed by a prescribing practicum. Alice is now a designated RN prescriber in diabetes, meaning that the medications she has authority to prescribe are limited to diabetes and cardiovascular medications from the medicines list for RN prescribers.

Alice was one of the first RN prescribers in the city. In the following quote she reflects on the process of becoming a prescriber.

> *I have to say that being a nurse prescriber you have to be very self-motivated. I don't think there's anyone going to come to you and say "you'd be an amazing nurse prescriber, I really think you should think about this journey". You've really got to look for it yourself, you've got to get your support on board with your practice, your own supervisor. Yeah it's not all set in black and white.* (RN prescriber [RNP] 1)

The GPs Alice works with had no previous experience of working with nurses in advanced practice roles and, subsequently, had no prior knowledge of what this would entail. In order to pursue this pathway, Alice had to actively promote the role.

> *I'd asked for their assistance and consent for me to go ahead and do the study and their support. It was a matter of me, advocating for that role. The GPs would have no idea that this was even something that was available without the nurse highlighting this is a pathway that's possible. It was kind of like, just falling into it, not in a bad way but it was just sort of evolving all the time.* (RNP 1)

Alice introduced the idea of becoming a designated RN prescriber to the GP employers and the practice manager. She explains how she had to drive the project herself:

> *You work a wee bit in isolation. The setting up of the whole thing has been in isolation. Writing the policies, you know saying, this is how it's going to work, you have to be the person doing that. There's no manager sitting in her office writing this for you, it's got to come from you.* (RNP 1)

There was no strategic process or plan within the practice to introduce a RN prescribing role within the team. As Alice explained, "*the role had to be made up*".

The GPs

The two GPs interviewed in this team have been practising for more than 30 years. Peter is a partner in the business and Roger describes himself as an "associate". Alice (RN prescriber) describes a "*line of command*" amongst the doctors in the practice with the GP partners in the top position followed by the associates. The GPs refer to themselves as "independent practitioners" and as clinical leaders. Patients are enrolled in the practice under a GP, as their chosen primary healthcare provider, and this GP assumes overall responsibility for patient care. The GPs refer to the patients enrolled under their name as "my patients" suggesting they perceive this as a proprietary relationship.

As previously discussed, this practice is GP owned and led, which manifests in a stratified relationship. Some of the GPs are the employers, and all of the nurses

and some GPs are employees. This dynamic impacts the relationships between team members. The GP shareholders, and other GPs by association, are credited with symbolic capital in the form of recognised authority over the team. This is illustrated in the following excerpt from Ann's (RN) interview when she suggests that the GPs demand automatic respect as her employer.

> *What's interesting about primary care is that we're working shoulder to shoulder with the people who pay us! Which is quite different to the hospital model. So these are our employers, but also our colleagues you know so there's a really interesting dynamic at play. Because you really want to treat your employer with a lot of respect, you know! So for me I find that puts them, into a hierarchical position.* (RN 1)

Peter (GP owner) denies the existence of a social hierarchy in the team. Like Ann, he compares the primary care model to hospital. Peter's opinion differs to Ann's, in that he considers a hierarchical model is more common in the hospital setting. In the following quote Peter talks about the impact of hospital doctors coming to work in general practice.

> *They bring the hierarchy with them. And they will often cause problems and conflicts by the way they talk to the nurses or the receptionists. Like directional hierarchy. And, you become aware then of the difference that we normally operate compared with that. But I think 90% of us don't have that. You know we don't have a hierarchy. We have a collaboration we work as equal members in the team. Just we have slightly different roles, we all have morning tea together, we all talk about what we do on the weekend.* (GP B1)

Peter appreciates that hierarchy is an attitude engrained in individuals, as opposed to an organisational approach. This is reflected again in the following quote; this time in reference to practice nurses.

> *Sometimes it's the other way around, it's the way that the other person sees themselves. And particularly some of the older nurses, you know who will sometimes call me "doctor". I think oh for god's sake you don't need to do that. But, it's sort of where they've come from and their background. Some people I think feel safe in that. You know if, if you feel you're part of a hierarchy and you're not at the top, then you don't actually have to take full responsibility for it.* (GP B1)

Roger (associate GP) has a different appreciation of hierarchy to Peter's. Roger suggests that hierarchy is apparent in the work people do and the way work is allocated. In the following excerpt, he refers to the historic hierarchical order whereby practice nurses worked in a subordinate position to GPs, and suggests in some practices this still occurs.

> *You'd think eventually it would go away but, when the doctor is the employer sometimes that's the critical thing isn't it? They want a nurse who, somehow, the handmaiden position you know.* (GP A1)

In reference to team one, Roger suggests the historic hierarchy characterised by the practice nurse as handmaiden is "evolving". He compares the RN prescriber's position to that of the GPs suggesting with time her position may change.

> *If you've got a skilled nurse who's in a place for a while she will have her own position. If Alice [RN prescriber] was there another five years, she's very capable you know, she would be, you know, in the hierarchy, she'd be sort of separate from the doctors but when it comes to diabetes she'd be, she might be above the doctors. Currently I suppose the hierarchy is that we use Alice as somebody to assist us.* (GP A1)

Roger appreciates the potential for change in the future; however, as he indicates, currently the RN prescriber's role is to assist the GPs. Both of the GPs explain that they work "very closely" with the practice nurses.

RN Practice Nurses

All of the nurses employed in the practice, including the RN prescriber, are referred to as "practice nurses". As highlighted below the nurses work collectively for the practice.

> *In our practice, we nurses work for all the doctors. So we tend to see whoever. So we'll be on with a set of GPs each day and you see the patients under their care. And we would take phone calls for the patients in our building.* (RN 1)

Regardless of whether the GP is a partner or an employee, the nurses consider themselves as working "for" the doctors. Every day there are three or four practice nurses rostered to work across each of the two practice sites. The nurses speak of working "on the floor" which means they congregate in a centrally located shared nursing office and are readily available to the GPs to assist as requested. The nurses' contribution to patient care is largely directed by the GPs. In the following quote, Peter explains the way in which the work of the practice nurses is completed 'alongside', 'before', or 'after' a GP.

> *We work very closely with the nurses. The nurses will often see patients, at the time and in conjunction with when we're seeing them or consecutively. You know like if they come to see us and there's something to be done. Whether it's blood taken or some procedure or some dressing or some other aspect. Then we communicate with them and they will deal with that. Sometimes the nurse, will see the patient before us. And do some procedures, if someone comes in for something, say an accident or*

> *something of that nature they will take the dressing down or they will have a look at, what the problem is and then they will do the obs and take the notes and then come and grab one of us.* (GP B1)

The nurses' work frequently involves completing assessments on behalf of the GP to inform their clinical decisions or administering a directed treatment. The practice nurse's role is referred to by the GPs as being "general" and they perform a range of "routine" practical duties often referred to as "skills" or "procedures".

Peter perceives the role of the practice nurse in team one to have changed over recent years enabling the nurses more responsibility. The following quote suggests that as opposed to working "on the floor" and completing tasks and procedures assigned in an impromptu fashion by a GP, having a dedicated list of patients represents a more advanced and autonomous position.

> *Nurses have their own lists. …So they're actually seeing, patients. And their role has expanded, considerably really in the last, probably 5 years or so. So they've ended up doing a number of other things autonomously that we never see. They're doing technical things, ECGs, spirometry, sleep studies, well child checks. Giving intravenous phosphonates for osteoporosis. They're giving intravenous iron infusions and they take responsibility for that. And really coordinate it so they're acting as practitioners in their own right.* (GP B1)

The "technical things" Peter alludes to represent tasks assigned to the nurses by the GPs. For Peter, the reorganisation of the way tasks and time are allocated into "nurse's lists" suggests that the nurses' work is now more self-directed and autonomous. In addition to the nurse's list, nurses with more experience and perceived knowledge (cultural capital) in chronic obstructive pulmonary disease (COPD) and diabetes are given what one of the GPs referred to as a "portfolio" which equates to more responsibility than those who work "on the floor".

Summary of Social Topography

The social positions occupied by each member of the team have been described in relation to the positions occupied by other members of the team. Social position in team one is dependent, as it is in any field, on the resources (capital) at their disposal. The portfolio of capital held by the GPs and the nurses (including the RN prescriber) differ, both in the type and volume of capital held.

The first form of capital that is valued and distributed disparately in team one is cultural capital. The GP qualification, and the knowledge and skill it represents, is collectively recognised in the team as more valuable than the qualifications, knowledge, or skill of any other member of the team. The GPs' cultural capital manifests as institutionalised cultural capital in that it is guaranteed to the individual

when awarded the qualification. Bourdieu (1986) referred to institutionalised cultural capital as “collective magic” (p. 248), in that the power it evokes is unconditionally accepted and guaranteed.

The second form of capital noted as a salient resource influencing social position in team one is economic capital. The GPs who have a financial investment in the practice stand to make monetary profit from it, earning them economic capital. Whilst not all the GPs have a financial interest in the business, it appears all GPs are credited with economic capital by association. None of the nurses share ownership in the business, and as employees this form of economic capital is not available to them. The disparity in economic capital produces an obvious power imbalance, with the GPs as employers and the nurses as employees.

The third and final form of capital evident is symbolic capital. The GPs hold a monopoly over this form of capital. Symbolic capital arises as an aggregate of all other types of capital and from the recognition the team have of the GPs’ authoritative positions. The GPs have inherited symbolic capital, in that the role has been awarded symbolic value as a legacy of history. As bearers of symbolic capital, each GP has their own patients and their own office; they work autonomously, choosing how they work and who they will work with. In contrast, the practice nurses have considerably less capital; they work in a collective and dependent manner, reliant on the GPs to assign responsibility.

Exploration of the distribution of capital in team one demonstrates a relationship between the capital possessed by the GPs and nurses and the degree of autonomy they have over their work. Those with the greater wealth of all forms of capital are more self-determining than those with lesser capital. The professional roles and responsibilities of the two groups are polarised by their disciplinary classification and their possession of capital. This polarisation is ‘taken for granted’ and determines the social stratification of the team, in turn determining the opportunities and limitations experienced by members of the team.

Bourdieu (1986) asserted that capital evokes power. The apparent inequitable distribution of capital in team one represents a power differential, a dominant group of GPs and a dominated group of practice nurses. The social order grounded in the GPs holding a dominant position and the practice nurses and RN prescriber as dominated is reflected in almost every way the team functions. In this way the social order has become inscribed in the objective functioning of the team. For example, the GPs have a private office, the practice nurses share an office; the GPs have their own appointment diary, the practice nurses share a patient list.

This classification is accepted as doxa within team one and is internalised in the habitus of all team members. Social position is 'taken for granted' and in being so, the underlying power relations are concealed. The GPs assume the role of leaders—working autonomously, delegating work to nurses, and directing patient care. The practice nurses organise their working day around the needs of the GPs, following instructions and ensuring they are readily available to assist when required. This doxic order is considered unremarkable within team one, as the GPs do not appear aware of their dominating approach, and neither do the nurses appear aware of their dominated position.

Working with a RN Prescriber

These findings suggest that in team one the adoption of RN prescribing has the potential to challenge the doxic order, and the habitual classification of GPs' and nurses' work as being distinct. Prescribing has previously been considered part of the GP's role, and the practice nurse's role was to assist the doctor rather than to contribute to clinical decision making or treatment decisions. The following section explores the way the GPs have responded to the implementation of RN prescribing in team one.

Threatened Professional Autonomy: Chipping Away at GP Practice

When Alice first raised the subject of applying for designated prescribing authority with the GPs, they expressed concerns. As Alice explains, the GPs were apprehensive about losing autonomy over their perceived ownership of patients, as well as their ownership of specialised diabetes knowledge.

> *One of their big concerns about me being a prescriber was that they were going to be left out of the loop and I was going to take over. …I think they thought that I was just going to be dealing with their patients' diabetes I'd be starting them on drugs that they wouldn't know I'd done. Going off in a direction with their diabetes care without them perhaps knowing and I have had it said to me, "well we're also worried that you're going to know more than us" you know they've said that to me.* (RNP 1)

Ann (RN) recalls a meeting held to discuss Alice's proposal to become a RN prescriber. In the following quote she corroborates Alice's suggestion that the GPs were apprehensive about losing control of patient care.

> *I think initially it was a bit scary for them [GPs], that was the vibe that I picked up. Just concerned "well are you going to be changing things, under our noses with our patients that we've been working with for many years". And we had a specific meeting about it, to all talk together about how it might go. And she [RN prescriber] made it really clear there would be nothing that*

> *would be done without their knowledge. And I think that was reassuring for the GPs.* (RN 1)

Roger (GP) verifies these concerns, suggesting that in addition to losing autonomy over patient care the GPs worried that the inclusion of a RN prescriber would detract from their own skill set:

> *There is the possibility that we get deskilled. In diabetes, if you had too much exposure to nurse prescribers in the practice that the doctors can lose confidence because they're not doing it. I know some doctors in the practice have worried about that a bit. …I think that it's probably quite important for a nurse prescriber in a general practice situation to be aware of the history a bit, that you know you, do need to consider the doctor's personality a bit and deal with them.* (GP A1)

Roger refers to a shared history that he perceives has influenced the GPs' attitude and response (habitus) to RN prescribing. Both GPs spoke of their belief that the traditional role and work of GPs has been gradually eroded by other professions who are taking on aspects of their work.

> *Nurse practitioners in various fields and physios and podiatrists and you know all sorts of other specialities, are chipping away at general practice and taking things. The midwives have taken away obstetric care.* (GP A1)

Peter expressed past concerns about midwives prescribing in a capacity that he considered was "out of their scope". He also shared concerns about the role of a nurse practitioner, suggesting that he would not employ one in the practice because "*you actually can't replace a doctor with a nurse*".

The community pharmacist associated with team one noted several of the GPs to be concerned about maintaining autonomy over the care of patients enrolled in their practice. The pharmacist suggested that their ability to work collaboratively is largely dependent on "*the relationship that the GP practice is prepared to have with you*" and that some of the GPs control access to patients. The pharmacist described several initiatives she had been keen to implement but felt the GPs would not agree. Medication reconciliation is one such initiative, designed to optimise safety and minimise the risk of prescribing errors. However, the pharmacist feels it would be unlikely to work, suggesting:

> *I don't think it would ever work here, because of the few GPs that are very sort of, territorial of their own patients. Some of them are more receptive of me doing reviews than others.* (Pharmacist 1)

Another initiative discussed by the pharmacist was international normalised ratio (INR) blood tests used for establishing the dosing of the anticoagulant medication, Warfarin. The pharmacist felt this would be a valuable service for the pharmacy to offer, enhancing access for the local community. However, she explained:

> *We haven't gone down that track for the mere fact it would break the relationship [with the GPs]. Because they said "well, they're coming in to you but they're not all your patients". So they wanted to maintain that patient, I guess ownership.* (Pharmacist 1)

Roger explained that in addition to having concerns about other disciplines encroaching on their practice, they also worry about other GPs. Retaining authority of enrolled patients is important to GPs and they feel a sense of pride and satisfaction in maintaining this cohort. This general practice currently has a large and growing population of patients; however, as described by Roger, competition arises between GPs when there is a shortage of patients.

> *A doctor can feel ownership of the patient. That they're "my patient". That's something which exists more than in hospital you know. If you feel that somebody's taking your patient away from you, and sometimes that happens in a completely underhand way where, a doctor may snaffle as many patients as he can from all over the place. The doctors are very prickly about losing patients to other people.* (GP A1)

Bourdieu (1997a) asserted that the habitus is acquired though experience, and is essentially "history turned into nature" (p. 78). The GPs' experience of having aspects of the work they were traditionally responsible for taken by other professions has impacted their habitus. Their habitus, in turn, is structuring the field in the way they respond to the inclusion of RN prescribing as a threat.

Conceding Aspects of Care: Paraphernalia, Protocols, and Practicalities

The GPs and RN prescriber in team one have negotiated ways of working together that enable the GPs to maintain control over clinical decisions regarding the patients enrolled in their practice. The following discussion illustrates the ways in which the two GPs, who were interviewed, maintain authority over patient care while working with a RN prescriber. Both GPs commend Alice's knowledge in the area of diabetes. The following quotes illustrate the way they forefront Alice's knowledge of the practical aspects of diabetes, contrasting it to their own knowledge that is more complex and multifaceted.

> *Alice has developed an expertise in an area, and has probably, got a knowledge, in many areas of diabetes superior to, day to day stuff, than I would know. Just because, she's dealing with it all the time. And I'm talking*

about, the devices and starting people off on insulin and that sort of thing. if I've got someone, say a type II diabetic , who's not well controlled I can say look, I'd like you to go and see Alice. She's got a protocol set up specifically with all the recording sheets and has done it many times starting someone off on insulin. And it's quite a big thing to take a person who's never injected before doesn't know the paraphernalia, it's a lot of education. And so she does all of that stuff. You know so if she's going to start someone on some lantis [insulin] or something I mean it's a no brainer that she should do the prescription. I don't have any feelings about, you know possessiveness about that. I think it's appropriate that she does that. And there's all the testing strips and all the machines and everything that goes with it. (GP B1)

She's, becoming more and more knowledgeable and certainly knows more than I do about certain aspects of diabetes care, particularly the practicalities of it. The things like insulin pens, some of the prescriptions, are quite tricky you can write down the wrong prescription because it's a pen fill this or it's not a pen fill whatever where you haven't actually made a mistake, but you haven't specified enough exactly what's needed. So Alice is about for that sort of thing and I will actually talk to her in between patients about someone who I've seen who's got diabetes who I'm intending for her to see in the future. And I'll say I've seen a new patient I'm going to send them to you because of this and this. (GP A1)

Both GPs acknowledge Alice's growing knowledge (cultural capital) in the area of diabetes. They contrast her knowledge to their own in several subtle ways. Firstly, they indicate that her knowledge is specifically in the area of diabetes, suggesting their own knowledge is broader encompassing all areas of health care. Next, they suggest her knowledge is in the routine, aspects of diabetes management, while they are also versed in the complex aspects. The GPs indicate that Alice's knowledge relates to the practical aspects of diabetes management. They refer to her command of the equipment used to monitor the patients' blood glucose levels and the devises used to administer the insulin. Finally, both GPs refer to Alice following "protocols" suggesting they see her prescribing as more formula based and perfunctory than their own. As Roger suggests, in the quote below, in perceiving Alice as working from "protocols" she is not making her own decisions in the way that a GP does.

She probably has to base her treatment around protocols more than I do I think. You know we're allowed to make our own decisions, aren't we? (GP A1)

The GPs are happy to relinquish what they consider to be some of the more straight forward and practical aspects of their work. They refer patients to Alice for education and support, particularly when they need a patient started on an insulin

regimen. In these circumstances, they are delegating a task. After the GPs have completed the patient assessment and established the treatment plan, they then refer responsibility to Alice to complete the process by providing the required education and the prescription. Working in this manner enables the GPs to maintain overall authority and control of patient care.

The GPs have placed mental boundaries around the RN prescriber's cultural capital, distinguishing it from their own and established it as being of less value. In classifying Alice's knowledge as practical, general, and protocol based, the GPs are able to discredit her cultural capital. At the same time, they have valorised the value of their own cultural capital. In this way, they can reconcile Alice prescribing within the team and maintain their own greater wealth of cultural capital. The GPs are preserving their capital which is an unconscious and intuitive response to their perceived position of threatened autonomy rather than an intentional or predetermined act of domination.

Misrecognition and Symbolic Domination

As described previously, the GPs hold a dominant position in this team. They are the clinical leaders and, in some cases, employers. The GPs hold the authority (symbolic capital) to control who works in the team and how the work is allocated. This is the accepted order of the team as it is taken for granted and embodied in the habitus of the team and accepted as doxa or the 'way things are'. Analysis of the findings from this study using Bourdieu's concepts demonstrates that the introduction of RN prescribing has incited a power 'struggle' through which the GPs have defended and maintained their position of dominance. Bourdieu referred to a subtle and figurative struggle over power and social position, such as this, as symbolic violence.

Symbolic violence is not an intentional violence and is in no way physical; rather, it is invisible, covert, and performed below the level of consciousness (Bourdieu & Wacquant, 1992). Symbolic violence accounts for the manner in which a dominant group retains symbolic power and a position of authority over a dominated group. Bourdieu (1977a) suggested that symbolic violence, as an exercise of power, is concealed by acts of misrecognition. Through acts of misrecognition, the GPs in team one have justified the restrictions and control they have placed on the RN's prescribing. Misrecognition enables the GPs to covertly maintain their position of authority.

Peter, a GP partner in the practice, justifies his conservative approach to enabling RN prescribing by suggesting he is responsible and accountable for her

clinical practice. In the following quote he focuses on the potential for her to make an error and impose risk on the patients and the practice. Peter misrecognises his need to maintain control over patient care for concern for the patients, the practice, and the RN prescriber. He exonerates his dominating behaviour by denouncing the capitation funding scheme as influencing his approach.

> *If you've got a patient population, as a GP, with capitation you are responsible for them. You know you are responsible for decisions that are made on a day-to-day basis. You're responsible for the drugs they're on. You're responsible for the tests and the test results. So, if you're working in a team that sense of responsibility, gets transferred. So, if you need to transfer that responsibility to, another person like a nurse prescriber, you need to be quite sure in your own mind that they are, capable of making decisions which are in keeping with decisions that you yourself would make. Because if something goes wrong or a decision is made badly or, there's a disaster or…, you're dealing with all that risk to the patient, risk to the practice, risk to the nurse prescriber.* (GP B1)

Peter refers to his concern that the RN prescriber will, at some point, make a prescribing error and, in citing his own "medical protection insurance", he suggests that as a nurse Alice will not have the same protection. Peter misrecognises his concerns regarding RN prescribing detracting from his position of autonomy for genuine concern for Alice from a clinical liability and medico legal perspective.

> *It will only be a matter of time before there's something will come up and I'm thinking well will they have the same level of protection that I get from my organisation? You know like if a nurse comes up in front of the Health Practitioners Disciplinary Tribunal for example, will they have the same level of support and defence provided?* (GP B1)

The RN prescriber, in turn, misrecognises the GPs controlling attitude as genuine concern and support. In the following excerpt from Alice's interview, she acknowledges the GP's assumption that her prescribing implies risk to the patients and the practice. Rather than seeing this as undervaluing her knowledge, skills, experience, qualifications, and the NCNZ prescribing endorsement, she explains it as natural, collegial, and caring.

> *I know they worry about me. …these concerns are real and they're concerned about me as a person and a professional. It is very nice that they are concerned in that way. They have that concern and sort of empathy as a fellow prescriber that you know things don't always go right but we trust in you that you will do what's right and if you didn't know you would ask. That you would speak to your supervisor, your colleague, the GP, before you do anything, that could compromise anyone's safety. But they certainly would not want me to be in a position where something dire had occurred because of my prescribing. I think they have that in the back of their mind like this is*

> *quite scary because you know this is someone taking on something that has never happened before and what would happen if something went wrong. And it could reflect badly on you know the practice as well if something did go wrong. Nobody wants the Health and Disability Commissioner knocking on their door you know so it has to be a very trusting relationship between the GP and the nurse prescriber.* (RNP 1)

In this excerpt from her interview, Alice is seen to view her prescribing from the GPs' perspective. The GPs hold symbolic capital; the RN prescriber has internalised their "concerns" and "worry" about the risk of her making an error. Alice's acceptance and 'misrecognition' of the GPs' actions enable the GPs' interests of maintaining symbolic power and control to be normalised, disguised, and accepted. The GPs' domination is misrecognised as natural and masks the potential contribution her prescribing authority could make to the team. The doxic order of the team is reconfigured and the traditional division of labour in the team reproduced.

Bourdieu suggested that symbolic violence "is the violence which is exercised upon a social agent with his or her complicity" (Bourdieu & Wacquant, 1992, p. 167). Alice has been a practice nurse for many years; she is accustomed to working in a model of health care where nurses work 'for' the doctors in a dependent manner. Alice accepts that as a RN prescriber her opportunities in the future will remain largely unchanged from her current circumstances. Rather than seeing the limitations and boundaries that various GPs place on her prescribing as dominating and controlling, she sees this as natural and to be expected. She appreciates her situation more from the GP's perspective than her own. This is apparent in the way that she empathises with their unfamiliar and "scary" position of having to work with an RN prescriber. Even though Alice expressed a sense that the GPs do not fully appreciate the extent of her knowledge, and that she could potentially contribute more, she demonstrates no compulsion to defend her dominated position and address it.

The doxic order has been maintained. The GPs, as the holders of symbolic power in this relationship, are the gatekeepers in a position of controlling Alice's access to patients. As an employee, Alice's ability to prescribe in her role is completely dependent on the degree to which the GPs are prepared to allow her to do so. Alice inherently understands her dependent position, she responds by adhering to the conditions placed on her practice.

Patterns of Communication

Establishing Trust

In team one, the RN prescriber suggests that trust is a determining factor when it comes to the GPs allowing her to prescribe for patients in their care. Trust refers to the GPs feeling confident that Alice will adhere to the negotiated way of working. Those GPs who are more trusting of Alice enable her more autonomy, appreciating that she will keep them informed if anything untoward arises. Those that are less trusting expect Alice to communicate with them before and, potentially, after each prescribing intervention.

Alice recognises that the long-established relationships she shares with the GPs enable them to "trust her" enabling her more opportunities to contribute as a prescriber to the care of patients under their care. These trusting relationships are an important form of social capital for Alice. As the following excerpt suggests, a new RN prescriber may not have the necessary social capital to be supported.

> *I think I was really lucky because, I had already been in the practice by then for like three years doing that diabetes role. So there was a really good relationship between me and the GPs which was essential. And there was like a relationship of trust. You know they knew that I was not a person that would do anything rash …they need that reassurance of a nurse prescriber they need that, relationship. I think it would be quite hard for a nurse prescriber to go into a practice where there was no relationship with the GPs you know beforehand.* (RNP 1)

In team one, the RN prescriber is required to establish an individual, informal agreement regarding how she will contribute to patient care with each GP. In the following quote, Alice explains how she is careful to consider which GP the patient is enrolled under before prescribing for patients with diabetes.

> *Every GP works in different ways. I know them all individually and I know how they like to work. Some are just happy for me to go ahead, they have trust that I will do the right thing and I'll let them know what they need to know, if I've got questions, they know I'll come to them. Whereas others like to, before I would do something I would make sure I discussed it with them. So each one's different! We've got a lot of GPs in our practice, so there's about 15 I think. You know everyone works in a different way so it's just sort of knowing their individual way of working. And some GPs just like to manage their own little world, they don't really want too much intervention from me.* (RNP 1)

This quote reinforces, the independent way in which the GPs in team one work, illustrating the way they each choose the degree to which they will collaborate with other health care providers in the team.

Interpretation of the GPs' interviews corroborates the RN prescriber's suggestion that communication is central to their acceptance and ability to trust Alice. Alice is expected to discuss her prescribing decisions with the GPs.

> *We feel comfortable because she will talk with us and say look I saw so and so and, I found so and so, and I was thinking about, doing this what do you think? Yes good idea or no maybe not, whatever. And so within that, within that realm, it's a good idea, it's working well.* (GP B1)

In this quote, Peter conveys his comfort in knowing that Alice will not prescribe or change a patient's treatment without first discussing it with him. This supports his position of being an 'independent practitioner' and his preference to maintain autonomy over his practice and his patients. In trusting that Alice will always talk with him, he is able to closely monitor her practice and ultimately maintain control of patient care and the RN prescriber's practice.

Discretion and Diplomacy: Minding your Ps and Qs

In team one there are tacitly appreciated ways of communicating. Both GPs spoke positively of the way Alice communicates with them. Roger explains that diplomacy on behalf of the nurse is essential. When asked how a new RN prescriber might be integrated into the team, he suggests that in order to be accepted a new nurse would not want to get the GPs' "*backs up*". He offers the following insights into how he thinks a prescribing nurse should communicate with GPs.

> *I think that a brand new nurse prescriber coming in would need to have a really good diplomatic quality if she was to succeed. She'd have to have a certain amount of humility and a good level of skill. But if she had that it wouldn't take long. The personality of doctors is quite, you know there's touchy doctors and there's doctors who aren't completely confident and don't want to look stupid in front of somebody. That can be because they're a young doctor or it can be that's just their personality. You get the nurse who can suggest something without, you know making you look like you're stupid, you know, she has a real skill.* (GP A1)

Roger concludes that "*like Alice, you've got to mind your p's and q's and fit in*". Alice apparently conforms to these expectations.

> *I think she's got that discretion, you know she knows how to be diplomatic about it. And I haven't had anybody complain about anything she's done.* (GP A1)

Ann, the non-prescribing RN in team one, also recognises Alice's manner of communicating with the GPs. In the following quote she describes the RN prescriber's ability to communicate and command an audience with the GPs as

unique, suggesting she has linguistic capital not appreciated by other members of the nursing team.

> *She comes in with very good ideas. And she's quite, I guess assertive you know and she's got a good relationship with the GPs so she'll make recommendations which is really cool isn't it? The GPs will often say yes let's try this or you know. Which I think is really positive.* (RN 1)

When Ann suggests that Alice can make recommendations, she implies that it is not standard practice (doxa) for nurses to do this within this team. Ann suggests that Alice's relationship with the GPs and her contribution to decision making is unique and unprecedented for a nurse within the team. This adds support to the suggestion that the nurse's role within this team, prior to the implementation of an RN prescriber, had been largely a dependent and supportive role rather than actively contributing.

In summary, these findings suggest that the GPs set the tone in terms of how nurses communicate with GPs in team one. The linguistic environment (market) is largely controlled by the GPs, and the RN prescriber has adapted and learned to communicate with diplomacy in order to fit in. The nurse prescriber is expected to communicate her intentions but speak carefully, seeking permission to be involved in patient care and respecting that the GPs hold the right to control her access. Alice manages her relationships with each GP in a measured and tactful manner avoiding conflict. There is congruency between Alice's linguistic habitus and the linguistic market in which it was formed. The RN prescriber is aware that not all of the GPs in the practice wish to have her involved in a prescribing capacity with patients enrolled under their care. Rather than actively promoting her potential contribution as a prescriber, she appears to accept these limits. The constraints placed on her prescribing are generated by the structure of the field (the rules) and equally by her internalisation of these rules. Bourdieu referred to this moderation of linguistic response as "self-censorship" (Bourdieu & Thompson, 1992, p. 19) that results from a sense of anticipation.

Maintaining the Status Quo of GP Led Care

Alice introduced the idea of becoming a nurse prescriber in team one not long after the legislative changes enabling nurse prescribing came into place. At that time the GPs were not familiar with the regulations around designated prescribing authority or what the RN prescribing role would entail. Alice navigated the journey to becoming a RN prescriber alone, developing policies for the practice and educating

the team. She describes a lonely journey but speaks respectfully and with gratitude of the team and the support received from the other practice nurses and the GPs.

Using Bourdieu's theoretical concepts, analysis of the findings from team one demonstrates that the GPs hold more of every form of valued capital in the field. This includes institutionalised cultural capital in the form of GP qualifications, as well as economic capital in the form of business ownership and associated financial profit. Symbolic capital arises from the respect, prestige, and overall authority awarded to the GPs by the team enabling them to legitimate their position at the top of the social hierarchy. The inequitable distribution of capital manifests in a social stratification that is internalised and embodied in the habitus of all members of the team and in the team habitus as a whole. This social order culminates in the classification of work within the team as either doctors or nurses and is reflected in the objective structure and practices of the team. These findings illustrate and emphasise the dialectic and interdependent relationship between habitus and the field, in that the habitus of the team is generated by the objective structures of the field and the field is in turn generated by the habitus of the team.

The GPs in team one perceive that the traditional role of a GP as independent practitioner caring for the community across the lifespan has been threatened by other health care professions in recent years. The introduction of RN prescribing is interpreted by the GPs as another threat to their autonomy over their work and their knowledge base. The GPs respond to their threatened position by adopting conservation strategies of discrediting the RN prescriber's newfound cultural capital, which has the added benefit of valorising their own. Acts of misrecognition justify this unconscious act of symbolic domination whereby the GPs legitimise the constraints they place on Alice's prescribing with concerns for the safety of the patients, the practice, and Alice herself. Alice responds with, equally unconscious, acts of complicity by justifying the restraints placed on her prescribing, suggesting her prescribing compromises the GPs in some way and that their efforts to place boundaries on her practice are both protective and collegial.

The outcome of this power struggle is that the pre-existing social order whereby the GPs are the dominant partner, holding autonomy and controlling practice is reproduced in the way they work with the RN prescriber. Alice has little control over the way her work is structured. The GPs maintain control over which patients she can prescribe for, which medications she can prescribe, as well as the degree to which she is required to communicate her prescribing decisions. Each GP in the practice has individual preferences and expectations for how they choose to work with Alice, requiring her to establish an informal agreement with each. On

some occasions, Alice is prescribing medications based on a request from the GP. The way that Alice works as a designated RN prescriber is reminiscent of the way she worked prior to gaining prescribing authority, and of the way the other practice nurses work.

Despite the RN prescriber in team one having completed a postgraduate certificate and having endorsement from the NCNZ to prescribe in diabetes, her position and role within the team has not significantly changed since gaining prescribing authority. Alice continues to work as a practice nurse and runs a nurse led diabetes clinic one day each week. There have been no apparent changes made to the way Alice's work is structured since she gained prescribing authority. What has changed is that she now prescribes to patients with diabetes both on the days when she is running the diabetes clinics and when the opportunity arises during her other days working as a practice nurse.

Undoubtedly, Alice's prescribing in the team enhances the provision of quality care and access to health care for patients with diabetes in team one. The findings of this research do not dispute this; rather, they suggest that Alice's work is restricted, culminating in her not being in a position to work to the top of her scope as a RN with designated authority in diabetes. Alice is potentially disadvantaged by the social conditions apparent in the team. She is not free to fully realise the merits of her qualifications and prescribing in contributing to patient care. The findings suggest there is potential for Alice to work more autonomously and to make better use of her knowledge, skills, and prescribing authority.

The reproduction of the existing social order in team one opposes the requirements of a truly collaborative approach to working with an RN prescriber. The team function in a multidisciplinary way whereby health care professionals work in parallel rather than together in an interprofessional manner. In this team there are limited opportunities for the RN prescriber to be integrally involved in collaborative decision making.

Summary

This chapter has introduced team one as a GP led general practice. In mapping the social topography of the team the disparity of capital has been noted. The clearly delineated social positions of the GPs and the practice nurses, including the RN prescriber, are grounded in the disparate distribution of the various forms of capital within the two disciplines. The role of the GPs has been described as independent and autonomous. The GPs claim proprietary right to the patients "under their care" valuing their autonomy and ability to lead patient care. The role of the

practice nurses and the RN prescriber is dependent on and complementary to the GPs.

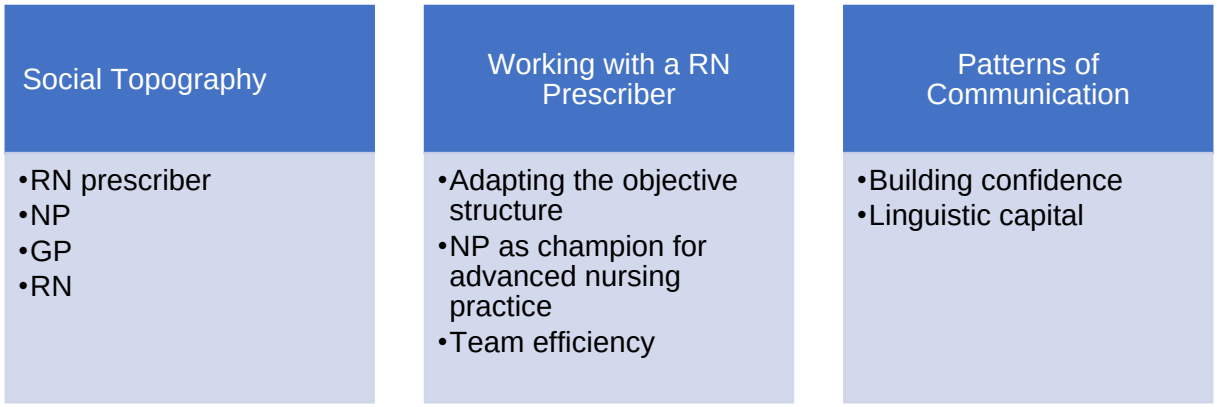
These findings suggest that the GPs in team one have internalised past struggles over professional autonomy, and this is expressed in the threatened way they have responded to the introduction of RN prescribing. Bourdieu's methodological concepts of symbolic violence and misrecognition have been applied to these findings and have revealed some of the hidden mechanisms that have supported the perpetuation of GP dominance in this team. The following chapter introduces the second team included in this study.

Chapter Six: Team Two Findings

The purpose of this chapter is to present the findings from team two—the second general practice team included in the study. The format of this chapter follows the structure of the previous findings chapter, presenting the three general themes common to all teams of social topography, working with a RN prescriber, and patterns of communication, along with sub themes pertinent to team two. Figure 4 presents the themes and sub themes for team two.

Figure 4

Themes and subthemes for team two



Team Two – Not for Profit General Practice

Overview of the Team

This health care team (field) is situated in an urban general practice located in an economically deprived suburb. The practice falls under the umbrella of a larger field or PHO and provides primary health care services. The patient population has complex needs and many lack the financial resources required to pay for their health care. The following members of this team were interviewed: GP, NP, RN prescriber, and RN. In addition, a community pharmacist was interviewed to gain their perspective on RN prescribing. The pharmacist is not located on the same premises as the other members of the team but is available for consultation when required.

The practice is privately owned by an external party who is neither employed nor closely involved in the daily running of the practice. This practice is supported by the government's Very Low Cost Access (VLCA) scheme. This means that the practice receives additional government funding enabling it to provide primary health care to a community who could not otherwise afford to pay for it.

Social Topography

The health care disciplines involved in patient care on a daily basis are the RN prescriber, GPs, NP, and RN practice nurses. Following is an account of the roles, responsibilities, and social position of each member of the team, as perceived by the participants.

All members of this team described their motivation to work in this practice as being driven by their concern for a disadvantaged community and a desire to improve their access to health care. As explained by the GP, the aim is to provide affordable care:

> *There are far easier places to work. I think everyone could work somewhere else and things would be much easier and simpler, so we work here because we want to. Overall, we're concerned about the client group who have tended to miss out in life generally. And at least we can try and provide the best we possibly can for them and I think that that's our aim, to be cheap but not cheap care in terms of quality of care.* (GP 2)

As described by both the RN and NP in team two, the team share a concern for social justice and equity for the people who live in this disadvantaged suburb.

> *I think we're all pretty committed to, justice issues perhaps working in a place like this. You know we have a passion for, the people who live in this area, and the equity issues. I think everyone here has that otherwise they wouldn't end up here. And yeah, I guess that colours how we do things here.* (RN 2)

> *I believe that I'm very privileged and that was just an accident of birth, just happened to be where I was born at the time. People sometimes in this area of town start on the back foot, and it's not fair. It's just so unfair. So I think we are here trying to make life more fair for those people.* (NP 2)

Most members of the team identify as Christian and suggest they share associated Christian values. As the RN prescriber explains, the practice is not mandated with making financial profit.

> *Most of us are Christians and we have a faith-based element. Or faith-based values I suppose you could say. And, we see our practice as more, based on service than on business. So that makes a really big difference to how you treat people because, we don't shuffle people through appointments to make more money.* (RNP 2)

The pharmacist who is located in the same neighbourhood shares much the same philosophy as the general practice team.

> *We're a local pharmacy who serve an often economically deprived population with broad and often complex medical needs. We have a similar approach to our patients, less of a you know mainstream, $50 doctors and*

> *the retail pharmacies because that's not what we are. People struggle to pay for scripts and struggle to pay for a lot of other aspects of their care. We approach our patients in a similar way and we try to meet their needs best we can.* (Pharmacist 2)

Throughout the interviews the team cited the challenges of working in the practice and with this community. These challenges included a high workload in terms of patient demand; insufficient resources, with regards to staff, space, and consumables such as wound dressings; the impact of drug and alcohol addiction in the patient community; and frequently stressed and verbally abusive patients. However, as the previous quotes illustrate, the team choose to continue working in this practice, with many having worked there for more than 10 years.

RN Prescriber

Jenny, the RN prescriber, has worked as a practice nurse in this team for 13 years. She holds a postgraduate diploma and was already engaged in postgraduate study before learning that by completing a final prescribing paper she could apply to the NCNZ for prescribing authority. Jenny had been prescribing for just over one year at the time she was interviewed. In the following quote, Jenny describes the impetus to become a RN prescriber was driven by her sense of frustration arising from delayed care and wasted staff and patient time arising from having to ask a GP or NP to write a prescription.

> *I've often sat in consultations with people and thought gosh if I could just prescribe this. You do a smear and, you do swabs and they come back with a STI [sexually transmitted infection]. If you could just prescribe it instead of sending a note to the GP or people come in because they can't see the doctor and they sit and say "oh I just need my medications". I could just prescribe these you know it would, save me writing a note to the doctor, would save the doctor doing it, would save him taking it to the receptionist, would save her faxing it, it just saves a whole chain of things.* (RNP 2)

At the time Jenny first introduced the idea of becoming a RN prescriber, she was the first nurse in her team to pursue this possibility. The lead GP in the practice had no previous experience of working with an RN prescriber; however, the practice employs a NP, and Jenny senses that having a nurse working in an advanced scope within the team helped with her transition. Jenny's job title within the practice has not changed since she gained designated prescribing authority; she continues to work as a practice nurse incorporating her ability to prescribe medications.

Jenny refers to sometimes feeling uneasy in her new social position as a RN prescriber. In the following excerpt from her interview, she describes herself as

straddling the two positions of the doctor and the nurse but not fully able to identify with either.

> *I'm doing stuff that he [the GP] would do. And I feel a bit like piggy in the middle because I'm doing nurse stuff, I'm doing prescribing stuff, so I'm helping the doctors and I'm helping the nurses and I haven't dropped anything that I've been doing. I still order supplies and I'm still mentoring nurses and I'm still doing the basic stuff, the before school checks and immunisations and taking blood and all of that but I've added another level to my scope of practice which means I'm helping the doctors as well. Sometimes if Sue's [NP] busy I'll take one of her patients and see them for her, and she's very happy for me to do that. So I do feel a bit like piggy in the middle, I suppose I'm just getting used to the new role because we really weren't sure how it was going to, how it was going to work out in practice.* (RNP 2)

Bourdieu (2020) suggested close attention be paid to self-classification of social positioning in a field suggesting that "In so far as these words themselves express the structures that have produced them, some part of social reality passes into even the most vacuous typologies" (p. 191). Jenny's representation of herself as "piggy in the middle" provides insight into the way she has internalised her conceptualisation of the social space she finds herself. Jenny is faced by a challenge to her identity (habitus) as she reconciles the contrasting sense of simultaneously doing what she recognises as doctor's work and nurse's work.

The GPs

There are two GPs who work in the practice. One works just one morning a week. The team make little reference to this GP, suggesting that in working just one session the team have little interaction with her. Phil (GP) has worked in the practice for 25 years, previously as the business owner and currently as an employee. Phil describes himself as the "lead clinician" in the practice. He has his own office where he sees patients who are booked for 15-minute appointments. The team recognise Phil's knowledge and experience in general practice medicine (cultural capital) and they also value his long-standing relationships shared with the patients (social capital). Phil is recognised as the "most senior" clinician in the practice; in the eyes of the team he holds a position of authority (symbolic capital).

Nurse Practitioner

The NP in the team joined the practice 3 to 5 years ago; she also works in another general practice part time. The NP occupies her own office and sees patients in the same way as the GPs. Sue explained that it was due to a crisis that she came to be employed in the practice. She explained that when Phil owned the

practice he was overworked, "*exhausted*", and in need of a break. Unable to attract a GP to relieve in the practice, Sue recounted that Phil "*took a risk and employed a NP*". Phil described the situation leading to Sue's employment differently; explaining he was unable to attract a GP and Sue came highly recommended by a GP colleague. Whilst Phil may have been initially apprehensive about working with a NP, now he suggests he is "*very comfortable*" and has demonstrated his confidence in Sue by offering her the clinical lead role in the practice. Sue has declined the clinical lead role due to workload and time demands.

During their interviews, both the RN and RN prescriber often compared the role of the NP and GP. They agree that the NP has the knowledge, skills, and professional authority to meet patients' needs in the same way that the GPs do. Whilst they see the GP and NP doing the same work, they concur that they do it in a different way. The nurses both refer to Sue as "thinking like a nurse" and being more holistic in her approach to patients. The way in which the team values the NP's knowledge, skill, and authorised prescribing authority credit her with symbolic capital.

RN Practice Nurses

There are five RNs, referred to as "practice nurses", employed in the practice. In addition to the NCNZ endorsed RN prescriber, one other nurse is studying to become a RN prescriber. The RN who was at the time completing her prescribing education was not able to be interviewed due to requirements outlined in the ethics agreement. The work of the practice nurses is allocated in two ways. First, the nurses see patients according to a prebooked "nurses list" where they do what is described as "usual" or "routine" work for a practice nurse such as "vaccinations, blood tests, before school checks, smears, and dressings". Second, the nurses see patients who present but cannot be seen by the GP or NP as their lists are full. In these circumstances the nurses see a wide range of patients independently.

Mary, one of the RNs, explained that the nurses in this team work in a less dependent manner than colleagues from other practices. The nurses are expected to conduct patient assessments independently and to make clinical decisions engaging another member of the team if and when necessary. The nurses have received additional education and training in health assessment; their skills in this area are considered a valuable form of cultural capital by the team. In the following quote Mary compares the way the nurses work in team two to other practices suggesting they do more than "just triaging":

> *We've got a few nurses that fill in here and they say they love coming here because they get to be a lot more autonomous and do more than just taking*

blood tests and vaccinations and that kind of thing. They get to actually have a bit more autonomy. (RN 2)

Mary explains the way she works suggesting she does all that she can for patients, referring them on to another member of the team with prescribing authority when necessary. The work of the practice nurses is considered more autonomous than elsewhere in that a considerable amount of their work involves assessing patients and making clinical decisions (within the RN scope of practice) without the direction of another member of the team.

Summary of Social Topography

Analysis of the social positioning in this team reveals a recent crisis resulting in the introduction of Sue, the NP, to the team. Nearing the age of retirement and feeling tired and overworked Phil was not able to attract another GP to work in the practice and instead he employed Sue. Phil grew to appreciate Sue's contribution recognising her to be as capable as a GP in providing primary health care. Phil held the position as clinical lead of the practice for many years. Now he describes himself as "old and grey", he has trust in Sue, and in offering her the clinical lead role he demonstrates he is prepared to abdicate his dominant role within the practice.

The introduction of a NP coupled with the lead GP nearing retirement has catalysed a change in social positions within team two. Sue and Phil hold a comparable volume of cultural capital albeit in slightly different forms. Phil's cultural capital lies in his extensive experience in general practice; whereas Sue's lies in her commitment to staying abreast of the latest evidence and current best practice. Phil holds a great deal of social capital, both in his relationships with the patient community and in his long-standing relationships with the team.

The nurses are recognised as holding less cultural capital than both the GP and NP; however, their knowledge and skill are recognised and valued. The nurses, including the RN prescriber who have or are completing postgraduate study, are considered to hold more cultural capital than the newer nurses who are not currently studying toward a prescribing role.

Working with a Registered Nurse Prescriber

Adapting the Objective Structure

At the time Jenny achieved prescribing authority, the team had not established how they would practically incorporate her prescribing into day-to-day practice. In an effort to facilitate her new role, the practice manager elected to work from home so that Jenny could have her office on two days of the week. Drawing on

Bourdieu's concept of field, the allocation of this scarce physical space, an office, is interpreted as a symbol of the recognition of Jenny's advancing social position. Bourdieu (1999) suggested "social space translates into physical space" and that "an agent's position in social space is expressed in the site of physical space where that agent is situated" (p. 124). As a practice nurse, Jenny is accustomed to sharing a communal space with other practice nurses but now, like the GP and NP, she has been allocated her own space.

In addition to being allocated her own office as a RN prescriber, Jenny was also assigned her own patient appointment 'template' or 'list'. This means that patients can be booked in to see her individually in the same way as this occurs for the GP and NP. The transition from sharing a 'nurses' list' to having her own RN prescriber list signifies a symbolic transition in social position much like being awarded her own office.

Changes to the allocation of office space and the addition of a RN prescriber list represent the team's recognition of her new status as a RN prescriber. However, when it comes to her prescribing role, Jenny has found neither change enabling. Jenny explains she had trialled this new system but few patients had been booked with her (most likely because the receptionist was not fully informed of what she could do) and there were some patients that did not turn up (not unusual in this practice), so she returned to working as previously.

> *Yesterday what I did was, I said to the girls well I'll just work off your lists so there were three nurses on the floor. And that worked really well because I just did a smattering of things but I did some prescriptions and on the days that I am on the floor just as a nurse, just doing the general work, I do find that I get lots of opportunities to do prescriptions.* (RNP 2)

As depicted in this excerpt, Jenny perceives herself to be most effective when working alongside the other nurses. It appears that traditional structures adopted in general practice such as appointment lists and private consultation offices, while offering recognition of cultural and symbolic capital, may not be the best ways of enabling the RN prescriber to optimally contribute to patient care.

Jenny reflects feeling out of place. While she can physically occupy the allocated office and attend to the patients booked onto her newly devised list, she does not occupy this new social position comfortably. Bourdieu (2018) suggested "it is the habitus that makes the habitat" (p. 111). Jenny's habitus is at odds with the new objective structure in the field. As illustrated in Jenny's previous quote, she describes herself as feeling like "*piggy in the middle*" and gravitates to work alongside the other nurses.

The RN prescriber's new prescribing authority enables her to work more autonomously and meet the patients' needs more comprehensively. Her cultural capital has been converted to an objectifiable form of cultural capital. In the excerpt below, Jenny explains how working in a flexible manner enables her to respond to patient needs in a responsive and unrestricted manner.

> *We are very opportunistic in our care. If someone comes in for one thing, they come in and they get everything. A good example of that is last week I saw a lady who's a diabetic and I've been trying to get her for ages. She came in with her husband who's also diabetic and he was seeing the doctor but I saw her in the waiting room, I said I'll see you. And I spent an hour with her and honestly I did so many things. And now I can't get hold of her. But, we just work opportunistically and we really do serve our patients and it's sometimes very challenging because when you're in a low cost practice, people come with poor health literacy and, very complex long term conditions and lots of things as well as all the social stuff in the background.* (RNP 2)

The RN prescriber is seen to be taking a 'trial and error' approach to finding the best way to structure the incorporation of her role. Her objective is to best meet the community's needs; she is restrained by limited fiscal resources but supported by the freedom to trial a variety of approaches.

NP as Champion for Advanced Nursing Practice

For Jenny, having a NP in the team has had a profound influence on her ability to advance her practice and become a prescriber. Jenny is extremely grateful for her support, suggesting she "*literally couldn't have done it without her*" and describing her as a "*god send*". As suggested in the following quote, Phil has been supportive of Jenny adopting prescribing authority largely due to his experience of working with a NP.

> *She's [NP] really championed nursing I think, when she came a few years ago I think she broke the back of it in terms of, really showing Phil what nurses could do and you know she's always picking his brains and has had endless discussions about lots of patients and I just think that's really helped him to see and understand that nurses can do a lot and he's just, been very supportive.* (RNP 2)

As suggested in this quote, prior to Sue joining the team, Phil may not have been fully cognisant of the potential contribution nurses could make to patient care.

Sue reflected on her own nursing journey, describing a history of feeling "*frustrated*" and that as a nurse her point of view was not "*listened to by doctors*".

> *I just feel like I spent 30 years trying to convince someone, a doctor, that I'm working alongside, that maybe that's not the best option, or we could be doing more and now I don't have to do that anymore.* (NP 2)

Sue recognises the ways in which social conditions can constrain advanced nursing practice. Her experiences, both as a "frustrated" RN and as an "autonomous" NP, have informed and transformed her attitude and motivation (habitus). Sue is a strong advocate for advanced nursing practice, her motivation coming from her own experience as a RN when she felt her opinion and contribution was not "*respected and regarded*".

The NP in team two has mentored both Jenny and another RN in the team who is completing her postgraduate diploma to become a prescriber. She is considered by the nurses to be exceptionally generous with her time, even working with them in her unpaid time to ensure they receive the supervision required. Postgraduate and continuing education study is a valued and recognised form of cultural capital for the nurses in this team. A flow-on effect is evident—in the same way that the NP has encouraged the RN prescribers, Jenny has also encouraged and motivated one of the less experienced RNs to engage in further study to advance her knowledge.

Team Efficiency

Mary (RN) feels she and the other practice nurses benefit from Jenny's role as a RN prescriber. The practice nurses will often call on the RN prescriber to see patients when they perceive a prescription is required. Previous to Jenny gaining prescribing authority, if the GP and NP were too busy to be interrupted these patients would be asked to return the following day or directed to an after-hours clinic where they would wait to see a doctor or NP. The RN explained that the patients enrolled at this practice if turned away will often not come back, and the nurses worry about the detrimental health and social effects of not meeting their health needs at the time they present.

> *She can just see them from woe to go instead of this two tiered thing where we see them and then we have to basically get a doctor or a nurse practitioner to do the script. I had someone on Monday who came in and she'd had this cold and she'd been seen a week ago by one of the nurses who had reassured her that it was an upper respiratory tract infection. And she'd come back and she still had it and she was feeling particularly bad after the weekend and it seemed that she had some sinus infection as well. So, because she was a solo mum with five kids and this had been going on I thought, I'll see what Jenny thinks. And Jenny came in and …decided to go for the antibiotics rather than just waiting for it to hopefully go away. You*

> *know I couldn't of, I wouldn't of done it if it was the GP or the nurse practitioner because, just you know how busy they are and I might of given her a voucher [to cover cost] but you know that would have been really difficult for her with, balancing picking up kids from school and getting to, the after-hours, so it was really very good to be able to get Jenny in and, take over that consult in a way.* (RN 2)

Mary suggests that she feels comfortable asking another RN (with prescribing authority) for assistance but would not as likely interrupt the GP or NP. This suggests Mary recognises Jenny as potentially more approachable. In summary, the RN was supportive of Jenny as a RN prescriber. She feels the nursing team can work more efficiently and effectively having a RN prescriber on the team.

Phil, the GP in team two, described having a RN prescriber in the team as an "*asset to the practice*" in that having another member on the team who can prescribe enables team efficiency because more people can enable patients with access to essential medications. Phil also referred to his own personal position being benefited by the inclusion of an RN prescriber. Phil explains that "*everything's about time really*"; he feels his time is limited and due to the complexity of the patients' needs he struggles to keep to his 15-minute consultation times. This was corroborated by the nurses who suggested that Phil is often running behind schedule. Phil suggested that all the nurses in the practice have advanced health assessment skills which he sees as an asset (cultural capital). Now that Jenny can prescribe, his time with patients is less often interrupted by the nurses with requests to generate prescriptions.

> *I can't see how we lose out of it. I mean it makes, being selfish, it takes pressure off me because the prescribers can prescribe stuff and, if they even never decide to do that final step to be prescribers, they're going to be much, more well trained nurses who are going to do all that stuff and then I will be able to take 1 or 2 minutes and nip and double check and do things without having to spend 15 minutes or even 5 minutes doing it.* (GP 2)

Phil demonstrates his appreciation of the economic value to the practice of including a RN prescriber in the team and, at the same time, his frustration that Jenny's rate of remuneration has not changed since she gained prescribing authority.

> *The reality is this practice is always on a knife edge financially and you know there's no sugar daddy out there for us if we run at a loss. But I think that, having nurse prescribers, if you want to just be mercenary about it, will allow us to see more people, enrol more people and therefore increase the income for the practice. So I think there needs to be some process for recognising that [in the RN prescriber's salary].* (GP 2)

In summary, as the lead clinician in the practice, the GP expressed unreserved support for RN prescribing in the team. There was no evidence of concern regarding patient safety or tension regarding professional boundaries.

Patterns of Communication

Building Confidence

Unaccustomed to the responsibility of prescribing, Jenny explained that at first she found prescribing "scary". Regardless of her advanced knowledge and endorsement, when the time came to prescribe she did not feel fully prepared, commenting: "*At first you don't obviously feel confident, and you think hell heck where do I start?*" (RNP 2). Jenny described how she relies on the GP and NP to assist her by being available to answer questions and to check her prescribing decisions. The following vignette from Jenny's interview suggests she relies on the GP and NP for support and collaboration when prescribing.

> *What I've done which has been really helpful is whenever I do a prescription, especially if it's a list of meds, I will always send a note to either Phil or Sue or whoever the GP is or NP who is on, I send them a note "can you please check my notes I've done a prescription". So they'll look at it and say yeah that's good or have you thought about that or yeah whatever. So, that's a really good safety net for me. I've felt very comfortable with that. It's very good.* (RNP 2)

Jenny suggested that over time her confidence has grown and she feels more comfortable. However, she continues to seek reassurance: "*I will continue to ask them to check stuff that I, need a second pair of eyes on. To make sure I'm safe. I think that's important*" (RNP 2).

While Jenny is a very experienced nurse, when she adopted the task of prescribing she was uncomfortable. Bourdieusian analysis suggests that over her 17 years as a practice nurse Jenny has internalised her social position as a nurse. Up until now the rules and regulations (objective structures) of the field have not allowed her to prescribe. Her habitus recognises prescribing as the work of the GP or, more recently, the NP. She has been socially conditioned to see prescribing as risky work and initially, regardless of her educational preparation and credentials, her habitus has not yet evolved and adapted. Jenny engages strategies such as having her prescribing checked in order to build her confidence and lessen her sense of vulnerability. Her relationships (social capital) shared with the GP and NP are more important to her now than previously. The following quote illustrates the way in which Jenny values positive feedback received from the GP.

> *And the really nice thing for me is that when I send notes to Phil particularly, "can you please read my notes I did a prescription", he'll come back and he'll say yeah that's really good, well done. And he doesn't, he's always grateful and he's very kind but he doesn't always give verbal praise. So it's really nice getting that kind of feedback from him.* (RNP 2)

Phil's feedback and positive affirmation helps Jenny build her confidence in prescribing. It takes time and support for the nursing habitus to adjust to the change in the field brought about by RN prescribing authority.

Linguistic Capital

These findings suggest that Jenny shares different styles of communication with the GP and the NP in her team. Sue (NP) has always encouraged Jenny to contribute to problem solving rather than passing on the responsibility. She explains this in the following quote suggesting Sue is:

> *Very encouraging, and helpful and pushy sometimes! ...like you go to her with something and she'll say well what do you want to do? And I, before I used to say well I don't know, I'm not the prescriber, you need to prescribe it because I'm not taking responsibility for that but now I am the prescriber so that, she doesn't say that to me so much. I'll say to her this is what I want to do, is that okay? And we'll have discussion about it.* (RNP 2)

Sue's own experiences as a RN have informed her approach to mentoring Jenny. In her interviews she recalled times when doctors were reticent about engaging her in meaningful conversation about patient care stating: "*How on earth is a RN supposed to start changing her way of thinking if people aren't having those discussions with her in the first place?*" (NP 2).

The NP in team two is clear that as a RN prescriber Jenny must participate in conversations with other prescribers around diagnosis and treatment. She has coached Jenny to be accountable for her own decisions. Jenny, as a new prescriber, has moved from avoiding responsibility and asking "what do you want to do?" to accepting responsibility and saying "this is what I want to do". The GP, however, took time to adapt to involving Jenny in clinical decision making.

> *Before if I went to Phil with a question he would sometimes brush me off. But now I notice if I go to him with a question, he will actually engage with me, he'll sit down and give me a decent answer and we'll discuss it together. I think that's changed, particularly with him. With Sue it's always been the same.* (RNP 2)

Jenny describes moving from a communication style where her questions to Phil would be briefly answered and she would be effectively dismissed to a situation where she now engages in a reciprocal discussion about a clinical decision. The

following quote illustrates that Jenny now feels she can actively contribute to shared decision making and offer divergent opinions.

> *We probably have our biggest discussions around insulin and diabetes because that's the one I've probably had most experience with. And Phil wanted me to do something with someone and I said well actually no I don't want to do that because of this, this, and this reason and we discussed it and he left it with me which is quite good!* (RNP 2)

When questioned about what the GP meant by leaving it with her, Jenny explained

> *He was happy with it because the thing with anything you do, if you do it if you have, if you do something you've got to have reasons why, you do that. And I thought I had good reasons why we should do, you know take a certain course. And, and he was happy with that in the end.* (RNP 2)

In explaining the importance of providing rationale and justification for her arguments, Jenny demonstrated her growing linguistic competence in the realm of advanced clinical decision making. Since becoming a prescriber she has built cultural capital, expressed in her ability to communicate confidently, engage the GP, and have her contribution and perspective recognised and valued. Jenny is engaged in informal conversations about patients and the team's approach to clinical decision making occurring on a daily basis.

Nurse Centric Model

There is a strong sense of pride and shared professional identity (group habitus) apparent among the nurses in team two. The social structure of the team is fundamentally different from the traditional GP led model of general practice apparent in team one where the medical culture is dominant. Jenny suggests that with a NP in the team the nurses can operate the practice independently.

> *The thing about our clinic is we're nurse centric. We've become nurse centric. We're not GP centric. Because Phil's the only GP. We do have another GP who works on a Monday for one shift. ….But we're nurse centric and we think that, possibly, we could run this clinic, just with nurses. Actually, there are days when we have done that. So we're pretty proud of that.* (RNP 2)

The NP in team two has been an agent for transformative change and a champion of advanced nursing practice. In exposing the entire team to the NP scope of practice and demonstrating her knowledge and skill as an independent practitioner, she has raised the team's awareness of the potential of all nurses. While the nurses appreciate Sue's ability to perform the work of a GP, they recognise her as first and foremost a nurse.

> *Sue works very much like a GP. Except she thinks, she's got a nurse's brain. She thinks like a nurse.* (RNP 2)

Sue firmly identifies as a nurse, and as this quote from Jenny's interview illustrates that the nurses recognise her as being 'one of their kind', as sharing their group nursing habitus. In sharing a habitus, the nurses feel inherently comfortable working alongside the NP.

> *I think nurses recognise nurses too because somehow it's like the culture we understand each other. Which makes it very easy to work together because, we kind of know where each other's coming from. Yeah I think that's a good, actually probably a good way of describing it, the culture.* (RNP 2)

The inclusion of a NP in the team has effectively raised the value of the cultural capital attributed to being a nurse and, in doing so, elevated their social position. The nurses recognise the NP's advanced scope as positioning her in a more elevated social position than their own and thus raised their consciousness of what they can potentially achieve themselves. Postgraduate nursing education is seen as a catalyst for improving their position and the contribution they can make to the team.

As a strong advocate for advanced nursing practice, Sue has transformed the nursing group habitus within the team and the objective structure of the team. The field is structured in a way that places nurses in an integral and autonomous position. All of the nurses are required to work to the top of their RN scope of practice. Their advanced assessment skills are highly valued; they are responsible for assessing patients as they present. The nurses seek the support of the RN prescriber, GP, or NP when they reach the ceiling of their ability or the patient requires a prescription. The team function by maximising their individual and professional strengths and working to the top of their professional scope. As the RN prescriber in the team, Jenny plays an important role in both participating in and supporting this collaborative model. She is integrally involved in clinical decision making and participates in clinical conversations and joint decision making with other RNs and the NP and GP as necessary.

Summary

The team describe significant changes over recent years culminating in a revaluation of the forms of capital that are most valued in the team as well as the distribution of capital. The NP has been a strong champion of RN prescribing, mentoring and supporting the RN prescriber. The inclusion of a NP in the team has

resulted in the objective social structure of the team (field) evolving—becoming more inclusive and valuing of advanced nursing practice. These changes in the field have generated a collective nursing habitus encouraging the nurses to seek opportunities for advancement. Recognising the potential of their contribution, several of the nurses are engaged in postgraduate education. For Jenny, RN prescribing authority has enabled her to be more autonomous in her contribution to patient care.

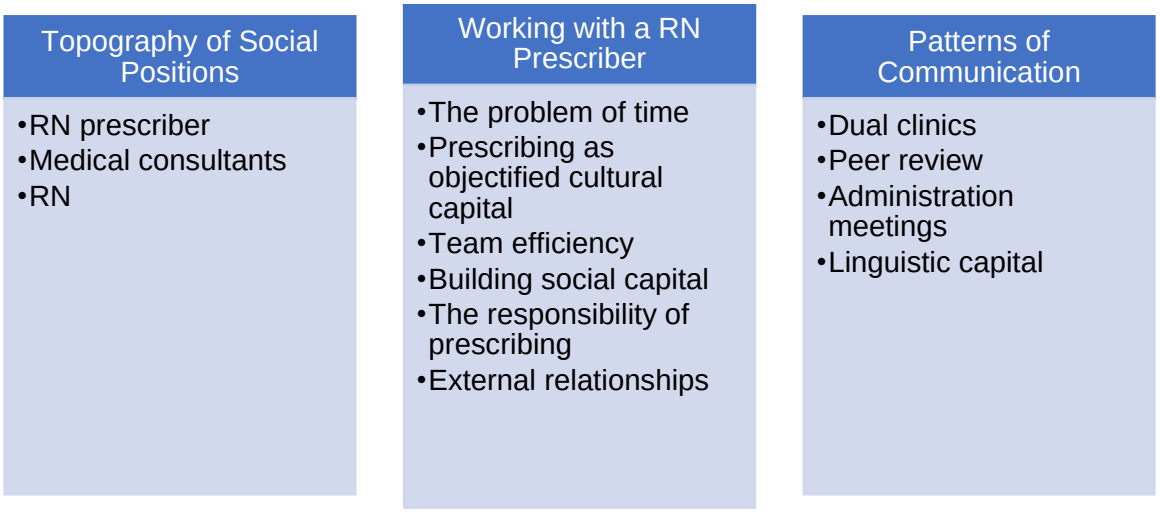
Health care practice in team two is collaborative. The team have a collective goal of meeting the needs of the disadvantaged community for whom they care. The RN prescriber role is regarded as significantly contributing to meeting this goal. RN prescribing in team two improves patients' access to medications and enhances team efficiency.

Chapter Seven: Team Three Findings

The purpose of this chapter is to present the findings from team three. Team three work in an area of specialty clinical practice demonstrating a very different model to the previous two general practice teams. The format of this chapter follows the structure of the previous two findings chapters presenting the three general themes common to all teams of social topography, working with a RN prescriber, and patterns of communication, along with sub themes pertinent to team three. Figure 5 presents the themes and sub themes for team three.

Figure 5

Themes and subthemes for team three



Team Three – Specialty Practice

Overview of the team

The healthcare team described in this chapter provide predominantly outpatient specialist health care within a large urban hospital. The team function independently but are a conglomerate of a larger field which is the hospital located within an overarching field of a DHB. The DHB is responsible for the governance and funding of the team; therefore, all staff are employees.

At the time the research was conducted, members of the permanent team included three medical consultants from a range of specialties, a clinical nurse specialist (CNS) who is the RN prescriber, and a RN. Medical registrars rotate through the service on a six-monthly basis. At the time this research was conducted there was no registrar attached to the team. Only two of the consultants were

available to be interviewed. A pharmacist who consults to the team was interviewed to gain their perspective on RN prescribing.

This small team provides specialist healthcare to patients suffering from and at risk of developing serious and potentially life threatening illness. The service provided is aimed at detecting risk and providing prophylactic and pharmacological treatment and education. The team predominantly provide care on an outpatient basis but also see patients who have been admitted to the hospital as required. Due to being largely an outpatient service, the team are not co-located in the same physical space. The two nurses are permanently employed to work in the service and share an office. The doctors employed to work in this service are part time, also working in other hospital departments. When consulting, they do so from shared outpatient offices.

Social Topography

A traditional hospital hierarchy of professional positions operates in this team and this objective system of stratification informs social positioning. Each member of the team is recognised by their role based on their discipline, professional qualifications, experience, and position of employment. A separate hierarchy exists within each discipline. The doctors in the team range from senior consultants, followed by less experienced consultants and medical registrars. The nurses include the more senior position of clinical nurse specialist (a designated RN prescriber), and a RN. This historic hospital hierarchy generates the social classification and accepted doxic order of the team.

In their interviews, the team reflect a united appreciation of the goal of the service as assessing and treating this specific community of patients. The goals of this team centre around the needs of the patient population for whom they care; the team are committed to meeting these needs and are proud of the service they provide. Following is an account of the roles, responsibilities, and social position of each member of the team, as perceived by the participants.

RN Prescriber

Sarah has worked in this team for in advance of 10 years. Her role, both prior to gaining prescribing rights and after, is as the CNS. Sarah had been engaged in postgraduate study well before the legislation changes that enabled RN prescribing in 2016. She had already completed a clinical master's degree with the intention of someday becoming a NP. She had no difficulty gaining the necessary support from her director of nursing and the medical consultants happily agreed to

supervise her first year of practice. At the time of interview Sarah had been a designated RN prescriber for one year.

The impetus to apply to the NCNZ for prescribing rights came from Sarah who saw the adoption of prescribing rights as an opportunity for her to enhance both patient care and the capacity and efficiency of the team. As the only nurse prescriber in her service, and one of the first in the hospital, Sarah talks of having to "*pioneer the role*". Besides some initial problems with ordering laboratory tests and the interface between primary and secondary services, she described a smooth transition into her prescribing role. Sarah attributes much of this to the support she has received from the consultants with whom she works. In the following quote Sarah describes the attitude of the senior consultant in her service to RN prescribing.

> *Tony, the main consultant is fantastic, he is pro-nursing going wherever you want. He's very, very supportive of whatever nursing wants to drive, and he was very proactive in supporting a lot of this [RN prescribing]. He's very keen to see nurses working to the absolute top of their scope.* (RNP 3)

Sarah's job title as CNS has not changed since she gained prescribing authority; however, her role has changed in that she now runs nurse led clinics where she prescribes. Sarah refers to herself as having been a CNS in her field for a long time. She speaks confidently about her ability, describing herself as "*seeing the consultant's patients*" and "*taking over and doing the registrar's clinic*". In asserting she can fill the role of the doctors when required, Sarah conveys her perception of sharing a similar social position to the doctors. Having noted this, Sarah is quick to point out that she continues to identify as a nurse: "*I'm not out there to compete with medicine. I'm not out there to say I'm a doctor. My knowledge is in my specialty*" (RNP 3).

Medical Consultants

Don (Consultant A) has been involved with the clinic for the past 25 years as a "support clinician" but, with the recent departure of other "very senior clinicians", now describes himself as "*by default in one of the lead positions*". In addition to consulting to this team, Don works across three other services in the hospital. Ben (Consultant B) works as a consultant in this service and one additional service and has done so for the past three and a half years. Both consultants referred to the clinic using the possessive pronoun "our" as in, "our clinic", "our team", suggesting they perceive ownership of the service as being shared by the team. When asked, both consultants denied the presence of a hierarchy within the team. Don described the

team as working "*cohesively*", suggesting everyone works at a "*fairly horizontal sort of level*". Ben agreed with this sentiment suggesting the team "*work together for patients to be able to achieve the best health outcomes*".

Both nurses attest to the cultural and symbolic capital held by the consultants in team three. The nurses used the words "*fantastic*" and "*amazing"* to describe the consultants' knowledge. Years of experience apparently adds value to this knowledge, evidenced by the nurse's response to the recent retirement of a senior consultant.

> *Tony's knowledge is phenomenal and that's going to be a big gap when he goes. We will miss that knowledge, because 30 years of knowledge in the field is pretty difficult to replace.* (RNP 3)

> *Tony's unfortunately just gone, so that's a power of knowledge just left.* (RN 3)

In addition to experience accumulated over time, a professorial title apparently adds status and professors are considered to occupy the most influential and powerful positions within the team: "*Two out of the three consultants are professors, so we're a fairly high-powered group*" (RNP 3). The previous quotes demonstrate the degree to which the consultants' knowledge and qualifications are revered by the nurses in this team. For the nurses, the specialist knowledge of the consultants and their professorial titles equates to power.

Both in this team and within the broader hospital hierarchy there is a historically grounded and inherently accepted understanding that consultants are positioned at the top of the health care professional hierarchy. The title of 'consultant' equates to institutionalised cultural capital in that it guarantees respect and prestige regardless of the person who uses it. Consultants are appointed as clinical leaders and are rewarded by the institution with highly paid positions of authority and influence. Furthermore, and as a result of their distinguished position, medical consultants hold symbolic capital, equating to prestige and culminating in respect from others.

Registered Nurse

Tania, the RN in team three, has been working with the team for four years. She repeatedly referred to herself as "*the newbie of the team*", suggesting that with the exception of one consultant everyone else has worked in the team for "*many, many years*". When asked to explain how she considers herself new after four years she referred to her self-perceived lack of knowledge: "*I still feel very under*

educated, like my knowledge is still nowhere near where it should be, it's quite hard to gain a lot of knowledge in a very, small team" (RN 3).

Tania spoke of feeling she is sometimes not informed or involved in aspects of team practice. She finds this frustrating but suggests that this may be because these discussions are held *"at a higher level"* or are *"over my head"*. Tania was the only interviewee who indicated a hierarchy exists in the team, and she was very clear that she is positioned at the bottom of it. In the following excerpt she offers a ladder analogy, depicting herself as occupying the lowest position in the team and the most senior consultant, a professor, at the top.

> *I'm kind of at the bottom rung of that hierarchy. When Tony was here he was obviously at the top of that hierarchy, he's got the most knowledge. From there I guess Sarah and the doctors are probably, possibly on quite an even hierarchy system. Sarah can quite often tell them what to do! Not always. But yeah I do feel quite, quite at the bottom of that, of that list.* (RN 3)

When questioned further about how it feels to be at the bottom of what she perceives as a hierarchy, she responded:

> *It's not always easy and it's not that I want to climb to the top of the list by any means. I would just like to climb up to here instead of down here where the others are up there [indicating levels with her hands]. I would like to sort of be, somewhere in the middle.* (RN 3)

Tania depicts a definite appreciation of her social position in relation to others in the team. While she has ambition to be higher up the hierarchy, she is modest in her aspirations.

The consultants compared the RN to the RN prescriber, both suggesting that she is not as experienced in the area and has not completed postgraduate study, with Ben suggesting she is "*still learning her ropes*". The RN prescriber also pointed out that Tania has not yet completed any postgraduate study and suggested she "*mentors*" the RN.

Summary of Social Topography

This analysis of the ways that members of the team categorise themselves and the work they do sheds light on the prevailing social structure within the field. The perceptions and insights shared by the team reflect their internalised experiences (habitus) which have been generated within the team and have contributed to the structure of the team.

In team three, clinically based knowledge relating to this specialised area of medicine is the most valued resource in the form of cultural capital. The consultants hold the most cultural capital in an institutionalised form. In this team the professorial

title held by several consultants places them in the undisputed top tier of the social hierarchy. The team recognise this system of stratification, recognising the position of all the consultants as one of prestige and authority—they are endowed with symbolic capital.

The RN prescriber's postgraduate qualification and her endorsed prescribing authority is recognised in the team as a valued form of cultural capital. Whilst not as valuable as the consultants' institutionalised cultural capital, her knowledge and extensive experience place her in a position below but near the consultants. The RN has no postgraduate qualifications and therefore has little capital in comparison to everyone else in the team.

Working With a Registered Nurse Prescriber

The work in this team is structured around patient clinics. All members of the team run specific clinics tailored to both patient needs and the skills and ability of the clinician to meet those needs. When referred to the service, patients are booked into one of a range of clinics based on the acuity of their needs. The patients are placed on a waiting list and how long they will wait for their appointment depends on the urgency of their condition and who they have been booked to see. If they are booked to see a consultant, they will wait considerably longer than if they are booked to see a nurse.

The Problem of Time

Both consultants interviewed in this study spoke of feeling constantly under pressure to meet patient demand in the face of limited time. "*Time pressure is always a problem. Because resources are always limited. And sometimes you just run out of time during clinic hours to do the things you need*" (Consultant B3). Fiscal restraints imposed by the DHB, along with the demands of working across several services, have added to this time pressure. The consultants and registrars often run late and on occasion are not able to attend scheduled clinics.

Following referral patients face a long wait time, particularly to see a consultant. Because there are limited consultant hours and excessive demand for these hours, the consultant's time is highly valued, further adding to their symbolic capital. In the following excerpt from her interview, Sarah explains that prior to gaining prescribing endorsement she would fill in for both the registrars and the consultants, running their clinics when they were unable to attend.

> *Our clinic waiting lists were getting really huge, times were tight, and I was quite often seeing the consultants' patients for them. Our registrar had scheduled clinics, but because of the workload in the ward would be ringing*

on the morning and saying "I can't make clinic today, I'm tied up in the ward". So I'd be taking over and doing the registrar's clinic. (RNP 3)

The majority of the patients engaged with the service require regular medications. Prior to gaining prescribing authority this posed a problem for Sarah, requiring her to negotiate prescriptions with the consultants on her behalf. Since gaining designated prescribing authority, the team have formalised her additional responsibility and established a new "nurse led" follow-up clinic where Sarah can titrate and commence new medications, as she suggests she is now able to "manage" this group of patients. As highlighted in the following quote prescribing is associated with a greater level of responsibility.

But in terms of prescribing, she's looking more, sort of into, pharmacotherapy the, interaction between medications that the patient's on and basically looking at lists of new medication based on the current medication the patient's on. Or whether it's the right direction which usually is more of a physicians' job I think she's taking more of that role as well so it's, it's good that you know. It's a bit of a shared care! (Consultant B3)

Prescribing as Objectified Cultural Capital

Sarah's ability to prescribe enables her to carry out work previously completed by the consultants. As Ben asserts in the previous quote, the addition of prescribing for Sarah means she can "*share*" the care of the patients. Sarah's designated prescribing authority is legitimised by the consultants in the way they recognise her ability to work in a similar way to what they do.

I think the parameters that apply to her apply to me or any other medical person. I mean I'm certainly very comfortable with it given that I've worked with Sarah for many, many years. And I know that she's an appropriately experienced person with very good insight into the conditions involved. Good insight into the drugs and how they work and how to use them. (Consultant A3)

Sarah has transformed her postgraduate qualification and previously acquired cultural capital into a more valuable resource, which is objectifiable. As objectified cultural capital, Sarah's designated prescribing authority enables her more autonomy in her role and the opportunity to complete a patient consultation in a similar way to the consultants.

Sarah's ability to prescribe has enabled her to run an additional clinic; this in turn has had immediate ramification for the work of the consultants. The consultants can now use their time to focus on the patients considered to have more urgent

needs. As the following quotes from the two consultants illustrate, this has ultimately saved the consultants' time.

> *It's had the effect that it's made our overall clinic maybe more time efficient. That people like myself and other SMO's, RMOs can stay more focussed on people that need more attention. I think being able to see those patients, and enable us to focus on the more high-risk ones is good.* (Consultant A3)

> *I guess since Sarah became a prescriber what I find is that we're able to get through more volume in a way. Rather than stuff like all the medication adjustment being done by a physician, a registered nurse can look at that and if appropriate have a chat to see whether that kind of things need some adjustment.* (Consultant B3)

Application of Bourdieu's principles of capital recognises Sarah's accumulation of objectified cultural capital as a strategy to improve her social position within the team. This redistribution of capital has resulted in salient and transformational changes to the objective structure of the field. As Bourdieu would suggest, the redistribution of capital does not happen in isolation. Sarah's newfound capital indeed alters her social position but, in doing so, directly impacts the experience of others in the field (team).

The consultants recognise the value of Sarah's prescribing authority. When asked to describe how the RN prescriber's contribution impacts the team Consultant A responded:

> *I think the general efficiency of the team, enabling others to be more appropriately targeted where they can add value. So less distracted or bogged down by less productive interactions. I think it has been helpful and I think Sarah does it very well.*

In response to the same question, Consultant B referred to RN prescribing as:

> *A way to bridge the gap. Because the health resources are quite limited, some of the patients might get a full medical review kind of once a year but if they can see the nurse in the interim as well, and to kind of tidy up those small targets, make sure that those risk factors are appropriately treated.*

In both quotes the consultants compare the contribution of the RN prescriber to their own. Consultant A suggests that Sarah takes care of the "*less productive*" patient interactions and, in a similar way Consultant B refers to Sarah tidying up the "*small targets*". The language used by the consultants distances their own contribution and authority from that of the RN prescriber. This is a subtle form of symbolic domination which enables the consultants to reconcile the sharing of power by designating the RN prescriber's cultural capital as being of less value than their own. This evidences a power struggle orchestrated to reproduce the pre-

existing social order and to maintain the consultants' position of dominance in the team.

Team Efficiency

The inclusion of a nurse with designated RN prescribing authority has impacted all members of the team. Sarah has more autonomy and is able to meet patient needs in a more comprehensive manner. The consultants' workload has lessened, and they are able to focus more on the patients presenting with greater risk. Sarah's new prescribing authority has also impacted the RN's position. Tania (RN) explained that since Sarah had become a prescriber and taken on additional clinics, her own role within the team has also changed. She manages some of Sarah's previous work and feels she now has more autonomy and the ability to get more involved with interesting and challenging aspects of patient assessment which she finds rewarding and more satisfying.

The other group, and arguably the most important, to benefit from Sarah's prescribing are the patients. The team describe a more streamlined service where patients are not inconvenienced by repeated trips to the hospital. When Sarah sees new patients, she can assess them and, if necessary, initiate treatment. By the time the patients see the consultant in clinic, the team have an idea of how they are responding to newly initiated therapy. Sarah's new clinics offer the team more flexibility in offering clinics very early in the morning which is more convenient for patients who work. Finally, the impact of Sarah's new follow-up clinic has had a substantial impact on patient waiting lists.

> *The waiting lists for [Consultant A] and for the registrar have come down. Remarkably because Sarah is pulling patients from their follow up lists and seeing them. So instead of waiting six months or so after their appointments it's sort of down to two or three months, so it has come down quite dramatically and will, I imagine, keep falling down that way as well.* (RN 3)

Designated prescribing authority has enabled the team to provide a more flexible service that better meets the needs of the patients.

Building Social Capital

Over the past decade of working in this team Sarah has developed salient working relationships with the medical consultants. Sarah's alliance with the consultants has enabled her to benefit from the collective prestige and symbolic capital of the medical team which, for Sarah, equates to social capital. Sarah attributes much of her success, particularly in terms of knowledge growth and achieving prescribing authority to her relationships with the consultants.

> *I am so lucky. I have amazing physicians, amazing consultants I work with. I am just so blessed. It's wonderful, because they've seen me grow and know that they have contributed so much to that [prescribing knowledge].* (RNP 3)

Sarah describes her journey to becoming a nurse specialist and a prescriber as much like an informal apprenticeship, in that she has learned experientially by observing the consultants and emulating their practice.

> *I used to attach to Gen Med [the general medical team] ward rounds, acute and post-acute, in the weekends. It was just something I did in my own time, as a really good learning curve, for getting my assessment skills and getting my knowledge right up there.* (RNP 3)

Another strategy Sarah has employed to build her knowledge has been to sit in on the consultant's patient consultations.

> *I would actually see the consultant's patients for them, with the consultant sitting there. So, so I'd do his clinic, with some of his patients, and so he could see how I consult, what I cover, what I don't. How I do my physical examinations. All those things. And that's really important, because that's part of them understanding how I practise and it's part of a learning thing as well. …So we just pick a standard patient. The consultant takes a seat. We sit together. I do the patient management, all the things like that.* (RNP 3)

When asked what transpired after these consultations, Sarah responded:

> *Feedback. Constructive feedback. I take it on board, and I change what I need to do. And it's actually great for both of us, because I'm bringing some different things, and they've come away with some different things to think about too.* (RNP 3)

Sarah's initiative of running the doctors' consultations was initially intended as a learning opportunity for Sarah but resulted in mutual learning for both parties, with the consultants benefiting from an enhanced appreciation of the contribution a designated RN prescriber can make to patient care. In team three, Sarah considers there to be mutual appreciation between her and the consultants regarding the knowledge and contribution each discipline brings to the team: "*If we've got a really complex patient we have a meeting of what we call 'The Brains Trust', and that's when we call everybody together. We just say 'Brains Trust Meeting to discuss*" (RNP 3).

The RN in team three described quite a different experience to Sarah's. Tania feels she has had limited opportunities to learn since joining the team four years ago. In the following excerpt from her interview, Tania refers to her desire to extend her knowledge and her frustration at accessing opportunities to learn from the team.

> *When you're just in a very small clique it's very hard to, to get that quite the same especially when your doctors you only see for a couple of hours a week and they're busy and all the rest of it. So it is hard to get in there with the knowledge base a little bit more.* (RN 3)

In referring to the team as a "clique", Tania intimates that she does not belong. She refers to the exclusive relationships shared by Sarah and the consultants, suggesting she is located on the periphery of the group and is not party to the same benefits in terms of knowledge development and learning opportunities. Tania does not share the wealth of social capital in terms of relationships shared with the consultants and she sees this as a disadvantage.

The Responsibility of Prescribing

In addition to relying on her alliance with the consultants (social capital) for learning, Sarah relies on this relationship to assist her to prescribe both confidently and safely. Sarah adheres to a belief that all prescribers, at some time in their career will make an error: "*Because human error happens, and you will make a prescribing mistake. Everyone does at some time*" (RNP 3). She reflects a level of apprehension and vulnerability as a relatively new prescriber: *"And it's friggin scary… Yes, I do not feel complacent at all when I write a prescription. I'm very careful and I read it, and I read it [laughs] and I read it*" (RNP 3).

In anticipating the likelihood that she will make an error Sarah has underlying concern about what the consequences would be for her. Sarah consciously employs practical strategies like carefully checking her prescriptions to mitigate the risk of making an error. In addition, she works to build alliances with the consultants. As she explains in the following quote, she senses that should the situation arise, she will be in a better position and the consequences will be less detrimental if the consultants can attest to her competence and safe prescribing practice.

> *And I think as a nurse prescriber we have to be very respectful, that yes we may have prescribing rights, but, they still need to know what we're doing. And it's really important, because if ever anything happened, God forbid, then if you ever had to stand up in front of Nursing Council, you can say actually this is not a normal part of my practice. You've got others who can say, that's not part of how she would normally practise. If someone's, "oh she's slapdash all the time", that's a whole different ballgame. But if they say "no, she is always thorough".* (RNP 3)

These words demonstrate Sarah's appreciation of the elevated position of power and authority that the consultants occupy and, in contrast, her own position of vulnerability. Sarah has employed a deliberate strategy of ensuring each of the consultants she works with has personal experience and evidence of her

competence, as well as understanding of the parameters and sanctions around her designated prescribing authority and scope of practice.

> *I probably have more clinical supervision than Nursing Council say you need. …So, when we had two new consultants they needed to know where my practice is. So I needed to be able to take things to them on a regular basis so they could see, this is where Sarah's practice is, this is what her scope is, all those kind of things. 'Cause it was new, it's new for them. So, that was a big, big part of it, is ensuring that they're kept safe as well.* (RNP 3)

This quote suggests that Sarah perceives she shares responsibility for her prescribing with the doctors, and that in agreeing to supervise her they are, in some way, jointly accountable for her practice. Sarah has chosen to keep a written record of her prescribing practice including the consultant's authorisation.

> *I keep a prescribing log of every prescription that I do. So for every consultant's patient that I've seen, where I've done a script adjustment, initiation, whatever, I put which consultant it was that I talked with the patient about, and then we sit down on a monthly basis. I try and do it weekly it doesn't always happen….And they read through what I've written and sign off.* (RNP 3)

A prescribing log, such as Sarah describes, is a requirement when completing a prescribing practicum but now that Sarah has had prescribing authority for more than a year it is no longer a requirement of the NCNZ. Rather, this is a practice that Sarah has chosen to continue, suggesting that in having the doctor's signature to support her prescribing decisions she will have that documentation to fall back on if her practice is ever called into question.

The responsibility of prescribing and the associated risk is new to Sarah. She is the first nurse prescriber in her team and has no past experience (habitus) on which to interpret her current circumstances. As a novice prescriber, she is cognisant of the sanctions imposed by the NCNZ on her prescribing and the consequences of making a prescribing error. Sarah does not allude to any personal experience of making an error or receiving a penalty; however, she has internalised the threat which manifests in her feeling "scared" and vulnerable (habitus). Put another way, Sarah has been socialised to anticipate, as a nurse, a negative outcome if called to defend her prescribing position. The objective social structures, in the form of NCNZ regulations and related consequences of making an error influence her habitus, rendering her to feel dependent on the consultants for support and defence should the need for it arise.

In addition to drawing on her social capital for indemnity, Sarah relies on these relationships for confidence when prescribing. This is not a conscious

strategy; rather a subconscious adaptation of the habitus. Bourdieu (2020) referred to this as the “practical sense” (p. 69) which generates adaptive behaviours, not as a calculated response to an unfamiliar situation but a gradual acquisition of new dispositions in response to being confronted by novel social situations. This is evidence of Sarah’s evolving habitus in response to her changing social position within the team.

External Relationships

Recognising the need for further support and continual learning, Sarah has extended her social network beyond the immediate boundaries of the team. Sarah organised a support group for RN prescribers in the hospital where they meet with the pharmacist. As Sarah illustrates in the following quote, she recognises the pharmacist has unique knowledge.

> *The other thing I do is I meet once every second month with our, area pharmacist and this is something I initiated. …We get, get our prescribing from our consultants, so we use their knowledge, as well as our own, but a pharmacist brings a different perspective.* (RNP 3)

Sarah has actively grown her social capital in the form of a relationship with the pharmacist which, in turn, has enabled her to extend her knowledge (cultural capital). She shares a relaxed and informal relationship with the pharmacist enabling her to call on him anytime she needs his assistance: “*It’s fantastic. Phone a pharmacist [laughter] phone a friend - phone a friend*” (RNP 3).

In summary, Sarah has actively engaged in building relationships with other health care professionals whom she considers will benefit her position within the team. Relationships built over time with the consultants have enabled her access to learning opportunities that would not have been available without this social capital. In addition, Sarah relies on the trusting relationship she shares with the consultants to allay her sense of vulnerability and apprehension in the face of prescribing. In widening her pool of support beyond the immediate team to the pharmacist and other RN prescribers in the hospital, Sarah has extended the support she has in her new prescribing role.

Patterns of Communication

Although the members of team three are not permanently located in the same physical space, they find opportunities to work together in a meaningful way. Dual clinics, peer review meetings, and administration meetings enable the team with opportunities to share clinical decisions and learn from one another’s

perspectives regarding patient care. Data recorded in the form of field notes taken following my observation of both a peer review meeting and an administration meeting are included in the following analysis.

Dual Clinics

The RN prescriber and consultants run what they refer to as "dual" or "joint" clinics. In these clinics both the RN prescriber and consultant attend along with the patient and family.

> *And it's really important that if we're altering medication, starting medication, doing all those things, it's life long, long term meds, that the family have a good understanding of it, that the child has an understanding of it, that we're all on the same wavelength, that there's a good knowledge base, and that the family has a port of call if there are any problems. Now if I'm not there, how the heck am I going to have a really good grasp on what's been told, what's been interpreted, and then what's happened?* (RNP 3)

As this quote suggests, Sarah is adamant that in order for her to provide ongoing follow-up care she needs to be present with the consultant at this initial meeting. Sarah was quick to point out that her participation in these dual clinics is not only to listen to the consultants' perspective but to also to actively contribute.

> *Yeah, and to contribute as well. So there is a mutual respect for each other's knowledge, and the combined knowledge is what we bring to the service, to enhance patient care.* (RNP 3)

Sarah explained that dual clinics enable the sharing of perspectives. When asked to provide an example of the perspective she brings to the consultation as an RN, she shared an example relating to medication compliance, explaining that her holistic nursing perspective enabled her to build on the consultant's prescribing plan by ensuring it was flexible and appropriate for the patient's unique lifestyle.

> *We bring a different perspective than medicine. For example, I do a lot of the, work around contraception, pregnancy, post-partum, all of those kinds of things. I do some of the counselling, minor, you know base counselling stuff. And often nurses just come with a different view.* (RNP 3)

The consultants corroborated Sarah's account of bringing a different perspective that adds to their own specialist medical focus.

> *And there are certain areas I mean that she can probe and that she has a lot of knowledge of. Like for example younger women, when they start talking about contraception and lifestyle, family planning and things like that. So she's got probably quite a bit more insight into those areas which are also important.* (Consultant A3)

Shared clinics enable joint decision making between various team members and the patient and family. They also have the added advantage of enabling the various members of the team to appreciate the perspective of other team members, and to gain an appreciation of what they can contribute to patient care. As demonstrated in the previous quotes, the consultants express an understanding of what Sarah brings to the team and vice versa.

Peer Review Meetings

Team three meet weekly after clinics to conduct what they refer to as "peer review". The meeting provides an opportunity for the consultants, registrar, RN prescriber, and RN to review the care of the patients seen in clinic that week. Assessment findings and treatment decisions are discussed, enabling the team an opportunity to discuss concerns and share cases of interest. Observation of one such meeting demonstrated Sarah taking a lead role in facilitating the meeting. The meeting was held in a patient consultation room. Sarah sat at the desk in front of the computer and led the meeting. Analysis of a sociogram recorded during the observation suggested Sarah initiated most of the dialogue and spoke more than any other member of the team. Sarah contributed to discussions about every aspect of care including laboratory findings, medications, referrals, and clinical research.

Administration Meetings

Sarah meets with the lead consultant weekly to assist with triaging of new patients and manage communication with the clinic. This provides Sarah with a one-to-one opportunity to discuss her treatment plans with the consultant. The following excerpts from Sarah's interview provide examples of the type of things discussed in these meeting.

> *I forwarded that email to Don with my response of what I think medication wise, what I want to do management wise, and he and I will sit down and discuss that. And then we'll formulate an appropriate letter, back together.*
>
> *The other thing we do is go through difficult cases. For example, I'm seeing a patient whose father had a drug reaction and took four years to come right. Now they're wanting to look at the same, similar, family of drugs for this person. So I'm going to be discussing some of the extra tests that I would like to add in and get his advice on anything else.* (RNP 3)

I observed one of these meetings between Sarah and Don. Sarah confidently presented each clinical case. She frequently referred to laboratory findings and medication regimens, asking questions of the consultant such as: "how aggressive to be with treatment?", "is this a candidate for the drug trial?" Sarah confidently

answered questions directed at her such as: “What type of reaction did he have?”, “has he got previous LFTs (liver function tests)?” There was evidence of joint decision making during the meeting. The consultant was planning an overseas trip and Sarah offered to check blood results in his absence and to see some of his booked patients in her clinic. Don had arranged a meeting with an external medical specialist and invited Sarah to attend.

Linguistic Capital

Over the past decade, Sarah has worked more often and closely with doctors than with nurses or any other health care professional. Her work experience has involved unique opportunities to communicate such as attending medical ward rounds and attending dual consultations. In addition to her postgraduate education that has informed her linguistic competence, these social conditions have informed and continue to inform her linguistic habitus. Sarah’s linguistic habitus is very much in tune with the linguistic market that characterises the field. As was demonstrated in both meetings I observed, Sarah is comfortable in this team and communicates with confidence.

Sarah explains that the consultants will take her calls any time. This suggests she has linguistic capital in that she can command an audience as and when required. As she explains, the consultants are “*very available*” to her. Tania testifies to Sarah’s cultural capital suggesting she “*can quite often tell the consultants what to do!*”

Symbolic Capital

The findings presented previously demonstrate that since gaining prescribing authority, Sarah has gradually extended her portfolio of capital. She has transformed her previously acquired cultural capital into a more tangible and valued asset which is her designated prescribing authority. Sarah has worked to build new and strengthen old alliances with both the consultants in the team and pharmacists and other RN prescribers on the periphery. These relationships assure her social capital benefiting her in terms of opportunities for learning and support in ensuring she is safe in her prescribing. Finally, Sarah has established linguistic capital both in her ability to express herself and contribute to clinical decision making within the team and in securing an attentive and committed audience.

Sarah’s accumulation of capital, embodied in her habitus has, in turn, influenced the work of every other member of the team as well as the patient population they serve. An additional nurse led clinic supports the consultants in that it enables them the ability to focus their limited time more on seeing high-risk

patients. The non-prescribing RN has picked up some of the work that Sarah used to do, meaning her role is more challenging, varied, and interesting. The patient waiting list has significantly reduced and the team can provide a more streamlined and flexible service that better meets the needs of the community.

The key finding from this team is that in addition to building cultural, social, and linguistic capital, Sarah has established symbolic capital. Rather than being a separate form of capital, symbolic capital is the aggregation of all forms of capital when recognised and, therefore, legitimated by others in the field (Bourdieu, 1989). Sarah is highly regarded by the team who recognise her knowledge and experience. The team appreciate the overall benefit of Sarah's contribution and are able to function more efficiently and meet patient needs in a more timely manner and reduce the overall waiting list for the service.

The accumulation of symbolic capital by the RN prescriber in team three does not represent a revolution of power. The consultants continue to hold more symbolic capital and the dominant position in the social structure. These findings have illustrated a subtle struggle as the consultants have asserted their superior knowledge and skills. Sarah has not campaigned to position herself in a dominant position. In maintaining her RN scope of practice and reinforcing her interdependent relationship with the consultants, she is complicit in maintaining the status quo.

The status quo in team three reflects a negotiated and flexible space where Sarah, as a designated RN prescriber, has had the opportunity to influence and enhance collaborative team practice in the following ways:

- Increasing opportunities for health care professionals from different disciplines to work together and alongside patients and family
- Enabling the consultants to focus their limited time on the patients whose health conditions pose the greatest risk
- Empowering the RN prescriber to work to the full potential of the RN scope incorporating designated RN prescribing authority
- Providing opportunities for peer review of clinical cases, leading to enhanced appreciation of each other's roles and learning from each other
- Enhancing the efficiency of the team culminating in shorter wait times for patients to be seen in the service

Summary

This chapter has presented a specialty practice team contained within a large hospital. A traditional hospital hierarchy of positions is evident within the

structure of the team. Analysis of the social positioning of the team and the personal resources (capital) available suggests cultural capital in the form of esoteric clinical knowledge is a highly valued asset. The medical consultants are considered to have the most cultural and symbolic capital and, in turn, hold a symbolic position of dominance.

As an RN prescriber, Sarah has built on her wealth of almost all forms of capital including cultural, social, and linguistic. This has resulted in salient changes to the objective structure of the team culminating in personal benefits for all members of the team and the patient population. Over time, these resources have been legitimated by the team culminating in symbolic capital. Symbolic capital is apparent in the way others in the team recognise her as holding a position of authority. Sarah's prescribing and the subsequent inclusion of an additional clinic has been attributed to have had far reaching and beneficial effects on the team and the patient community they serve. Collaborative practice is apparent in the ways the team are seen to work together, respecting and valuing each other's contribution and sharing decision making.

The previous three chapters have addressed the findings of each team individually. The following discussion chapter addresses the commonalities and differences in each team, and discusses the key findings in light of existing literature.

Chapter Eight: Discussion

The previous three findings chapters introduced the health care teams included in the study. Each findings chapter addressed the overarching themes of social topography, working with a RN prescriber, and patterns of communication. Within each theme, sub themes were identified as they pertained to the individual team. Each team is unique in terms of the disciplinary makeup of the team and the health care they provide; and in the relationships shared between team members, the way they interact, communicate, and the way the work of the team is organised.

This final chapter synthesises the findings, drawing on the similarities and differences between teams and discusses these within the context of what is already known from previous research. The chapter begins by revisiting the original research question and aims, followed by a brief summary of the key findings. The findings are discussed in three sections, each section resembling the overarching themes as presented in the previous findings chapters. Next, recommendations for education providers, health policy makers, and health care teams are provided. Finally, important ideas and recommendations for further research are proposed, along with the strengths and identified limitations of the study. The chapter ends with a summary and concluding statement.

The Research Question and Aims

This study set out to answer the question ‘how do registered nurse prescribers influence collaborative team practice in New Zealand?’ The aims of the study were to understand:

- How RN prescribers interact with other members of the health care team
- What social processes are at play within each health care team

This research was conducted within a transformative paradigm grounded in the recognition that power differentials are inevitable in all social relationships. Bourdieu’s ‘Theory of Practice’ was chosen providing a critical approach with which to interpret the findings.

Summary of Key Findings

The findings from this research illustrate that a pervasive system of classification operates in each health care team. Team members classify themselves, and those they work with, according to the disciplinary group to which they belong. This system of classification informs the objective structures including

division of labour, as well as the allocation of time and physical space within the team. An interdependent relationship exists whereby the organisational objective structures that manifest in the team generate subjective structures apparent in the dispositions or habitus of the team members. The patterns of communication shared by RN prescribers and other team members reflect the power dynamics at play within each team. The ability of the RN prescriber to contribute to collaborative clinical decision making is enabled or constrained by both the social structures (linguistic market) and the value of their linguistic contribution.

Social Topography and a Pervasive Taxonomy by Professional Discipline

The previous findings chapters presented three fields as structured social spaces, each field representing a health care team. Within each team, individuals occupy positions classified according to their professional discipline. Each position is defined and structured based on professional qualification and role. These positions exist in the team regardless of the individuals who hold them. When asked to articulate their role within the team, each participant identified themselves as a nurse, doctor, or pharmacist. Depending on the clinical area, the doctors and nurses used job titles to further distinguish their role within the team. In general practice, the doctors are referred to as GPs and in specialty practice as consultants and registrars. In relation to nurses, in general practice the RNs are referred to as practice nurses or NP and in specialty practice as CNS or RN and RN prescriber. Attached to each disciplinary label are collective institutionalised expectations regarding the competence and role of the person who holds the label.

Within each team the participants described the work they do and the routine of a working day in relation to that of other members of the team. The exact nature of the work performed by doctors and nurses differs between teams; however, in each team there is a tacit and shared appreciation of what is expected from a team member belonging to each discipline. For example, in teams one and two the teams referred to the “routine and normal” things a practice nurse does. This system of classification is deeply engrained in the habitus of all participants, the social order based on discipline is taken for granted and accepted as the doxic order or natural way of the world. The disciplinary classification provides an established social order on which daily practice and understanding is based.

The disciplinary classification is grounded in history, and both recognised and reinforced by powerful political influences outside of the team. The broader fields of power including DHBs, PHOs, professional regulatory bodies, and

educational institutions all recognise and reproduce this system of classification. Resources, remuneration, opportunity, and responsibility are distributed according to a taxonomy of professional discipline. The collective classification of health care professionals, based on disciplinary group, perpetuates and reproduces the social stratification of health care teams resulting in the potential for inequitable allocation of valuable resources and opportunity.

The observation that health care teams adopt a taxonomy based on professional discipline is a finding grounded in the data rather than a ubiquitous and convenient assumption. Bourdieu warned researchers against adopting socially preconstructed terms to categorise the characteristics of groups, blaming everyday language for constructing misleading publicly stereotyped conceptions (Bourdieu & Wacquant, 1992). These findings concur with Bourdieu's viewpoint, suggesting that the engrained system of classification apparent in each team has produced and, over time, reproduced practice that is constrained by outdated conceptualisations. This tendency to universalise the contribution of team members based on their discipline is revealed in this study as being problematic for nurse prescribers. When members of the team make automatic assumptions of what a RN prescriber can contribute based on traditional nursing roles, they are blinded to the future potential of the role.

These findings describe a dialectical relationship between an engrained system of classification by professional discipline, the organisational structures (objective structures) this produces and the embodied social or subjective structures (habitus) that are in turn generated. This research is grounded in a relational ontology, in the belief that people cannot be separated from society. According to Bourdieu (2020) social existence manifests in objective structures, "in mechanisms and things" (p. 28) and, at the same time, in subjective structures, in "bodies" or the habitus. In keeping with this ontological position of relationism, this research views team practice from a position that appreciates the way in which the objective structures informing each team intersect with the embodied habitus, the subjective structures, of the individuals who work in it.

Subjective structures are embodied mental structures conceptualised by Bourdieu as the habitus. The habitus culminates from the internalisation and conditioning of the objective structures to which an individual has been exposed; so habitus is the embodiment of history (Bourdieu, 2020). In each team the health care professionals interviewed expressed dispositions in the form of attitudes and actions as manifestations of their disciplinary position. These dispositions have been formed over a lifetime; however, this research focused on the participants' experience in the

team they currently work in and the impact this has had on social conditioning. In the same way that the habitus of each member of the team is generated by the objective structures of the way the team function, the habitus of the team members influences the objective structure of the team. The dualism arising from the objective structures that generate the social structures profoundly impact the way individuals from different disciplines work together and provides invaluable insight into the ways in which the inclusion of an RN prescriber influences collaborative team practice.

Working With a Registered Nurse Prescriber: Enablement and Censorship

Each team is unique, differing in tangible ways including the health service they provide, funding and governance structure, and the disciplinary makeup and size. The teams also differ in less tangible ways. The following discussion reveals some of the less visible influences, including the forms of capital, that scaffold the daily practice of each team.

The Established Order: Symbolic Power and Establishing the Value of Registered Nurse Prescribing

Types of capital differ between each team—in the forms that manifest, the way it is distributed, and the power it evokes. These findings illustrate that in all teams the authorised prescribers, doctors, and, in team two, a NP, hold more of all valued forms of capital than other members of the team. This is especially apparent in relation to cultural capital, in the form of educational qualifications, field specific knowledge and independent prescribing authority; economic capital, in the form of business ownership and associated financial gain; and symbolic capital, in the form of authority and respect as recognised and legitimated by the team. Symbolic power arises from the aggregate possession of substantive volumes of all forms of capital (Bourdieu, 1989).

As the bearers of symbolic capital, the authorised prescribers in each team are accorded the power to lead patient care. The extent of this power and the ways in which it is employed differed in each team; however, the authorised prescribers hold a dominant position of authority in the established order of all teams. Several previous studies have noted similar findings in relation to the medical profession, suggesting it is a dominant profession, particularly in relation to holding authority over clinical decision-making and prescribing (Cooper et al., 2012; Kroezen, Mistiaen, et al., 2014).

The findings of this study demonstrate that as clinical leaders, the authorised prescribers determine the distribution of aspects of patient care. In some instances, this culminates in general patterns of practice, such as in team three where the lead consultant triages patients with the RN prescriber's assistance into clinics that are autonomously run by assigned members of the team. On other occasions, such as in team one, the GPs delegate aspects of individual patients care, such as the administration of medications or assessments to be undertaken. In holding the leadership position and determining how patient care is distributed, the authorised prescribers establish the value of the contribution of each member of the team. From this dominant position the authorised prescribers play a salient role in determining the value of RN prescribing.

These findings suggest that when authorised prescribers perceive a tangible benefit of RN prescribing they are more inclined to value their contribution. This was apparent in both teams two and three. In team two, the GP and NP appreciated that the work of the RN prescriber meant they could each spend more time with patients and their consultations were less often interrupted by nurses asking for prescriptions. In addition, the authorised prescribers saw value for their disadvantaged practice community as it meant that more patients could be seen in a day. Despite this practice being a very low cost 'not for profit' operation, the GP also noted an additional benefit of having a RN prescriber as bringing additional financial resource into the practice. The authorised prescribers, consultants, in team three also attributed value to the RN prescriber role. They valued the way the RN prescriber could see the stable and follow-up patients enabling them to spend time with the more acute unwell and complex patients. The consultants in team three also noted the positive effect that the RN prescriber had for the service and patients in reducing the waiting list.

In contrast to teams two and three, the GPs in team one had initial concerns regarding RN prescribing and the impact it would have on their own positions. For these GPs, RN prescribing presents a threat to their professional autonomy. This situation is reminiscent of previous experiences where they perceive other health care professions have encroached on their professional territory. The GPs in team one responded by imposing limitations and restrictions on the way in which the RN prescriber can practice. Some of the GPs delegated aspects of prescribing while maintaining overall control of decision making and clinical management; others chose not to engage the RN prescriber in patient care at all. The limitations imposed on the RN prescriber's practice reflect a strategy of capital conservation. The GPs

work to preserve their position of symbolic power as clinical leaders within the social hierarchy of the team.

In team one, the GP's initial response of patch protection reveals a professional boundary struggle not apparent in the other two teams. Previous studies have also cited professional boundary disputes as a barrier to the implementation of nurse prescribing (Cooper et al., 2012; Kroezen et al., 2013). The business model of general practice in team one contributes to inequity in economic capital. The financial interest the GPs have in the way the team functions places them in a position of power and control over the team, including the RN prescriber. Both the RN prescriber and non-prescribing RN in team one recognise the GP owners, and other GPs by association, as their employers. As employees, the nurses have little control over the way their work is structured; they accept the GPs dominant position of authority. This finding supports that of a previous NZ study that explored non-prescribing primary health nurses' perceptions of RN prescribing. Some of these nurses noted reservations about the support they would potentially receive from GPs as business owners. These nurses viewed the GPs as "gatekeepers" and expected they may see RN prescribers as "taking away business" (Wilkinson, 2015, p. 304).

Objective Structures: Space and Time

RN prescribers face opportunities and limitations in their practice generated by the rules and norms of the team. In each team, the RN prescriber's contribution and ability to influence team practice largely reflects the objective structure of the team. The limitations and opportunities that influence the way the RN prescribers work are engendered both externally by objective structures and internally in the form of self-censorship by the internalisation of these objective structures.

The allocation of physical space and time scaffold the daily routine of a working day in each health care team. Previous research has noted time and space to be salient and interdependent factors impacting collaborative practice (Oandasan et al., 2009). In the current study, physical space and time are noted as objective and interrelated structures organised according to tacitly understood customs and norms. These customary practices, in many instances, originate from a historical appreciation of the team members' roles based on classification by professional discipline. Analysis of the distribution and use of space and time in each team reveals congruence between professional discipline, accumulated capital, and perceived social position. The findings suggest that organisational objective

structures inform and reinforce the participants' sense of place within the team, generating and, in some cases, reproducing the social order.

Congruence between the objective structure informed by the disciplinary classification and the internalised social structures (habitus) of each member of the team results in the established social order or doxa within each team. Each member of the team appreciates their role and position in the team in relation to those with whom they work. Each understands the boundaries of their role and their place within the social hierarchy. This taken for granted sense of place is what Bourdieu referred to as the "practical sense" (Bourdieu & Wacquant, 1992, p. 20).

Teams one and two (general practice teams) deliver care from buildings that are spatially organised in a traditional manner with a waiting room for patients, private offices for the GPs and NP (in team two), and shared spaces including the practice nurses' office and treatment rooms. The allocation of space in these general practical teams is organised according to the previously discussed hierarchy of discipline positions. Permanent private offices are allocated to the GPs and NP who work independently from their office, occasionally interacting with each other when requesting a second opinion or with a nurse when requesting assistance. In contrast, the practice nurses, including RN prescribers, are mobile; they share office space and consult with patients in treatment rooms and vacant offices.

Work in general practice centres around traditional ways of booking patients an appointed time to see health professionals. GPs and NPs see patients by prearranged appointment. Most practice nurses see patients from a shared list and respond to requests from other members of the team in the moment. The RN prescriber in team one is allocated space and time disparately depending on their role on the day. The RN prescriber is allocated an office one day a week when they hold a clinic as a specialist diabetes nurse; on the other days, when working as a practice nurse, they share space with the other nurses. The RN prescriber in team one operated the diabetes clinic from an allocated office prior to obtaining prescribing authority; therefore, prescribing authority has not changed the way they are allocated either time or space.

Prior to the RN prescriber in team two gaining prescribing authority, little thought had been given to how their working day would be structured. Initially the practice manager agreed to work from home to enable the RN prescriber to work from a private office on two days a week. This change is significant as it represents the team re-evaluating the role and position of the RN prescriber. This physical move suggests the RN prescriber's role is recognised as transitioning from a practice nurse role, working from a shared list of patients and shared space to a role

more like the GP and NP who are allocated their own appointment diary and office. This redistribution of time and space, as objective structures, is reflected in the RN prescriber's sense of social position, whereby they refer to themselves as "piggy in the middle" suggesting they do the work of the doctors, the NP, and the nurses.

In team two, changes to the way work is allocated, as well as space and time, symbolises the redistribution of objective structures in response to a revaluation of the RN prescriber's contribution and position within the team. These changes emulate the way the authorised prescribers work; however, did not enable the RN prescriber to optimise their contribution to patient care. Rather, the traditional approach of pre booked appointments and corresponding office allocation manifested as a barrier between the RN prescriber and the patients. The RN prescriber felt isolated in their allocated office, preferring to work in what was described as an "opportunistic" and flexible manner alongside the other practice nurses.

Team three, operating as a specialty practice team, use physical space in a very different way to the general practice teams. In team three, most patient consultations are conducted in a shared outpatient space. Rather than working from a permanent office, each member of the team is allocated an office for the time in which their allocated clinic runs. Clinics are allocated by matching the patient's current needs to the capacity of the individual health professionals to meet the need. Needs may include initial assessment, acute assessment, education, treatment, review, and ongoing follow-up care. The capacity of the health professional is based on professional discipline, knowledge, experience, and prescribing authority. Patients are allocated to clinics by the lead consultant, assisted by the RN prescriber, who meet weekly to discuss new referrals and existing patient needs.

The adoption of prescribing authority by the RN in team three has culminated in intentional changes to the objective structure of the team. Recognising that it is more convenient for patients who are employed to attend clinics outside of work hours, the team enabled the RN prescriber to operate an early morning nurse-led clinic. In addition, since gaining prescribing authority, the RN prescriber sees all follow-up patients. These changes to the objective structure of the team symbolise the valuing of the RN's new prescribing authority.

In addition to the pragmatic implications previously discussed, these findings suggest the practice of allocating space according to professional discipline has symbolic implications for team practice. The rules and norms that regulate the use and allocation of physical space within the team manifest in the habitus of the individuals in the team. When people are excluded from spaces, allocated a less

prestigious space or communal space, this is internalised and embodied in their perception of social position. Bourdieu (2018) suggested that physical position is a metaphor for social positioning, in that “all the distinctions proposed about physical space can be found in reified social space” (p. 107). For nurses, the practice of waiting outside the doctor’s office door or interrupting the consultation places the nurse in a dependent and powerless position. The act of waiting and interrupting is internalised; the nurses appreciate their time as being less valuable. In contrast, the inhabitant of an office holds a dominant position, controlling the space by determining who enters and leaves.

The inclusion of a RN with prescribing authority has the potential to challenge traditional ways of working. These findings have noted that workload, space, and time have, in some instances, been previously based on professional discipline. RN prescribing provides opportunity for the team to re-evaluate and restructure the allocation of space and time based on patient need, the knowledge and skill of the team to optimise patient outcomes and the overall efficiency of the team.

The previous discussion has focused on the way participants in this study locate their position in the established order of the team in relation to the professional discipline of themselves and others. The objective structures apparent in the organisational practices of the teams reflect this system of classification based on professional discipline. Analysis of the objective structures, the distribution of capital, and resulting social order of the team illustrated the ways in which the teams work together. The objective structures in each team impose both limits and opportunities for RN prescribers to fully realise the potential of the prescribing role and to work collaboratively. The second section of this chapter extends on the first by exploring the impact of the established order and system of classification on the patterns of communication apparent in each team.

Patterns of Communication

The divergent patterns of communication shared between participants in each team manifested as a central theme presented in the previous findings chapters. Communication has been previously noted as being intrinsically linked to interprofessional collaboration in that collaboration cannot occur without effective, reciprocal communication (Morgan et al., 2015). Using Bourdieu’s linguistic tools, analysis of the patterns of communication shared between participants assisted with understanding how RN prescribers communicate and, in turn, collaborate in their respective teams. Bourdieu established a unique approach to studying linguistic

practice, drawing comparisons between linguistic practice and the expression of power. According to Bourdieu (1977b; Bourdieu & Thompson, 1992), linguistic practice reveals power in relationships, illuminating disparities between interlocutors. Underpinned by the overriding 'Theory of Practice', Bourdieu's linguistic tools inform an understanding of the use of language situated in a specific social and political context (field). Bourdieu's linguistic tools are used here to provide important insights into the way in which the patterns of communication shared between RN prescribers and other members of the health team reveal power dynamics and, in turn, determine opportunities to realise collaborative practice.

Realigning the Habitus

Prior to gaining prescribing authority, each of the RN prescribers embodied the habitus of a RN. They each had acquired a system of dispositions through their education and many years working as a nurse that enabled them to identify and assimilate in the team as a nurse. Bourdieu referred to the habitus as an embodied practical sense akin to having a "feel for the game" (Bourdieu & Thompson, 1992, p. 13). The nurses held a set of dispositions, including ways of thinking, acting, and communicating that had been generated, in part from working in the team, to meet the conditions of the team. These findings suggest that the adoption of prescribing rights disrupts the previously stable relationship between the nurse's habitus and the social context of the team (field).

For each of the RN prescribers, prescribing authority represents more than merely an additional tool to their existing repertoire of skills. The act of prescribing is synonymous with a greater level of responsibility and risk than any of the nurses had previously experienced. Each of the RN prescribers referred to the transition to becoming a prescriber as challenging, with two of the three saying they felt "scared" when initially faced with making prescribing decisions. The nurses referred to the potential harm they could inflict on a patient if they made a prescribing error. They also worried about being called to account by their employer, the NCNZ, and the Health and Disability Commissioner. This finding lends support to an earlier NZ study where NPs and doctors who were new to prescribing were noted to feel fearful and anxious due to the perceived responsibility of prescribing (Lim et al., 2018). This finding is also corroborated by studies conducted further afield in the UK, where nurse prescribers have reported a sense of risk associated with the additional responsibility of prescribing (Carey et al., 2014; Hales et al., 2010).

Bourdieu (1977a, 1990, 2000) used the term 'hysteresis' to conceptualise situations when change or crisis in the social setting results in the habitus being at

odds with the field. He suggested that “practices are always liable to incur negative sanctions when the environment with which they are actually confronted is too distant from that to which they are objectively fitted” (Bourdieu, 1977a, p. 78). For the RN prescribers, the negative sanction experienced when faced with increased responsibility is their sense of fear and apprehension. The pre-existing habitus acquired from their experience as a non-prescribing RN had not prepared them to respond to the responsibility they face as a RN prescriber; essentially the habitus of the RN prescribers and the social context of the team (field) are out of sync.

Shared Decision Making and the Linguistic Habitus

Prior to gaining prescribing authority, each RN prescriber communicated with others in their team in a manner that aligned with their position as a non-prescribing RN. In team three, the RN prescriber as a clinical nurse specialist, had a history of being involved in collaborative clinical decision making. However, in teams one and two, the practice nurses were less often engaged in reciprocal conversations with authorised prescribers regarding clinical decisions. Instead, the nature of their dialogue consisted mostly of brief exchanges whereby questions and answers were exchanged. The nurses’ previous experience of communicating with authorised prescribers is an integral aspect of their linguistic habitus.

The linguistic habitus is a component of the overall embodied habitus and is generated over time through experience of communicating in various social contexts (Bourdieu, 1993; Bourdieu & Thompson, 1992). Linguistic habitus informs all aspects of communication, extending beyond the use of spoken words. According to Bourdieu (1993), the linguistic habitus “is not a simple production of utterances but the production of utterances adapted to a ‘situation’ or, rather, adapted to a market or field” (p. 78). Prior to gaining prescribing authority, the RN prescribers had all established a sense of linguistic place within the team. Their linguistic habitus provided them with an intuitive sense of knowing how to engage others, and the degree to which they contribute to dialogue regarding clinical decision making.

These findings revealed that the patterns of communication shared between the RN prescribers and the authorised prescribers with whom they work changed when the RN prescriber adopted prescribing authority. The RN prescribers found themselves depending on authorised prescribers for advice and support when faced with unfamiliar situations, complex cases, or patients requiring medications not included on the RN prescribing schedule. To prescribe safely, efficiently, and with confidence, the RN prescribers found themselves dependent on their communication with authorised prescribers to share in decision making. Shared

decision making requires dialogue between the RN prescribers and authorised prescribers, including discussion of clinical assessment findings, differential diagnoses, and treatment plans. The findings of this study suggest that the propensity for the RN prescribers to be actively involved in clinical decision making is not only dependent on their linguistic habitus but on the linguistic market and relationships shared with other prescribers.

The Linguistic Market

Each team demonstrates a unique linguistic market, manifesting in divergent patterns of communication and determining the potential for collaborative practice. Bourdieu used the term linguistic market to represent the metaphorical space where two or more people exchange dialogue (Bourdieu & Thompson, 1992). While the conditions of the linguistic market differed in each team, one characteristic consistent in all teams was that the authorised prescribers (doctors and NP) have the power to control the linguistic market. The authorised prescribers hold a position of linguistic dominance, enabling them to establish the norms in the team regarding who is engaged in clinical conversations and decision making. As the gatekeepers to the linguistic market, the authorised prescribers establish the value of the RN prescriber's contribution and enable or limit their participation in joint clinical decision making. Ultimately, by enabling or denying the RN prescriber with an audience, they control the opportunity for effective interprofessional practice whereby health care professionals work together to deliver quality health care. Conversations that culminate in shared decision making are, in the context of this research, considered privileged conversations. These conversations are described as privileged because not all team members have equal opportunity to be included**.**

Building Social Capital

All three of the RN prescribers worked to establish and maintain alliances with authorised prescribers in their respective teams. These alliances provide a valued form of social capital for the nurses, serving two vital functions. The first function is pragmatic in that as a RN prescriber, the supervision of a doctor or NP is a formal requirement of the collaborative prescribing model. The NCNZ (2020) guidelines stipulate that designated RN prescribers must have a collaborative working relationship with a healthcare team including an authorised prescriber with whom they can consult. The NCNZ (2016) competencies for nurse prescribers require the nurse to engage with authorised prescribers in "open interactive discussion" regarding clinical assessment findings, diagnostic strategy, and

treatment options. Without support from authorised prescribers, the nurses would not have been able to gain prescribing authority within the current team.

The second reason the RN prescribers rely on social capital in the form of relationships shared with authorised prescribers is less tangible than the regulatory mandate but no less important. These findings demonstrate that as the nurses generate a new habitus (dispositions) that prepares them to prescribe with confidence, they draw on the resources of an authorised prescriber. As previously discussed, prescribing brings about a level of responsibility for which the nurses are not prepared. The nurses rely on the relationship established with one or more authorised prescribers to enable them to adapt to becoming a prescriber and to re-establish their role and position within the team.

Social capital, apparent in trusting relationships with authorised prescribers, serves as an essential resource for RN prescribers. These relationships enable the RN prescribers to draw on the knowledge and prescribing experience of their colleagues. The nurses look to the authorised prescribers with whom they work for validation of their prescribing practice. Each of the RN prescribers explained how they check their prescribing decisions with the doctor or NP, particularly when faced with unfamiliar circumstances. This strategy of verifying prescribing decisions builds self-confidence for the RN and, at the same time, generates the authorised prescriber's trust in the RN. Bowskill et al. (2013) noted a similar finding referring to this strategy of verifying prescribing practice as "permission seeking" and "doctor-checking", suggesting these behaviours assist new prescribers to secure the trust of doctors.

As addressed in chapter two, previous studies have consistently reported that support from other health care professionals positively influences RN prescribing (Casey et al., 2020; Jones et al., 2011; Maddox et al., 2016; McHugh et al., 2020; Snell et al., 2021; Stenner et al., 2010). The findings from this study concur with previous research confirming support from other members of the health care team is integral to the effective implementation of nurse prescribing. The RN prescribers in this study received unwavering support from the non-prescribing RNs with whom they worked. This finding is congruent with previous research conducted in NZ whereby non-prescribing diabetes nurses were noted to be supportive of diabetes nurse prescribing (Philips & Wilkinson, 2015; Wilkinson et al., 2013). In addition to support from other nurses, the RN prescribers in this study were most reliant on authorised prescribers for support and trust. The need for trust in relationships between doctors and prescribing nurses has been consistently noted in

earlier research (Coull et al., 2013; Kroezen, van Dijk, et al., 2014; McHugh et al., 2020).

The duration of relationships shared between RN prescribers and authorised prescribers is an important variable influencing the development of trusting relationships. The doctors in all teams referred to the prescribing nurse personally, suggesting the duration of their relationship and “knowing” the nurse assisted with their ability to build trust and accept the nurse prescribing role in the team. Of the three RN prescribers included in this study, two had worked in their current clinical area for more than 10 years and the other for almost 6 years. In all three teams the nurses were well known to the doctors before they began their journey to becoming a prescriber. This finding aligns with previous research that has noted prior experience of working together enhanced trust in the relationship culminating in cooperative prescribing (Kroezen et al., 2013).

Opportunities for Shared Decision Making

Habitual practices and objective organisational structures in each team inform patterns of communication and exert a degree of control over the ability of the RN prescriber to be involved in shared decision making. The organisation of physical space within each team impacts the ease of communication within the team. When the RN prescribers have opportunity to physically share space with authorised prescribers, they have more opportunities to share knowledge and jointly make clinical decisions. In both general practice teams, opportunities for collaborative discussion (the linguistic market) were limited by RN prescribers and authorised prescribers working from separate physical spaces. In teams one and two, practice nurses occupy shared space, ensuring they are often visible and approachable to others. In contrast, the authorised prescribers work from private offices. If the nurses wish to speak with a GP or NP they must either wait outside the office in the hope of catching them between patients or knock on the door and interrupt the consultation. Traditional ways of allocating space enable the authorised prescribers ready access to the nurses; however, the nurses do not share the same access to the NP and doctors. This generates a barrier to the RN prescriber accessing the authorised prescriber, in turn limiting opportunities to share information and decision making.

In contrast, the organisation of clinics in team three enables the team to communicate on a regular basis. Each member of the team runs a clinic conducting individual consultations with patients; in addition, the RN prescriber and consultants often consult together with patients. Although consultations are conducted behind

closed office doors, the team briefly meet together prior to clinics and again afterwards to discuss patient care. Weekly case review meetings provide an opportunity for the team to discuss patients, share perspectives, and jointly plan care—this constitutes interprofessional practice.

In teams one and two, the RN prescribers communicate with authorised prescribers regarding clinical cases via an electronic messaging service or brief corridor conversations or phone calls. Neither of these general practice teams enables formal opportunities for collective case review. Case review offers an opportunity for collective decision making and collaborative practices. Case review meetings also enable opportunity for the team to learn from each other and gain a better appreciation of what team members can contribute. Formal case review has been noted in previous research to be beneficial encouraging mutual knowledge exchange between RN prescribers and doctors (Snell et al., 2021; Wilkinson et al., 2013).

In this study, opportunities for team members to physically work together and provide interprofessional care were infrequently noted. One exception was in team three where prearranged dual consultations brought together the consultant, RN prescriber, and the patient. These consultations enable health care professionals opportunity to work together, sharing clinical decision making and exchanging perspectives, and to work actively with the patient as a key member of the team. The patient is integrally involved in planning the management of their future care, contributing their perspective regarding proposed strategies in relation to their lifestyle. Following on from the dual consultation, the RN prescriber provides follow up care.

Dual consultations in team three provide opportunities to physically work together and provide the RN prescriber with a valuable opportunity to demonstrate their contribution to the consultants. Previous research has noted that opportunities to observe what other members of the team do enhances the likelihood of valuing and respecting others roles (Wilson et al., 2016). These findings suggest that dual consultations, such as those conducted in team three, provide an ideal opportunity for the RN prescriber to work collaboratively.

Linguistic Capital – Establishing a Voice

Linguistic capital, in the context of these findings, refers to the overall ability of the RN prescriber to effectively communicate with authorised prescribers in the team. Linguistic capital is dependent on multiple factors. Firstly, competence—this was evident in the completion of postgraduate qualifications and the successful

attainment of prescribing authority. RN prescribers are required to complete an approved postgraduate diploma prior to applying to NCNZ for designated prescribing authority. Rigorous assessment processes ensure that all NCNZ approved RN prescribers have the required knowledge and skill to prescribe from a limited schedule of medications. These findings suggest the RN prescribers are well prepared with the knowledge to prescribe safely. Secondly, linguistic capital is contingent on the linguistic market. As previously discussed, the RN prescriber's ability to secure an audience within the linguistic market was dependent on physical location, proximity, and opportunities for clinical case discussion.

The final, and potentially most significant, component influencing the RN prescriber's capacity to communicate effectively in the team is the degree to which the nurse appreciates their contribution is valued and welcomed. This equates to what Bourdieu referred to as the "linguistic sense of place" (Bourdieu & Thompson, 1992, p. 82). These findings demonstrate that each RN prescriber has made an assessment of their linguistic position in the team based on previous experience and the social norms that prevail. According to this assessment, the nurses anticipate the likelihood they have of a receptive audience. For example, this was illustrated in team three where the RN prescriber reflected that all the consultants would answer her telephone calls at any time. In contrast, in team two, the RN prescriber suggested she would more readily interrupt the NP when in a consultation than the GP. Each RN prescriber establishes a way of engaging and contributing to conversations based on past experience and their anticipation of future reception.

The three RN prescribers included in this study represent positions on a continuum from holding little linguistic capital in team one, to an abundance in team three. In team one, the RN prescriber is accustomed to working in a supplementary capacity assisting the GPs who lead patient care. The RN prescriber is sensitive of the GP's need to maintain autonomy over patient care and responds by communicating in a "careful" and "diplomatic" manner. She assesses her position with each GP she works with, choosing when to offer a clinical opinion in a tactful manner and when to respond in a discreet and compliant manner. In team two, the RN prescriber has been actively "pushed" to contribute to clinical discussion in an assertive and active manner. Based on previous experiences, the NP in this team promotes the nurse's contribution to clinical decision making. The RN prescriber has responded to this challenge and gains confidence in articulating their position in clinical conversations. Finally, in team three, the RN prescriber was accustomed to being included in team discussions regarding clinical decision making as a non-prescribing clinical nurse specialist. The organisational structure of the team has

enabled this inclusion; they have been included in formal opportunities to contribute to case review and shared consultations. The RN prescriber in team three contributes to conversations with confidence, chairing case review meetings and leading clinical discussions.

Each RN prescriber censors their contribution according to the linguistic market. Their linguistic contribution reflects their perceived position and is shaped by what they sense others expect. RN prescribers are likely to avoid contributing to conversations if they anticipate their input will not be welcomed or accepted. Staying silent, electing to not question practice or offer an opinion is an option that nurses may choose if the team environment does not feel supportive and enabling. These findings suggest that the attitude of other members of the team, in particular authorised prescribers, impacts the RN prescriber's opportunity to contribute.

As addressed in the previous findings chapters, each of the RN prescribers included in this study hold different amounts of linguistic capital. The patterns of communication in each team reflect the distribution of various forms of capital, in turn reflecting the patterns of power within the team. The stratification of positions and perceived hierarchy of the team along with the capital held by others reflects the linguistic market which either constrains or enables the RN prescriber's propensity to contribute to shared clinical decision making. The nurses assess their position in the linguistic market and respond by either censoring their contribution or communicating with confidence.

Recommendations

The findings from this study have resulted in recommendations for three important groups including education providers, health policy makers, and health care teams who work with an RN prescriber.

Education Providers

The findings from this research have resulted in two key recommendations for education providers. The first includes an approach for postgraduate nurse educators to assist RN prescribers to prepare to work collaboratively in health care teams. The second recommendation describes a longer-term strategic goal of implementing interprofessional postgraduate education.

Recommendation 1.

The findings of this study support the use of reflexive activities and the promotion of critical thinking by postgraduate nurse educators when preparing RNs for collaborative prescribing practice. This research engaged Bourdieu's concept of

habitus to illustrate the impact of socialisation, including professional education and work experience, on the ways RN prescribers and other health care professionals work together. As illustrated in the previous findings chapters, the RN prescriber's habitus is, in part, generated by the social processes of the team in which they work. Furthermore, the RN prescriber's habitus informs the appreciation they have of their position within the team and their opportunities for advancing their practice. It may not be possible to make the unconscious habitus conscious; however, by encouraging critical reflection, educators can promote the RN's awareness of the social processes generating practice within the team in which they work.

RNs preparing to prescribe should be encouraged to reflect on their current position within the team and that of others they work with. Contemplation of the relationships shared with others may reveal hidden power mechanisms and hierarchies that exist within the team. RNs should consider their current contribution to team practice and question how this may change on gaining prescribing authority. Consideration of both the opportunities they see for advancing their nursing practice and the potential barriers will assist future RN prescribers to plan and prepare for the new role.

This recommendation is based on the premise that in encouraging critical reflection, nurse educators will empower new RN prescribers to become cognisant of social processes and power structures within the team that would ordinarily remain hidden. Critical thought is promoted as a way of unpacking social action revealing power inequities that are taken for granted and, in doing so, promoting opportunities for emancipatory change. Reflexive activities that incorporate these recommendations will assist the RN as they transition to becoming a prescriber within an interprofessional health care team.

Recommendation 2.

Interprofessional education (IPE) has been widely promoted as improving communication between team members as well as enhancing the quality of patient care (Reeves et al., 2012). Within the NZ context, the majority of health care education continues to be provided in a traditional uni-professional manner (Fouche et al., 2014). The findings from this research suggest those involved in providing education for RN prescribers consider the inclusion of interprofessional education in preparing RN prescribers to work in teams.

The WHO (2010) has defined IPE as "students from two or more professions learn[ing] about, from, and with each other to enable effective collaboration and improve health outcomes" (p. 13). There are few studies reporting on the outcomes of IPE initiatives involving prescribers. However, there are several studies that

suggest health care professionals have a positive attitude toward IPE and that learning together has potential for enhancing safety in medication management. A large UK study evaluating an interprofessional workshop involving non-medical prescribing students (including nurses) and pharmacy students noted participants to have a positive attitude to learning and working together (Hemingway et al., 2020). Similarly, the findings of an Australian study reporting on the perception of nurses, pharmacists, and doctors regarding interprofessional practice (Wilson et al., 2016), resulted in the promotion of IPE suggesting that interprofessional practice in relation to medication safety, is enhanced when team members understand and value each other's abilities and skills. A small study conducted in the UK including medical students and nurse prescribers suggested IPE promoted opportunities for mutual understanding (Courtenay, 2013). The only research exploring IPE in relation to prescribing in NZ evaluated a collaborative model of education involving pharmacists coaching junior doctors. While this study did not include prescribing nurses, it demonstrated positive findings including reduced drug errors and positive attitude of the health care professionals involved (Sheehan et al., 2021).

There has been no research conducted in NZ that reports on the implementation of an interprofessional approach to preparing RN prescribers to prescribe. The findings from this study, along with findings from studies conducted overseas, suggest IPE would assist with preparing RNs to work in collaborative teams. A recommendation from this research is that opportunities for IPE between RN prescribing students and other health care professionals, including doctors, pharmacists and NPs be explored. The ideal starting point is to gather educators and practitioners from the various professions to set goals and jointly plan feasible strategies to promote interprofessional learning. The WHO's (2010) framework for action on IPE and collaborative practice provides strategic direction for educators motivated to contribute to a workforce who are better prepared to work collaboratively. Further, the Centre for the Advancement of Interprofessional Education (CAIPE) offers multiple resources and forums including guidelines, a journal (the Journal of Interprofessional Care), workshops, and network opportunities all designed to promote the implementation of IPE (CAIPE, 2016).

Reforming the uni-professional model of education delivery in NZ would take time and considerable planning. Practice based opportunities for health care professionals to learn with, from and about each other may be the most feasible place to start. Mutually agreed initiatives between educational providers and health care agencies would enable practice-based opportunities for RN prescribing students to observe and work with patients and other professions with the

assistance of well-prepared educators. If RN prescribers are exposed to the way interprofessional teams function during their prescribing education, they will be better placed to potentiate collaborative practice within their own team.

Health Policy Makers

RN prescribing authority was introduced in NZ with the aim of optimising the knowledge and skills of nurses and assisting to meet the country's burgeoning demand for health care arising from an ageing population living with chronic conditions (Ministry of Health, 2022). Designated RN prescribing was supported by the Ministry of Health (2016a) as a way of assisting the health service to meet its objectives, outlined in the NZ Health Strategy of enabling all New Zealanders to "live well, stay well and get well" (p. 13). The findings from this and previous research conducted both overseas and in NZ support the promotion of RN prescribing as a way of optimising access to quality health care.

The findings from the current study note that the initiative to complete a postgraduate qualification and implement designated RN prescribing was driven by the RNs in all three teams. Aside from the NP in team two, other members of all teams had limited understanding or appreciation of the remit and potential of the RN prescribing role. Each of the RN prescribers was responsible for pursuing and promoting the role, securing support, mentorship, and educating the team. This was a small study; however, this observation is significant and suggests that the true value and potential of RN prescribing may not be fully realised in NZ.

Recommendation 3.

A recommendation arising from this research is that RN prescribing is promoted at a national level by the Ministry of Health and at a local level by DHBs, as the planners and funders of health care in NZ. Raising the profile of RN prescribing through publicity and inclusion in relevant policy will assist with the implementation of this important role, ensuring RN prescribers are effectively utilised and well supported in practice. DHBs and PHOs should strategically identify areas where RN prescribing could be introduced to best make use of the nurses' skills, meet health care demands, and align with national health priorities. This recommendation extends to DHBs when prioritising the allocation of Health Workforce Directorate funding to support postgraduate education for future RN prescribers. These recommendations are timely given NZ is facing impending health reforms aimed at increasing access to equitable health outcomes.

Health Care Teams

Two key recommendations for practice have emerged from the findings of this research. The first suggests careful planning by the team prior to the implementation of RN prescribing. The second recommendation highlights the importance of opportunities for interprofessional communication within the team.

Recommendation 4.

The first recommendation is that the inclusion of designated RN prescribing within the team is carefully planned before the role is implemented. In this study, the RN prescriber in each team was already engaged in postgraduate study before making the decision to complete a prescribing practicum and apply to the NCNZ for prescribing authority. In these teams, RN prescribing was introduced in an organic manner without a vision for how RN prescribing would be integrated and the role optimised. This allowed little time for the teams to learn about the role, reflect on the implications, and plan how it would be implemented.

These findings challenge health care teams to be responsive to the crises presented by an ageing population, chronic disease, and healthcare workforce shortage by considering new and innovative roles for designated RN prescribers. Teams should carefully consider how the inclusion of RN prescribing will best benefit both the needs of the patient population and the goals of the team. Consideration should be given to the way work will be distributed, where the RN prescriber will work from, and how they will structure their day in terms of time. As the findings from this study suggest, manipulation and reconfiguration of these objective structures can greatly enhance the opportunities for RN prescribers to make a meaningful contribution; work collaboratively, enabling other team members to work more efficiently; in turn, enhancing the efficiency of the team.

These findings highlight that the way in which the team organise their work impacts the opportunities for RN prescribers to contribute to the best of their potential. RN prescribing offers more than an additional tool in the RN's existing arsenal of skills. RN prescribing offers an opportunity for nurses to work autonomously and in collaboration with authorised prescribers enabling better use of the skills of both parties. When the prescribing RN is expected to work within the pre-existing structure, opportunities are missed. Furthermore, RN prescribing offers an opportunity for innovation and thinking beyond traditional models of care delivery. Teams have the opportunity to implement alternative approaches to allocating work and organising space and time.

Recommendation 5.

The findings of this research suggest that communication lies at the heart of collaboration. The model of designated RN prescribing introduced in NZ requires the RN to work in a collaborative team with an authorised prescriber. These findings highlight that for RNs, prescribing requires them to take on considerably more responsibility. With this responsibility comes a sense of risk and apprehension regarding making an error. RN prescribers are reliant on the authorised prescribers with whom they work for more than just the stipulated requirement of supervision. As designated prescribers, RNs require support to establish their new position, grow confidence, and learn. RN prescribers benefit from having the opportunity to actively contribute to conversations regarding clinical decision making. Health care teams should consider the organisational structures embedded in the workplace and the opportunities these provide for interprofessional communication. Opportunities to work together, to review clinical cases, and share perspectives are imperative. These opportunities will benefit the RN prescriber enhancing knowledge and confidence, and expose other members of the team to the nurse prescriber's perspective and contribution.

Further Research

This research focuses on the perspective of RN prescribers and other health care professionals and does not include the patient's perspective of RN prescribing. However, both the RN prescribers and other members of the teams referred to the benefits for patients of the implementation of RN prescribing. Benefits included improved access to timely, affordable, and quality health care. Except for evaluations of the diabetes nurse prescribing project conducted in 2011, there is no other recent research that includes the patient perspective of designated RN prescribing in NZ. Future research focusing on the patients' and their families' perspective would enhance understanding of the impact of RN prescribing on improving health outcomes.

These findings provide grounds for consideration of the use of organisational structure including physical space in the delivery of health care. Findings suggest that the allocation of physical space based on professional discipline has both material and symbolic implications impacting a team's opportunities to work collaboratively. Traditional methods of allocating space in general practice have the potential to accentuate professional boundaries between health care disciplines. Further research in this area of alternative models of practice is warranted.

Strengths and Limitations

Bourdieu conducted much of his research in the French education setting in the 1960's and 1970s, his research and methodological ideas were written and initially published in French. The contrast between the origins of Bourdieu's methodological principles and the context of the NZ healthcare system, is acknowledged as a limitation in this research. To mitigate this, Bourdieu's concepts have been thoroughly explained and the context of the research clearly defined. Bourdieusian analysis has proven invaluable as a way of appreciating both the individual dispositions of health care professionals and the social structures embedded in each of the three health care teams. His theoretical concepts enabled me to be better understand the RN prescribers' social position within the collaborative team.

A small sample was used in this study with the inclusion of three health care teams from one geographical location; the data were derived from individual interviews and observations. Focus groups were not conducted, the omission of this data source is a noted limitation. Focus groups had the potential to provide valuable insights into the workings of the team, however in practice it was not possible to gather all participants together for this purpose.

While the premise is that the interpretation of data collected in this study will have relevance to other RN prescribers and the teams they work in, the extent to which these findings are generalisable is not known. Both the model of RN prescribing in NZ and context of the NZ healthcare system were well explained to assist with the transferability of these findings to the international context. I endeavoured to include diversity in terms of the types of teams included and the professional disciplines represented. Careful team selection along with rich and robust data from the participants' transcripts has been included to enhance the potential for transferability.

Summary

This research sought to gain an understanding of how RN prescribers influence collaborative team practice. A shared system of taxonomy prevails in each health care team whereby team members are classified according to professional discipline and an established order of social positioning is generated. RN prescribers and other members of the team recognise their social position within the team in relation to the position of others. This disciplinary classification is pervasive and potentially limiting in that it determines the way that work is distributed and physical space and time are organised. RN prescribers internalise their experience

of the objective structures that influence and shape their practice; furthermore, their sense of opportunity to contribute to shared patient care is grounded in the objective organisational structures of the team. The propensity for the RN prescriber to both realise the potential of their prescriptive authority and to influence collaborative practice is determined by the historically grounded and pre-existing practices of the team.

Each of the RN prescribers included in this study has completed a postgraduate qualification and been approved by the NCNZ as a designated RN prescriber. All three RN prescribers have proven they have the required knowledge and skill to prescribe. These findings suggest that knowledge, competence, and regulatory authority do not assure the RN the ability to work collaboratively, engaging in shared decision making with authorised prescribers. Prescribing authority, for RNs, represents a greater degree of responsibility than previously experienced. All of the RN prescribers included in this study associated prescribing with risk, manifesting in them feeling apprehensive about making an error. These nurse prescribers relied on the social capital gained through relationships with authorised prescribers to support them as they transition. RN prescribers require opportunity to share and contribute to clinical conversations with authorised prescribers. Innovations such as regular clinical case review meetings and combined/dual patient consultations provide ideal opportunities for shared communication. Organisational changes such as these promote interprofessional practice by providing opportunities for teams to better appreciate each other's contribution, and to learn from each other. These findings challenge health care teams to be innovative, responsive, and flexible in considering new ways of organising practice and working together. RN prescribers have the potential to work in unique ways, in turn enabling other members of the team to make the best use of their knowledge and skills by working in an interprofessional manner.

Concluding Statement

Legislation enabling RN prescribing in primary health and specialty practice came into effect in NZ in 2016. In comparison to other countries who have implemented nurse prescribing, the NZ collaborative model is unique. RN prescribers are required to work in a collaborative team with an authorised prescriber available for consultation. The NCNZ suggest collaboration is "joint communication and decision-making with the expressed goal of working together toward identified health outcomes while respecting the unique qualities and abilities

of each member of the group or team" (College of Registered Nurses of British Colombia, 2014, as cited in NCNZ, 2020, p. 24).

The findings of this study suggest that labelling the prescribing model 'collaborative' and requiring prescribing RNs to work with authorised prescribers in teams does not necessarily result in the intended outcome of collaborative practice. This research illustrates that no two health care teams are the same; each differing in the services provided and professional make up but, more importantly, in the ways they share patient care and work together. The opportunities of the three RN prescribers included in this study to work to the limits of their scope as a RN and to fully utilise their prescribing authority differed in multiple ways. It is because of this diversity between teams that the outcomes of this research do not offer a recipe or an ideal model for the inclusion of a RN prescriber; rather they recommend that teams are responsive to their unique conditions and needs.

The recommendations from this research align with the recommendations of the Health and Disability System Review (2020) in calling for innovative change in models of care delivery that support health care teams to work together. These findings promote a departure from traditional models of multidisciplinary practice, where teams work in parallel, to interprofessional models where teams work together. As the Health and Disability System Review suggested, in order to meet the current health care demands NZ needs health care professionals who have both the skills and ability and the opportunity to work together. In doing so, patients will benefit from the collective knowledge and skills of the entire health care team. The findings of this research suggest that the ideal of a collaborative model of RN prescribing, as a social process, is best achieved when the objective structures of the team align with the subjective position of the RN prescriber.

To conclude, the findings of this research suggest the role of a RN prescriber is emerging and evolving. To use Bourdieu's (2020) words, the role of the RN prescriber is a "position in the making" (p. 186). Adherence to organisational practices based on a historic classification of health care team members by discipline reproduces the status quo of traditional practice. Health care teams, educators, and policy makers must commit to reconceptualising the role of a RN prescriber based on their potential contribution to health care rather than on traditional and outdated perception of the role of a RN. "*To change the world, one has to change the ways of world-making, that is, the vision of the world and the practical operations by which groups are produced and reproduced*" (Bourdieu, 1989, p. 23).

This research, conducted as part of a professional doctorate of health science, contributes to the body of knowledge in both clinical practice and post graduate nursing education. In the spirit of a professional doctorate, this research has generated knowledge from data grounded in nursing practice for the distinct purpose of benefiting future practice. It is anticipated that the findings from this research will be applied to inform changes that enhance and optimise the contribution that RN prescribers make to collaborative team practice and, ultimately, to improve the health outcomes of the populations for whom they care.

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Appendices

Appendix A: AUTEC Letter Outlining Conditions of Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

8 March 2018

Stephen Neville
Faculty of Health and Environmental Sciences

Dear Stephen

Ethics Application: **18/39 Registered nurse prescribing examined through the lens of Bourdieu**

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 5 March 2018, subject to the following conditions:

1. Reconsideration and revision of the recruitment process for the team meeting observation part of the research including:
    a. Management of the recruitment and consent by a more neutral and independent person;
    b. An assurance that the observation will not take place unless all participants agree;
2. Provision of an observation protocol that includes:
    a. a clearer identification of what it is that the researcher is observing;
    b. what data needs to be gathered as part of the observation;
    c. Inclusion of a warning that disclosure of patient information needs to be avoided;
3. Identification of where the interviews will be conducted and provision of advice around this in the Information Sheet;
4. Provision of a revised researcher safety protocol that better assures safety with the researcher notifying the person monitoring the interviews of when they have finished;
5. Amendment of the relevant Information Sheets as follows:
    a. Provision of better advice about the possible risks involved in the observation part of the study and about how these will be managed;
    b. Provision of clearer advice about the focus of the interviews;
    c. Inclusion of advice in the sections on risks and discomforts that people do not need to answer questions if they do not wish to do so;
    d. Inclusion of advice in the benefits that the researcher may obtain a degree;
    e. Inclusion of advice that as part of maintaining confidentiality and privacy, the employing organisations will not be identified;
    f. Inclusion of advice in the sections on privacy of the limited ability of the researcher to maintain confidentiality when the research takes place in a workplace;
    g. Provision of advice about how long the observations are expected to take;
6. Provision of a recruitment advertisement that includes information about the aim of the study as well as the Inclusion and exclusion criteria for the study and the AUT logo.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as

Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

I look forward to hearing from you,

Yours sincerely

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: kate.norris@ara.ac.nz; Marion Jones

Appendix B: AUTEC Letter of Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

23 March 2018

Stephen Neville
Faculty of Health and Environmental Sciences

Dear Stephen

Re Ethics Application: **18/39 Registered nurse prescribing examined through the lens of Bourdieu**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 23 March 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: kate.norris@ara.ac.nz; Marion Jones

Appendix C: Letter of Support From Annette Finlay

Tainui te waka
Waikato te awa
Taupiri te maunga
Tainui raua ko Arawa nga iwi
Ngati Hauaa te hapū
Te Iti a Hauaa Tauwhare te marae
Nō Kirikiroa Kaiangatuturu
No Otautahi ahau
Ko Annette Finlay tōku ingoa
Nō reira, tēnā koutou, tēnā koutou, tēnā tatou katoa

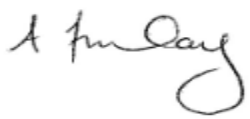
Annette Finlay
48 Lake Terrace Road
RD1 Little River
CHRISTCHURCH 7591

Tena koutou katoa,
I am writing this letter as support for Kate Norris, to confirm that we met in August 2017 to discuss her research project : *How Registered Nurse prescribers influence collaborative team practice? Working title : Registered nurse prescribing examined through the lens of Bourdieu.* Kate wanted to understand how her research could affect and may benefit Maori and also meeting the needs of any participants that identified as Maori.

I was able to offer some advice how this study is strategically important for Maori health in general and was also able to connect Kate with a pharmacist who is Maori and has a strong interest in improving health outcomes for Maori. I understand that Kate has met with him and found his kōrero has been of great benefit to her work as well.

Should you require any further information please contact me on 0272058421.

Naku noa



Na Annette Finlay
RCpN.BHSc
Chair, Ropu Kawa Whakaruruhau Ara

Appendix D: Letter Confirming Locality Authorisation From DHB

terbury
Health Board
Hauora ō Waitaha

Research Office Project ID	17195

2017 Request for Locality Authorisation Form
(Non-commercial/Non-government/Government Research Projects)

Instructions:

1. Complete the form. Please provide detailed answers as the CDHB Locality Authorisation will **ONLY** be provided for that outlined in this application.

2. Print the form and **obtain approval from the Clinical Director and Service Manager** of the host department where the research project will be conducted.

NEW

3. If using the services of Canterbury Health Laboratories and/or Pharmacy for services outside of standard of care please note that signatures are now required or a copy of the quote.

4. The following **MUST** accompany your Locality Authorisation Form:
   a. Ethics Approval Letter
   b. HDEC online locality authorisation request (cdhb.researchoffice@otago.ac.nz) where applicable
   c. CDHB Te Komiti Whakarite Maori Consultation Letter
   d. Source of Funding – e.g., contracts, email confirmation, proof of funding document
   *** Please note – additional documentation or evidence may be requested by the Research Office to assist with processing your application*

5. Send the completed Locality form along with the required documentation to Research Office, Level 5 Christchurch School of Medicine, University of Otago, Christchurch or send via email to cdhb.researchoffice@otago.ac.nz.

6. The Research Office will endeavor to process your locality within 5 working days WHEN ALL THE DOCUMENTATION REQUIRED IS RECEIVED.

7. STUDENT RESEARCH. If you are a student, please complete your details in the "Other parties involved" box. Please ask your supervisor to complete the "coordinating Investigator (CI)" box and request that they sign the form as CI.

Research Office I Canterbury District Health Board & University of Otago, Christchurch I PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand Tel +64 3 364 0237 • Email cdhb.researchoffice@otago.ac.nz www.otago.ac.nz/christchurch/research

RESEARCHER TO COMPLETE AND ATTACH ALL REQUIRED DOCUMENTATION

1. Research Team

CDHB Principal Investigator (PI)		Email:	
CDHB Contact Person:	Heather Gray	Email:	Heather.Gray@CDHB.health.nz
Coordinating Investigator (CI) and Organisation:	Associate Professor Stephen Neville (primary supervisor), Head of Nursing, School of clinical science, AUT.	Email:	Stephen.neville@aut.ac.nz
(if CDHB is not the lead site) Contact Person:		Email:	
Other parties involved (e.g. Sponsors, Collaborators, other Sites)	Kate Norris, primary researcher		

2. Project Details

2.1 Research Office Project ID:

17195

2.2 Project Title/Protocol Number:

Registered Nurse prescribing examined through the lens of Bourdieu

2.3 Project timeline *(If applicable, project start and end dates should be consistent with HDEC answer a.1.4)*

Project start date:	May 2018
Recruitment start:	July 2018 (if authorised)
Recruitment end:	September 2019
Project end:	May 2020

2.4 Brief Summary of the Overall Project *(if applicable, copy answer from HDEC question a.1.5 in the box below)*

In 2016 changes to the New Zealand Medicines Act (1981) enabled medication prescribing rights to suitably qualified Registered Nurses. Because Registered Nurse prescribing is a recent development in New Zealand there is little research that explores this area of practice. The Nursing Council of New Zealand stipulate that prescribing Registered Nurses must work collaboratively within the health care team. The primary researcher is interested in understanding how prescribing Registered Nurses actually work with other team members within the healthcare context and how the collaborative approach plays out in practice.

The question the primary researcher intends answering in this study is how do Registered Nurse prescribers influence collaborative team practice? The research methodology is informed by Bourdieu's 'Theory of Practice'. Bourdieu's methodology will assist the researcher to explore the complex interprofessional relationships that support health care practice. Participants will include Registered Nurse prescribers and other health care team members with whom they work.

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The researcher intends recruiting participants from at least two clinical areas, a minimum of one being in the primary health area and the other specialty practice.

Data will be collected through individual interviews, focus group interviews, and observation of collaborative team meetings. The data will be analysed thematically using Bourdieu's central concepts of habitus, field and capital. The findings from this research will illustrate the way that Registered Nurse prescribers work in and influence collaborative teams, therefore providing grounds for advocating models of collaborative interprofessional team practice.

Research Office Project ID	

2.5 Describe the methods/ procedures that will occur within CDHB (Note that locality authorisation will only cover the procedures that are detailed here)

Semi-structured interviews, focus group interviews and observation will be used as data collection methods in this study, each method is briefly explained below.

Semi-structured interviews:

Interviews with Registered Nurse prescribers and other members of the health care team they work in will be conducted and audio recorded. Depending on the information elicited, the participants may be invited to participate in more than one interview. Written informed consent will be gained from all participants prior to interview. All interviews will be carried out in a location and at a time that is comfortable and convenient for the participants and mutually agreed to by the researcher. All interviews will be audiotaped and transcribed verbatim by a transcriber employed by the researcher.

Focus group interviews:

Registered Nurse prescribers and other members of the health care team who have participated in an individual interview may be invited to attend a focus group interview. This invitation will depend on the information shared in individual interviews. It is expected that the focus groups will involve a maximum of six participants and will take approximately one hour. All focus group interviews will be audiotaped and transcribed verbatim by a transcriber employed by the researcher. Written Informed consent will be gained from all participants prior to the focus groups.

Observation of team meetings:

Depending on the information shared in individual interviews and focus groups the primary researcher may request consent to observe a team meeting. If all meeting attendees consent the primary researcher will observe the interactions that take place within these team meetings. Observation of a team meeting will allow the researcher to learn more about the way the team interacts and make decisions. No patient information will be recorded during a team meeting. Team meetings will not be audio-recorded, the primary researcher will document field notes and transcribe these personally.

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2.6 Outline which of those procedures in 2.4 above fall **within** standard of care.

This research will not influence the provision of patient care in any way.

2.7 Outline which of those procedures in 2.4 above fall **outside** standard of care. *(if applicable, copy answer from HDEC question r.1.1)*

This research will not influence the provision of patient care in any way.

NEW

2.8 Are you using the services of Canterbury Health Laboratories (including **within** standard of care)? NO

If **YES**, please:

1. Attach a copy of the quote for services,

OR

2. Obtain the signature of Kirsten Beynon, General Manager of CHL (Table 5).

2.9 Are you using the services of Pharmacy outside of standard of care? NO

If **YES**, please:

1. Attach a copy of the quote for services,

OR

2. Obtain the signature of Paul Barrett, Pharmacy Manager (Table 5).

Research Office Project ID	

3. CDHB Resources Used

3.1 CDHB Participants - Please outline the Recruitment Process and Number *(if applicable, copy answers from HDEC*

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questions a.6.2 and p.2.1 in the box below)

Initial contact with Registered Nurse Prescribers:

The Director of Nursing at Christchurch Hospital will forward an information letter to all Registered Nurse (RN) prescribers employed in the CDHB. The nurses will be asked to contact the primary researcher directly if they are interested in participating in the research. The primary researcher will then approach the RN's service manager for their signed approval to conduct the research in the department. When locality authorisation is confirmed the primary researcher will gain written informed consent from the RN prescriber to participate in the research.

Initial contact with other health care team members:

Other health care team members will be invited to participate after the Registered Nurse Prescriber has agreed to participate in the research. The primary researcher will place an advertisement in the clinical area inviting team members to participate in the research. In addition, and if the opportunity arises, the primary researcher will attend a team meeting to discuss the research and invite team members to participate. Potential participants will be asked to contact the primary researcher directly by email if they would like to participate. All potential participants will be offered the opportunity to discuss the research with the primary researcher and have their questions answered. All potential participants will be asked to sign the approved consent form before participating in any interviews or focus groups.

Initial contact with attendees of team meetings:

An email will be sent to all team members who will be attending the meeting attaching an information sheet. Potential participants will be asked to email the primary researcher if they are willing to consent to the researcher observing the meeting.

3.2 Access to CDHB Patient Data – Please specify data source (e.g. HealthOne, Health Connect South, Existing patient registry, Tissue bank samples, Data warehouse, non-electronic Clinical Records)

Access to CDHB patient data is not required

3.3 CDHB Staff – please outline key CDHB staff and their specific tasks for this project

	Name	Department	Role in the Project	Key tasks
1	staff not yet identified	Not identified	Research participants	Staff will be interviewed
2				
3				
4				
5				
6				
7				
8				

3.4 CDHB Facilities *(list specific location/s and department/s where the project will be conducted e.g., Burwood, Orthopaedic Dept.)*

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	Location / Department	Methods / Procedures at this Facility
1	Not yet identified	Interviewing of staff (Registered Nurse prescribers and other members of the health care team)
2		
3		
4		

3.5 Other Resources Required – please specify

None

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Research Office Project ID	

4. Evidence Required – THE FOLLOWING SHOULD BE SENT ALONG WITH THE COMPLETED LOCALITY AUTHORISATION FORM:

4.1 Ethical Approval or Out-of Scope Letter

a. If the project is "outside ethics review" then CI / PI should sign and date

b. If the project has been approved by HDEC, please ensure to request locality on-line via the HDEC website. You will need to type in our email address cdhb.researchoffice@otago.ac.nz

	Reference Number	Date of letter
HDEC :		
HDEC – Out of scope :		
Institutional approval :	AUTEC 18/39	23/3/18
Not required :	(sign here)	(date)

4.2 Local Maori Consultation from Te Komiti Whakarite:

Date of letter received :	24/1/18

4.3 Funding: If any procedures have been outlined in **Question 2.7**, please detail how costs will be covered
(attach proof of funding document e.g., contract, confirmation letter/email)

Not applicable

4.4 Proof of Indemnity for CI or PI - Not applicable (AUT student)

Is your role in this project within your CDHB or UOC employment capacity? YES / NO

If NO, please attach proof of Professional Indemnity Insurance from your Institution/Organisation.

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Research Office Project ID	

RESEARCHER TO ORGANISE APPROVAL FROM RESPECTIVE MANAGERS

CDHB Coordinating or Principal Investigator: *I hereby confirm that all information contained within this application is true and correct. I will take professional responsibility to conduct this research at CDHB and ensure all consents and approvals are obtained and sighted by the Research Office before research commences. Further, I confirm that conducting this research at CDHB will have no adverse effect of the provision of publicly funded health care at this locality.* ***(Must be CDHB staff)***	
Signed: Heather Gray Director of Nursing Department of Nursing Christchurch Hospital **Name: Heather Gray – locality only. Primary researcher is not CDHB employed**	**Date 13.07.2018**

5. Approval From All Areas Where Resources are Accessed

Approvals: *I hereby authorise this application to undertake this research within this CDHB Department and guarantee the availability of adequate facilities, equipment, staff and any special support which may be required as detailed in the application. I confirm that it is in accordance with current CDHB policy*

Department name:	**1.**	**2.**	**3.**
Clinical Director	Heather Gray Director of Nursing	Heather Gray Director of Nursing Services	
Signature		Deparnment of Nursing Christchurch Hospital	
Date	13.07.2018		
Service Manager	N/A		
Signature			
Date			
Other Approving Manager Name	**N/A**		
Title			
Signature			
Date			

RESEARCH OFFICE TO FACILITATE APPROVAL FROM CDHB GENERAL MANAGER/S

General Manager sign-off

This research will take place in your hospital, do you approve it?

Hospital 1	Pauline Caroline Clark General Manager Christchurch Campus	*Signature:*	*Date:* 16/07/18
Hospital 2	*Name:*	*Signature:*	*Date:*

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Appendix E: Letter Confirming Locality Authorisation From PHO

Research Audit Evaluation

Pegasus
partners in health
kia ataahai ki te tangata

Pegasus House
401 Madras Street
P.O. Box 741, Christchurch 8140
P: (03) 379 1739 I F: (03) 365 5977
www.pegasus.health.nz
info@pegasus.health.nz

18 September 2018

Kate Norris
Senior Lecturer- Nursing
ARA
City Campus
PO Box 540
Christchurch

Dear Kate

Thank you for your application for Pegasus Health research participation/support ref: RAE0066

We are pleased to advise you that your request has been approved.

We will need for our records copies of:

- The final study protocol when completed.
- The ethics approval letter (and approvals for any extensions)
- Copies of any other subsequent correspondence with the ethics committee including annual reports.
- A final report on the study

The following person is the designated contact person within the organization: Michael McIlhone

We wish you well with your research. Please contact the committee if we can offer any further advice that would assist you.

Yours sincerely

Prof. Derelie Mangin

Research Audit Evaluation

Request to Pegasus Health for Research Participation or Support

Pegasus partners in health kia atawhai ki te iangata

Pegasus Health receives many research requests and there are considerably opportunity and resource costs to the organisation in providing support for external research proposals. The organisation unfortunately is neither funded nor has capacity to respond to all requests.

This form is provided to help guide individuals to prepare a request for collaboration in or assistance with a research project.

The purpose of this application is to clearly define what the applicant requires and to ensure that what is provided by Pegasus Health (Charitable) Ltd is appropriate for the research question and fulfils the responsibilities and obligations of Pegasus Health (Charitable) Ltd.

How to use this form:
To activate fields, use the arrow keys on your keyboard to navigate between fields.
Please answer all questions (write n/a if questions are not relevant to your research).
Once you have completed the form please submit your application to research@pegasus.org.nz. Please attach other documentation where available (indicate documents attached below)

- ☐ The research protocol or plan
- ☐ Ethics approval and the ethics application or a letter from the ethics committee stating approval not required
- ☐ Completed Pegasus Health request for if data requested

Date: 23rd July, 2018

Request from (team names, qualifications and experience)
Kate Norris, RN, BN, MA (Nursing), PGCert (Health Sciences)

The primary researcher is a Registered Nurse of 27 years and has been involved in nursing education for the past 16 years. The researcher has a keen interest in the implementation of Registered Nurse prescribing and is a member of the South Island Workforce Development Hub Registered Nurse prescribing working group. The researcher holds a Master's degree (with distinction) for which she completed a large research project. The primary researcher is currently enrolled in Doctor of Health Science programme at AUT.

Click here to enter text.

Organisation: The primary researcher is employed as a senior nursing lecturer at Ara, and is conducting this research as a Doctoral candidate at Auckland University of Technology (AUT)
Primary contact and position: Kate Norris (as above)
Email for correspondence: kate.norris@ara.ac.nz
Phone: 027 2624496

1 What are the aims and hypothesis for this research project?

The question the primary researcher intends answering in this study is how do Registered Nurse prescribers influence collaborative team practice? Currently research exploring nurse prescribing in New Zealand is limited to studies focused on the implementation of the Nurse Practitioner role and the diabetes nurse specialist project of 2011. Due to the recent implementation of RN prescribing in primary health and specialty practice there is currently no research that explores the implementation of this role in the NZ context. The findings from this research will illustrate the way that RN prescribers work in and influence collaborative teams, therefore providing grounds for advocating models of collaborative interprofessional team practice. In addition, the findings from this research will be essential for informing policy as new models of care are utilised to meet the changing demands of the NZ health care system. The beneficial role that nurse prescribing can play in assisting NZ to reach its health care goals paired with the dearth of research in the area highlights the need for this important research.

Project name ***(if applicable)*****:**
Registered nurse prescribing examined through the lens of Bourdieu

Has the research proposal been peer reviewed? ☒ Yes ☐ No
OR Will it be submitted for peer review? ☐ Yes ☐ No

If yes by whom: _____
(please attach reviewer reports where available)
The research proposal has been reviewed and approved by the AUT postgraduate Board.

2 Type of participation requested from Pegasus Health

☐ Endorsement

☒ Involvement of members GPs and nurses

☐ Partnership

☐ Other

Please provide details
The primary researcher seeks authorisation to recruit registered nurse prescribers and other health care professionals that they work with (eg General Practitioners, Nurse Practitioners and non- prescribing nurses). Data will be collected through individual interviews, focus group interviews, and observation of collaborative team meetings.

Over what period of time will this participation be required?
Over a period of one year from recruitment.

3 Value to Pegasus Health

Explain why Pegasus Health is the appropriate organisation for this research? (List any other participants in the research/sampling frame)
The Nursing Council of New Zealand (NCNZ) stipulate the two types of clinical environments that designated RN prescribers can practice in as primary health and specialty practice (Nursing Council of New Zealand, 2014). Pegaus health is the largest PHO in Canterbury and is known to employ designated RN prescribers, therefore the researcher aims to recruit 1-2 nurses employed in primary health care teams from Pegaus Health.
The researcher has already gained locality authorisation from Canterbury District Health Board and intends recruiting 1-2 RN prescribers who work in speciality practice within the CDHB.

What is the value of this research question to primary care?

The findings from this research will contribute to the development of knowledge in the area of interprofesional collaborative team practice and in doing so inform and support the provision of high quality collaborative primary health care.

What is the direct value of this research to Pegasus health patients?
Although the Pegaus health patients will not be directly involved in the research the findings from this research will contribute to a deeper understanding of interprofessional team practice and therefore support the provision of quality collaborative health care delivery.

Are there any risks associated with this research (to patients or within primary care)?
There are no risks associated with this research. Patients are not involved in this research in any way.

4 Funding and Costs

How is the research being funded?
The research is funed by a AUT post graduate grant and by the primary researcher

Are there any commercial benefits from this research to you, your organisation or other organisations?
There are no commercial benefits from this research

Please list any other conflicts of interest.
There are no conflicts of interest arising from this research

Estimate the resource costs to Pegasus Health (for example where data extraction is required estimate time required)
There are no resource costs to Pegasus Health

Has funding been obtained/applied for and allocated to cover these costs?
There are no resource costs to Pegasus Health

5 Privacy/ethics (note where data are requested the request for data form should be completed)

What degree of patient identification/anonymity is envisaged?
Patient information will not be collected in this reseach

Will consent by patient or GP/practice nurse be required? ☒ Yes ☐ No

Is ethical approval required/been obtained? ☒ Yes ☐ No
(Please attach approval and application copy)
If no state reasons why approval not required – in some cases a letter from an ethics committee stating that approval is not required may be requested.
Please see attached letter of ethics approval from AUT ethics committee (AUTEC)

Is publication planned of the results? ☒ Yes ☐ No

If results are not to be published how will the results be made available in the public domain?
Click here to enter text.

For Pegasus Health (Charitable) Ltd use only:

ID No.: RAE0066
Date submitted: 23/7/18

Comments: Click here to enter text.

Decision on this Request: ☒ Approved ☐ Declined

Decision Criteria:
Click here to enter text.

Date of decision: 18/09/2018

Signature: _____
Vince Barry
Position: CEO Pegasus Health

Appendix F: Participant Information Letter: Registered Nurse Prescriber

Participant Information Sheet : Registered Nurse prescriber

Date Information Sheet Produced:

Project Title

Registered Nurse prescribing examined through the lens of Bourdieu

An Invitation

Hello, my name is Kate Norris, Registered Nurse and lecturer in the School of Nursing at Ara Institute of Canterbury in Christchurch. I would like to invite you to participate in this research, which I am carrying out as a way of understanding how the role of the Registered Nurse prescriber influences collaborative health care team practice. This research is being undertaken in partial fulfilment of a Doctorate in Health Sciences at Auckland University of Technology. Your contribution as a Registered Nurse prescriber is important and therefore your participation would be greatly valued and appreciated.

What is the purpose of this research?

The purpose of this research is to explore how the role of the Registered Nurse prescriber influences collaborative team practice. The findings from this research will illustrate the way that Registered Nurse prescribers work in and influence collaborative teams, therefore providing grounds for advocating models of interprofessional team practice. The findings from this research will be published in journal articles and presented at national and international conferences

How was I identified and why am I being invited to participate in this research?

The clinical area that you work in has been identified as a health care provider that employs a Registered Nurse prescriber. You have been chosen as a person who could contribute to this study through your experience of working in the health care team. Registered Nurses who are currently enrolled in a course that I teach are excluded from this research.

It is important that you understand that this research is interested in the Registered Nurse prescribing role and the influence of this role on the team rather than on individual people. I will not be asking questions about you personally, rather I will be focusing on your role within the team as a Registered Nurse prescriber.

How do I agree to participate in this research?

If you are interested in participating in this research please email me directly. I will then arrange a time for us to meet so that you can ask any questions you may have. If you agree to participate you will then be asked to sign a written consent form prior to our first individual interview.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you agree to participate in this research you will be invited to attend an individual interview at a time and place convenient to you. In this interview you will be asked to discuss various aspects of your experience of working in a health care team as a Registered Nurse prescriber. The focus of the interview questions will be on your role within the team, the influence your role has on other team members and the way that the team works together. It is most likely that you will only be interviewed once but I may invite you to participate in a second interview if there are topics I am interested in discussing further. This interview/s will be audio recorded and later transcribed.

You may also be invited to attend a focus group interview along with other members of your team. In the focus groups, participants will be asked to discuss the role of the Registered Nurse prescriber and the influence this role has within your health care team. The focus group interview will also be audio recorded and later transcribed.

Finally, the researcher may ask for the team's consent to attend one or more team meetings. Here the researcher will take notes relating to Registered Nurse prescribing and collaborative team practice.

What are the discomforts and risks? And how will these discomforts and risks be alleviated?

It is not anticipated that any harm will come to you from participating in this research. You do not need to answer any of my questions if for any reason you do not wish to. If you do find any of the subjects discussed

upsetting there will be an opportunity for you to discuss these with me or alternatively contact details for support agencies will be made available to you.

What are the benefits?

It is anticipated that on the successful completion of this research the researcher will obtain a Doctorate in Health Sciences degree. This research will promote a greater understanding of the role of the Registered Nurse prescriber and the influence of this role on the collaborative health care team. It is anticipated that the findings from this study will inform the development of interprofessional practice models that include Registered Nurse prescribing roles in the future. This research provides participants with an opportunity to share their experiences and in doing so contribute positively to health care delivery.

How will my privacy be protected?

While every effort will be made to keep your identity confidential as the only Registered Nurse prescriber in your team it is inevitable that other team members participating in the research will be aware of your involvement. Your confidentiality and those who you mention in interviews will be maintained, with all names replaced with pseudonyms and any identifying information removed from the transcripts. The name of your place of employment will not be used in any publications or presentations resulting from this research. Audio recordings and original transcripts will be assigned a code and held in locked storage in my office at Ara. Computer files will be password protected and all recordings and transcripts will be destroyed after six years.

What are the costs of participating in this research?

There are no financial costs. The individual interviews will take approximately one hour in order to gain an understanding of the subject area. The researcher may invite you to undertake a second interview to discuss emerging themes, this would be a shorter interview of approximately 30 minutes. If you are invited to attend a focus group interview this will take approximately one hour.

What opportunity do I have to consider this invitation?

If you are interested in participating in this study, I ask that you contact me within three weeks of receiving this information.

Will I receive feedback on the results of this research?

Yes. You will need to indicate on the consent form if you would like a summary of the research results. These will be emailed to you on the completion of the research.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Stephen Neville, Email: stephen.neville@aut.ac.nz, Ph: 09 9219379.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information sheet and a copy of the consent form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kate Norris

Email: kate.norris@ara.ac.nz

Ph: 027 2624496

Project Supervisor Contact Details:

Associate Professor Stephen Neville

Email: stephen.neville@aut.ac.nz

Ph 09 9219379

Approved by the Auckland University of Technology Ethics Committee on 23rd March 2018, AUTEC Reference number 18/39.

Appendix G: Recruitment advertisement

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

Research aim: Legislative changes in 2016 enabled the extension to prescribing rights for Registered Nurses in New Zealand. Registered Nurse prescribers are required to work in collaborative health care teams. This research aims to explore how Registered Nurse prescribers work in and influence collaborative health care team practice. It is anticipated that this research will provide grounds for advocating models of collaborative interprofessional practice

Who: If you work in a collaborative health care team with a Registered Nurse prescriber you are invited to participate in this research. If you are a Registered Nurse who is currently enrolled in a course taught by the researcher (Kate Norris, Nursing lecturer, Ara Institute of Canterbury) you will be excluded from this research.

What is involved: An interview of up to one hour with the researcher

Where: A quiet place that is convenient for you

When: Between May 2018 and May 2019

Organisation: This study is part of an AUT, Doctor of Health Science qualification

Contact: If you are interested in participating in this study, please contact Kate Norris within 3 weeks of receiving this invitation. Kate can then provide you with more information about what is involved.

Details: **Email:** kate.norris@ara.ac.nz

Ph/text: 027 2624496

Appendix H: Participant Information Letter: Health Care Team

Participant Information Sheet: Health care team

Date Information Sheet Produced:

20/7/18

Project Title

Registered Nurse prescribing examined through the lens of Bourdieu

An Invitation

Hello, my name is Kate Norris, Registered Nurse and lecturer in the School of Nursing at Ara Institute of Canterbury in Christchurch. I would like to invite you to participate in this research, which I am carrying out as a way of understanding how the role of the Registered Nurse prescriber influences collaborative health care team practice. This research is being undertaken in partial fulfilment of a Doctorate in Health Sciences at Auckland University of Technology. Your contribution as a member of the health care team is important and therefore your participation would be greatly valued and appreciated.

What is the purpose of this research?

The purpose of this research is to explore how the role of the Registered Nurse prescriber influences collaborative team practice. The findings from this research will illustrate the way that RN prescribers work in and influence collaborative teams, therefore providing grounds for advocating models of interprofessional team practice. The findings from this research will be published in journal articles and presented at national and international conferences

How was I identified and why am I being invited to participate in this research?

The clinical area that you work in has been identified as a health care provider that employs a Registered Nurse prescriber. You have been chosen as a person who could contribute to this study through your experience of working in the health care team. Registered Nurses who are currently enrolled in a course that I teach are excluded from this research.

How do I agree to participate in this research?

If you are interested in participating in this research please email me directly. I will then arrange a time for us to meet so that you can ask any questions you may have. If you agree to participate you will then be asked to sign a written consent form prior to our first individual interview.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you agree to participate in this research you will first be invited to attend an individual interview at a time and place convenient to you. In this interview you will be asked to discuss various aspects of your experience of working in a health care team with a Registered Nurse prescriber. The focus of the interview questions will be on your role within the team, the influence the Registered Nurse prescriber role has on the team and the way that the team works together. It is most likely that you will only be interviewed once but I may invite you to participate in a second interview if there are topics I am interested in discussing further. This interview/s will be audio recorded and later transcribed.

You may also be invited to attend a focus group interview along with other members of your team. In the focus groups, participants will be asked to discuss the role of the Registered Nurse prescriber and the influence this role has within your health care team. The focus group interview will also be audio recorded and later transcribed.

Finally, the researcher will ask for the team's consent to attend one or more team meetings. Here the researcher will take notes relating to Registered Nurse prescribing and collaborative team practice.

What are the discomforts and risks? And how will these discomforts and risks be alleviated?

You do not need to answer any of my questions if for any reason you do not wish to. It is not anticipated that any harm will come to you from participating in this research. However, if you do find any of the subjects discussed

upsetting there will be an opportunity for you to discuss these with me or alternatively contact details for support agencies will be made available to you.

What are the benefits?

It is anticipated that on the successful completion of this research the researcher will obtain a Doctorate in Health Sciences degree. This research will promote a greater understanding of the role of the Registered Nurse prescriber and the influence of this role on the collaborative health care team. It is anticipated that the findings from this study will inform the development of interprofessional practice models that include Registered Nurse prescribing roles in the future. This research provides participants with an opportunity to share their experiences and in doing so contribute positively to health care delivery.

How will my privacy be protected?

Whilst every effort will be made to keep your identity confidential if you choose to be interviewed in your workplace it is possible that other team members will be aware of your involvement. Your confidentiality and those who you mention in interviews will be maintained, with all names replaced with pseudonyms and any identifying information removed from the transcripts. The name of your place of employment will not be used in any publications or presentations resulting from this research. Audio recordings and original transcripts will be assigned a code and held in locked storage in my office at Ara. Computer files will be password protected and all recordings and transcripts will be destroyed after six years.

What are the costs of participating in this research?

There are no financial costs. The individual interviews will take approximately one hour in order to gain an understanding of the subject area. The researcher may invite you to undertake a second interview to discuss emerging themes, this would be a shorter interview of approximately 30 minutes. If you are invited to attend a focus group interview this will take approximately one hour.

What opportunity do I have to consider this invitation?

If you are interested in participating in this study, I ask that you contact me within three weeks of receiving this information.

Will I receive feedback on the results of this research?

Yes. You will need to indicate on the consent form if you would like a summary of the research results. These will be emailed to you on the completion of the research.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Stephen Neville, Email: stephen.neville@aut.ac.nz, Ph: 09 9219379.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this information sheet and a copy of the consent form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kate Norris

Email: kate.norris@ara.ac.nz

Ph: 027 2624496

Project Supervisor Contact Details:

Associate Professor Stephen Neville

Email: stephen.neville@aut.ac.nz

Ph 09 9219379

Approved by the Auckland University of Technology Ethics Committee on 23rd March 2018, AUTEC Reference number 18/39.

Appendix I: Indicative Interview Schedule

Indicative individual interview questions

Project title:	Registered Nurse prescribing examined through the lens of Bourdieu
Project Supervisor:	Associate Professor Stephen Neville
Researcher:	Kate Norris

These questions will be used to guide the individual interviews. The actual questions asked may alter during the interview depending on how the participants answer the previous questions. The primary researcher will ask additional follow up questions during the interview in order to seek clarification and to encourage the participant to explain things in further detail.

1. Have there been any changes in how medication prescribing is undertaken in this practice? Can you describe these changes?

2. What do you understand the role of the Registered Nurse prescriber to be?

3. How does your role interface with the role of the Registered Nurse Prescriber? (this question will not be asked of the Registered Nurse prescriber)

4. In your opinion has the introduction of an RN prescriber changed or influenced the role of any other team members, if so how?

5. I'd like to talk a little about the health care team you work in. Does the team have a common goal or direction? Can you describe this?

6. Can you tell me about some of the strategies your team use to communicate? For example do you use emails, team meetings etc

7. Are there common values and attributes shared by the various members of the team?

8. How would you describe the way the team works together? What factors enhance or constrain the team's ability to work together.

9. Do you believe that professional hierarchies exist within this team, and if so how do they impact on team practice.

   Additional questions for the RN prescriber

10. Is this your first role as a Registered Nurse prescriber? Can you tell me about how you came to this role?

11. Has your relationship changed with other team members since you became a prescriber? If so can you describe these changes?

    Additional questions for prescribers (Doctors/ Nurse Practitioners and RN prescribers)

12. In terms of your work place and the team you work with are there any factors that you have found particularly beneficial or constraining in terms of your prescribing practice? Can you tell me about them.

Appendix J: Individual Participant Consent Form

Individual Interview Consent Form

Project title: *Registered Nurse prescribing examined through the lens of Bourdieu*

Project Supervisor: *Associate Professor Stephen Neville*

Researcher: *Kate Norris*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

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.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 23rd March 2018. AUTEC Reference number 18/39

Note: The Participant should retain a copy of this form.

Appendix K: Researcher Safety Protocol

Researcher Safety Protocol

Project title: *Registered Nurse prescribing examined through the lens of Bourdieu*

Project Supervisor: *Associate Professor Stephen Neville*

Researcher: *Kate Norris*

I have indicated in my application that individual interviews and focus groups will take place in a location that is mutually agreed and convenient to the participants. No interviews will be conducted at my own home but it is possible that interviews will be conducted at the participants' homes if that is what they request.

As the participants are health care professionals I do not anticipate any concerns for my safety. However, I intend protecting my safety in the following ways:

- I will inform my supervisor Dr Kaye Milligan before I attend an interview including detail of where the interview is to be held and the duration of the meeting.
- On completion of the interview I will phone or text Dr Kaye Milligan to inform her that I have safely completed the interview
- Prior to completing any interviews I will discuss with Dr Kaye Milligan who to contact and what action to take should I fail to contact her to say I have safely completed the interview.
- I will have my mobile phone with me during each interview.

Researcher's signature: 

Appendix L: Transcriber Confidentiality Agreement

Confidentiality Agreement for Transcriber

Project title: *Registered Nurse prescribing examined through the lens of Bourdieu*

Project Supervisor: *Associate Professor Stephen Neville*

Researcher: *Kate Norris*

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details (if appropriate):

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.....

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

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Approved by the Auckland University of Technology Ethics Committee on 23rd March 2018 AUTEC Reference number 18/39

Note: The Transcriber should retain a copy of this form.

Appendix M: Team Meeting Observation Protocol

Observation protocol

Project title: *Registered Nurse prescribing examined through the lens of Bourdieu*

Project Supervisor: *Associate Professor Stephen Neville*

Researcher: *Kate Norris*

Depending on the information gathered during individual interviews and focus group interviews the primary researcher may attend and observe at least one team meeting with the consent of all attendees.

How will people be informed about the observation?

All team members attending the meeting will be provided with an information sheet about the study. All participants will be informed of the purpose of the observation, they will be made aware that the researcher will make hand written notes during the meeting observation and that no audio-recording will occur. The information sheet for participants makes it clear that if the researcher is privy to patient information during the meeting, this information will neither be recorded nor used in the research in any way.

How will people consent to the observation?

The primary researcher will gain the written consent of all team members prior to the meeting commencing. No observations will take place unless all meeting attendees agree to be observed.

What will be observed?

- The verbal interactions between people attending the meeting
- Non-verbal interactions and body language of meeting attendees
- Observation of which members of the team lead the discussion
- Observation of which members contribute to discussion and how often
- The manner in which decisions are made during team meetings

Demographic data that will be collected

- The date, time and duration of the meeting
- The physical setting in which the meeting occurs
- The people attending the meeting, roles will be recorded rather than names

Appendix N: Participant Information Letter: Observation of Team meeting

Participant Information Sheet: Observation of team meeting

Date Information Sheet Produced:

dd mmmm yyyy

Project Title

Registered Nurse prescribing examined through the lens of Bourdieu

An Invitation

Hello, my name is Kate Norris, Registered Nurse and lecturer in the School of Nursing at Ara Institute of Canterbury in Christchurch. I would like to invite you to participate in this research, which I am carrying out as a way of understanding how the role of the Registered Nurse prescriber influences collaborative health care team practice. This research is being undertaken in partial fulfilment of a Doctorate in Health Sciences at Auckland University of Technology. Your contribution as a member of the health care team is important and therefore your participation would be greatly valued and appreciated.

What is the purpose of this research?

The purpose of this research is to explore how the role of the Registered Nurse prescriber influences collaborative team practice. The findings from this research will illustrate the way that Registered Nurse prescribers work in and influence collaborative teams, therefore providing grounds for advocating models of interprofessional team practice. The findings from this research will be published in journal articles and presented at national and international conferences

How was I identified and why am I being invited to participate in this research?

The clinical area that you work in has been identified as a health care provider that employs a Registered Nurse prescriber. You have been chosen as a person who could contribute to this study through your experience of working in this health care team. Registered Nurses who are currently enrolled in a course that I teach are excluded from this research.

How do I agree to participate in this research?

If you are interested in participating in this study, by allowing me to observe the team meeting, please email as soon as possible prior to the scheduled meeting. If all meeting attendees are willing for me to observe the scheduled meeting I will ask you to sign a written consent form prior to the commencement of the meeting.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

I have already interviewed several team members both individually and in focus groups about their experiences of working in a health care team with a Registered Nurse prescriber. Today, I am inviting you to participate by agreeing to allow me to sit in and observe the team meeting that you will be attending. I will only observe the meeting if all team members consent to me being present. I will not contribute in any way during the meeting. I will not be audio recording what is discussed in the meeting, however I will be making some hand written notes. I am interested in and will take notes about discussion relating to Registered Nurse prescribing and collaborative team practice.

What are the discomforts and risks? And how will these discomforts and risks be alleviated?

It is not anticipated that any harm will come to you from participating in this research. It is possible that the researcher will become privy to confidential or sensitive information during the team meeting. The purpose of me attending this team meeting is to observe how the health care team work collaboratively rather than to gain any information about individual team members or patients. I would like to reassure you that I will not be audio-recording the team meeting nor will I write any notes pertaining to personal information discussed in the meeting.

What are the benefits?

It is anticipated that on the successful completion of this research the researcher will obtain a Doctorate in Health Sciences degree. This research will promote a greater understanding of the role of the Registered Nurse prescriber and the influence of this role on the collaborative health care team. It is anticipated that the findings from this study will inform the development of interprofessional practice models that include Registered Nurse prescribing roles in the future.

How will my privacy be protected?

Your confidentiality will be maintained and your name and the name of your place of employment will not be used in any publications or presentations resulting from this research. Whilst every effort will be made to keep your identity confidential it is inevitable that other members of your team attending the meeting will be aware of your involvement. I will transcribe my hand written notes following the meeting and any identifying information will be removed at this time. These transcripts will be assigned a code and held in locked storage in my office at Ara. Computer files will be password protected and all transcripts will be destroyed after six years.

What are the costs of participating in this research?

There are no financial costs. The researcher will observe the meeting for its scheduled duration, you will not be required to commit any additional time to this aspect of the research.

Will I receive feedback on the results of this research?

Yes. You will need to indicate on the consent form if you would like a summary of the research results. These will be emailed to you on the completion of the research.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Stephen Neville, Email: stephen.neville@aut.ac.nz, Ph: 09 9219379.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kate Norris

Email: kate.norris@ara.ac.nz

Ph: 027 2624496

Project Supervisor Contact Details:

Associate Professor Stephen Neville

Email: stephen.neville@aut.ac.nz

Ph 09 9219379

Approved by the Auckland University of Technology Ethics Committee on 23 March 2018, AUTEC Reference number 18/39.

Appendix O: Observation Consent Form

Observation Consent Form

Project title: *Registered Nurse prescribing examined through the lens of Bourdieu*

Project Supervisor: *Associate Professor Stephen Neville*

Researcher: *Kate Norris*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants, our discussions and notes taken during observation of team meetings are confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during observations.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the observation of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

***Approved by the Auckland University of Technology Ethics Committee on 23rd March 2018. AUTEC Reference number* 18/39**

Note: The Participant should retain a copy of this form.