Negotiating a New Role in a Gendered Order: A Cultural Lens

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Abstract

This article examines how advocates for the nurse practitioner (NP) role negotiated its implementation in a large urban health system that differentiates nursing from medicine on the basis of gender. Using a cultural perspective, analyses show how advocates envisioned the NP role as liminal—neither traditional nursing nor medical—and as expanding the boundaries of nursing work through appropriation of some medical work. Four key negotiation strategies are profiled that advocates used to successfully implement and sustain this role in most settings. The conclusion examines whether and how this new role altered or maintained the gendered arrangements and more generally points to the significance of liminal phenomena in producing fundamental change.

This paper examines how advocates for the nurse practitioner role negotiated its implementation in a large urban health system in western Canada. This particular health care context, like most in North America, differentiates nursing from medicine on the basis of gender, with nursing construed as feminine and a low power group, and medicine as masculine and a high power group (Ely & Padavic, 2007). In negotiating this new position, these individuals envisioned a role between the traditional categories of nurse and physician. They sought to appropriate medical tasks traditionally the responsibility of physicians. As nurses with additional education, training, and experience, nurse practitioners would claim authority to diagnose, prescribe, and treat health conditions. They also sought to integrate the ethos of ''caring'' into the practice of the medical work by nurse practitioners, a value associated with the nursing profession, often contrasted with

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the medical value of "curing." A cultural analysis of these negotiation efforts discloses how the creation of the nurse practitioner role as between existing categories—or liminal in character—produced both the possibility for altering the gendered order and shaped the design of negotiation strategies used to convince relevant others of the new role's value and legitimacy.

To situate and examine efforts to implement the nurse practitioner role in this context, a "negotiated order" analytic perspective is adopted, with special attention accorded the cultural realm. This perspective highlights negotiation as an inherently interactional activity that takes place on an everyday basis (Kolb & Williams, 2003; Strauss, 1988). To understand how a new role is introduced requires analytic attention to people's negotiation efforts as situated in particular contexts. Conceived by Strauss (1988, pp. 166–167) as interactional processes "because interaction is central to them, such negotiation efforts are the strategic means by which the work processes are started, maintained, strengthened and supported … without [which] work processes would not proceed." Integral to negotiating a new role are interactional processes such as gaining acceptance, mitigating resistance, and so forth.

Second, a negotiated order perspective regards all social order as negotiated. As Strauss (1988, pp. 5–6), "The negotiated order on any given day could be conceived as the sum total of the organization's rules and policies, along with whatever agreements, understandings, pacts, contracts, and other working arrangements currently obtained … agreements at every level of organization, of every clique and coalition, and … covert as well as overt agreements." This perspective views order as always negotiated and in flux, even when taken for granted by participants or even in its maintenance.

Extending this perspective, we see how introducing organizational change such as the new role of nurse practitioner renders the negotiated order more visible to participants, enabling them to reflect on, question, and potentially alter prevailing arrangements of structure, gender, and culture. The formal and informal organization of work becomes visible, as well as the status and authority granted for such work. Similarly, although Strauss and colleagues did not incorporate gender into the conception of negotiated order (Kolb & McGinn, 2009) the prevailing division of feminine and masculine work is rendered visible. Finally, culturally (Golden-Biddle, GermAnn, Reay, and Procyshen, 2006; Golden-Biddle, Hinings, Casebeer, Pablo, and Reay, 2006), the symbolic realm of meaning and symbolic forms through which people experience and express meaning—such as "caring," "curing," and "appropriate" work for nurses and physicians—become illuminated.

In contrast to prior work emphasizing cultural immutability, recent work on change in organizational studies and micro-sociology (see Golden-Biddle, GermAnn et al., 2006; Hallett, 2003) is exploring the strategic use of extant culture and creation of new symbolic forms. Here, we continue this work by illuminating cultural efforts associated with defining the role of nurse practitioner. Specifically, we integrate the concept of liminality (Turner, 1969, 1970) to examine the in-between space created for this role as neither traditional nurse nor physician, and practicing medical work with a foundation in the ethos of caring.

The word "liminal" is derived from Latin and means "threshold." Originating in the studies of ritual by van Gennep (1960) to demarcate the state in rituals between one status and another, Victor Turner (1969, 1970) developed the concept of liminality to portray a location in social life "betwixt and between" structural norms and roles. Liminal phenomena occur in the crevices of normal structuring devices in the organization. Not fitting into—and not able to be fit into—prevailing categories or classifications, such phenomena appear ambiguous to others. It is in this ambiguity that a liminal role embodies the potential to reshape the gendered order by provoking reflection on the prevailing division of labor between medicine and nursing. Whether and how gendered arrangements shift depends on everyday negotiations over authority and boundaries of the new role carried out in interactions with relevant others, especially physicians and nurses.

After a brief discussion of the methodology, we present analyses of the creation of the nurse practitioner as liminal role and then identify and describe the associated negotiation strategies used to convince relevant others of the role's value and legitimacy.

Methodology

Our study of the nurse practitioner role was part of a larger 5-year research program that investigated how organizational change in health care is implemented and sustained, with an emphasis on the role of individual agency in producing sustained change. We studied change in health organizations in Canada (Golden-Biddle, Hinings et al., 2006). Adopting a longitudinal and process-based research design (Langley, 1999) allowed us to follow individuals' efforts through time as they occurred in their natural setting.

We collected three types of data: semi-structured interviews, meeting observations, and archival documents. Sixty interviews were conducted with primarily female nurse practitioners (NPs) and managers over a 4-year period. Fourteen NPs were interviewed twice. Interviews were conducted at the workplace and lasted an average of 1 hr. In the health system profiled here, an internal task force was established to guide the introduction of the NP role. The two authors observed monthly meetings of this group, attending 25 2-hr meetings over a period of 3.5 years. We recorded by hand as much of the conversation in each meeting as possible. Our handwritten notes were transcribed and then checked for accuracy after each meeting. Finally, archival documents were used to cross-check other data sources and included meeting minutes, internal reports, memos, newsletters, and planning documents, as well as publicly available materials.

Throughout the research, our goal was to assure the dependability of the data (Diesing, 1971), a specific type of validity oriented to understanding human action in its context and to the extent possible from actors' perspectives. Dependability enables researchers to assert that uniformity exists in the data collected (a theme) and that the resulting interpretations authentically and plausibly (Golden-Biddle & Locke, 1993) explain the phenomenon.

Negotiating A New Role

Creating a Liminal Role

Most individuals involved in implementing the nurse practitioner role were nurses with common educational and workplace experiences. They and their managers (including those who were not nurses) shared a conviction that the profession of nursing stood for an ethos of caring for the patient that strengthened the delivery of care. They wanted the NP to have the authority to do medical work, but only by expanding the work boundaries of the nursing profession. They did not want NPs to become "mini-docs" even though, on an individual basis, they may have gained more status by being absorbed into medicine. As a collective they saw becoming mini-docs as diminishing the nursing profession and reducing clinical autonomy vis à vis the medical profession. This conviction was expressed in interviews, as seen in the following representative comments:

> A nurse once told me, "Well, you're a mini-physician. Why don't you just call yourself a physician?" I looked at her and said, "You know what? If I wanted to be a physician I would have gone to medical school. But I'm a nurse. And I'm proud to be a nurse. I'm doing an extended role of what a nurse does, but I'm still a nurse and will always be a nurse."

> In my mind, the NPs … should be our most expert group of nurses. They shouldn't be mini-doctors. They shouldn't be replacement doctors. They shouldn't be those things.

Congruent with this vision, these individuals claimed value for an NP role that was distinctively nursing, grounded in an ethos of caring, while also appropriating medical tasks such as diagnosing and prescribing more traditionally associated with curing. As such, they created an NP role that was culturally liminal. Had they, for example, located the role in medicine or envisioned it as a physician assistant or extender, the role would have fit into prevailing structures and not have taken on a liminal character.

Anticipating resistance to the role as envisioned, they also recognized the need to cultivate system support. To best develop the role and support its implementation, key individuals in nursing created a task force comprised of front line NPs, top and middle managers (including HR managers), and representatives of the provincial nurses association and university faculty of nursing. Members developed and carried out the first action items on their work plan:

- Identify and adopt a consistent definition [for nurse practitioner].
- Identify and review current positions utilizing advanced nursing practice.
- Define the scope of practices/responsibilities within these roles.
- Define consistent roles/titles to be used.
- Produce clear job descriptions.
- Define fit within the organizational structure, direct versus functional reporting.

Task force members worked diligently over a period of months to accomplish these action items, developing the first definition and first job description of an NP for this organization and articulating consistent terminology and expectations for the role. The

description also articulated the value for an NP role that "extends the boundaries of nursing's scope of practice and contributes to nursing knowledge and the development and advancement of the profession." In doing so, it enabled the enactment of the NP to be grounded in an ethos of caring while appropriating medical tasks more typically associated with curing. They defined the best fit of the NP role as one located in the nursing division for reporting purposes. This organizational location protected the role from dependence on medical needs and dominance that could have thwarted its growth or taken it in a very different direction in implementation.

Taken together, these efforts positioned the NP role so that it had the greatest opportunity to gain acceptance and legitimacy in the organization. Prepared for resistance, members had clarified the role and expectations, and fit it organizationally so as to buffer attempts to eradicate the position.

Negotiation Strategies

Yet, task force members also realized they needed to go beyond preparing the best role description. They knew there would be resistance to an NP role that was clearly a nursing role yet sought authority to do medical tasks. This new clinical authority also had implications for how everyday work was done. For example, rather than fading into the background when the physician entered a patient's room, the NP was expected to dialogue directly with the physician about the patient's treatment.

Consequently, task force members worked to develop strategies that would enable successful negotiation of the role. Analyses disclosed four general strategies used to claim legitimacy for the expanded boundaries and enhanced authority required to enact the role. To have the best chance at sustaining the NP role over time, these strategies were oriented to introducing the role in the least threatening manner, especially where physicians were involved. The first strategy was to seek physician input during the design of the role. When interacting with clinicians one-on-one or in groups during the conduct of work, NPs used two primary strategies of negotiation: teaching relevant others about the value of the role and making the role worthwhile for relevant others. Finally, once the task force had finished the design work, it became a sounding board for articulating issues and figuring out how to negotiate issues. We describe below each of these four strategies and give examples of how they were implemented in everyday interaction. We then provide an update on the progress made in negotiating the NP role.

Seeking Input From Relevant Others During the Design and Implementation of Role

Task force members worked to ensure this role would be accepted in the organization by first testing it with selected physicians. Although members indicated they wanted it to be a "nursing process," they knew from past experience that physician support was required in order to achieve executive approval.

> So our work was taken to the Medical Advisory Committee. The feeling was that we needed their input, advice, comments, concerns. … We're trying to make these essentially nursing roles, and unique nursing roles, yet they do have some aspects of physician practice. … Certainly the

> physician group is recognized as our highest impact group. So any of the pieces we've moved forward, we've taken to them before it's gone any further. They were actually quite supportive of it. For them it means being able to understand what the differences and the roles are.

Reviewing the role design with the Medical Advisory Committee—the main decision authority for medicine—helped to alleviate physicians' concerns about the impact of the role on medicine, while also establishing the desired nursing basis of the role and retained expanded work boundaries. It also created some alliances among the medical staff whose support helped to implement the role.

Teaching Relevant Others About the Value of the Role

Taking advantage of every opportunity over time to educate clinicians on the unit provided an understanding of this new role, what to expect of it, and how it fit into the overall scheme of delivering care. From a cultural perspective, this negotiation strategy helped to make the role familiar, providing a place for the position in the everyday interactions on the unit. It also enabled the NPs' clinical colleagues to get to know them through positive social connections. In the following examples, individual NPs shared how they took the necessary time with all physicians and nurses to tell them what an NP is and does.

> I just sat down one-on-one with the nurses, and said, this is who I am.

> The docs were describing my role as a "physician extender." I fought against this. Part of the thing was to fill [the doctors] in on the role. Part of educating them was I gave them some … of the information on prescriptive authority. I also gave them a really good article … that was on advanced practice in gerontological nursing. And so they looked at that and I think that's where they picked up on the idea.

Making the Role Worthwhile for Relevant Others

In addition to rendering the role familiar through education, individual NPs and their managers worked hard to have relevant others see the role as worthwhile. They wanted to make the value of the role visible through actual experiences on the unit. For example, they sought to enhance others' work by reducing physician overload, or by allowing the doctors to focus on more complex cases.

> The community was very much up in arms because the local doctor was overworked and was threatening to leave. He just couldn't cope anymore. So in order to relieve a bit of the pressure—I was the answer. … I try to reduce his workload as much as I can.

> Physicians started seeing the differences with the NP and [realized] that NPs are not trying to take over or be one of them. They started to see how much they benefit from the role—so they started supporting it.

Early on most of the efforts were directed at physicians. But, as difficulty emerged with nurses as well, NPs took similar efforts to make the role worthwhile for the nurses. The strategies were more difficult to implement, however, because NPs were also nurses. If they did too much nursing work, they would be seen as traditional nurses. Yet, if they

ignored nurses, they would lose the nursing base and be seen as mini-docs. Consequently, where NPs sought to make the role worthwhile to physicians by reducing their workload, with nurses, they made the role worthwhile by helping to solve their problems.

> The main thing is solving [nurses'] problems. Because when they have to go after the physician … it can take an hour or two for somebody to show up or do anything. If I'm right there, I look at the electrocardiogram, make some calls, and solve the problems right away. So they like that.

> Nurses know that they can call us. They'll say, "Hey, Mrs. So-and-so had a pacemaker yesterday, she's short of breath, and that doesn't feel right to me. What do you think?" And we actually have the power to say, "Yes, let's send her for chest x-rays." Nursing really likes that we can do something about it.

This strategy was especially helpful in creating support for the role among physicians and nurses. Many NPs recounted, for example, that once colleagues personally experienced the value of the role, they would orient newcomers and other clinicians about the positive contribution the NP role made to the clinical team and care delivery. At this point, NPs began to experience coalitions of support for the role across clinical groups.

Creating a Sounding Board for Articulating Issues and Negotiation Strategies

The use of the task force to address issues was an important system-level strategy for claiming legitimacy and negotiating boundaries of the role. In one respect, NPs and other task force members were able to share experiences of resistance. As they listened to each others' stories, they not only generated potential solutions to deal with the situations, but also began to see patterns across settings. In this way, the task force acted as an important sounding board for planning how to negotiate issues and resistance. They also learned which negotiation strategies worked best. The following excerpt from one of the task force meetings illustrates one of these exchanges:

> NP 1: One of the physicians I work with still doesn't know the difference between an NP and nurse.

> Manager A: Yes, many doctors don't know why we are developing this [clear job description for NPs], because "they know some really good nurses who would be able to fill the role."

> NP1: We need to get physicians to understand that it's not only about them! NPs are not their personal assistants.

> NP2: Right, but, I was able to use a recent editorial in a medical journal to show Dr. X how NPs provide care in ways that are different from physicians. It said that NPs give "touchy-feely" care. And although I don't think this was the greatest language, when I showed [the physician] the article, it actually helped him to get it!

In addition, through this process, members began to discern particular situations that needed to be handled on a system level, rather than on an individual basis.

Here, members coordinated their efforts and engaged the system to problem solve issues that were threatening the NP role. During one task force meeting, for example, group members identified all known system barriers preventing NPs from practicing to their fullest extent. Committee members developed a list of 17 policies, procedures, and directives that needed to be changed to better incorporate NPs. These items ranged from corporate directives that had not been updated to reflect NPs' ability to give telephone orders, to the refusal of printing services to create prescription pads that would include a space for an NP signature (not just those of MDs).

After generating the list, they started to work through it to identify possible solutions. An example of their work for two of these items is shown in the excerpt below:

> Manager A: OK, let's work these one by one.
>
> Manager B: First, NPs [in one location] aren't able to order x-rays.
>
> Manager A: We need to deal with that through Medical Affairs. … The crux of the problem is that radiologists can't be paid under the current structure.
>
> Manager B: NPs can't order special diets through [the electronic system].
>
> Manager C: We've tried to resolve this many ways with no success.
>
> Manager A: We can handle that easily! I know two people who can fix the problem, and I could have fixed it a meeting last week. I'll set up a meeting.
>
> Manager C: Good, because the signing authority was never in question—it was the electronic system that wouldn't accept anything but a physician order.

Update

While most of the time these negotiation strategies worked to alleviate concern and help clinicians realize the value of the nurse practitioner role, in some situations the role continued to generate resistance. For example, some physicians struggled with the expanded boundaries of the NP role. The following excerpt depicts an example of this frustration, and how the situation worsened to the point that this NP ultimately gave up and moved to a different unit.

> I was having difficulty with this physician because he did not understand the nurse practitioner role. He didn't understand that it was more than being the physician's handmaiden, and there was no moving him beyond that in spite of my best efforts. … I talked with management, and then I talked with the physician and said, "I can't do this." I know that what I said was taken to heart and there were some changes made, but I ended up leaving and going to [another department]. They ultimately replaced me with an international medical student.

In this case, the physician continued to express resistance to an NP role that took on greater medical authority. Neither a student intern nor a physician colleague, the NP did not fit into sensible categories for this physician and thus continued to be regarded

as unfamiliar and threatening. Although an exception, there were isolated examples of physicians who continued to resist the NP role regardless of negotiation efforts undertaken.

Nurses—especially RNs—also showed resistance to the role. They would ignore NPs, looking past them to ask questions of physicians. This was surprising for NPs, one of which remarked, ''RNs on many units were very, very guarded.'' Although physician resistance was anticipated, NPs had taken nursing support for granted. During one meeting with NPs, RNs very hesitatingly expressed concern that the role did not advance the profession so much as demarcate an elite group of nurses within the profession. Although most nurses over time came to appreciate and see the value of the NP role, some continued to quietly express critique.

In spite of some difficulties along the way, the negotiation strategies used to claim value for the NP role and to expand work boundaries of nursing have resulted in acceptance and continuing expansion of the role into a variety of clinical settings throughout this large urban health system. Although there are a few situations in which the NP role has not yet become consistently implemented, in most settings NPs seem to be well integrated into their health care teams and are relatively satisfied with the acceptance of the NP role. Reflecting on the progress made over time in negotiating the new role, an NP shared:

> I remember having to defend who I was, what my education was, and on and on and on. And orders would never get processed til they were blessed by the physician, … those kinds of things. Not anymore. Huge respect. The staff is really good here.

Concluding Thoughts

This paper has examined how individuals negotiated the implementation of the new role of nurse practitioner in a large urban health system that differentiates nursing from medicine on the basis of gender. Taking a cultural lens, analyses highlighted the creation of a liminal NP role that incorporated medical responsibilities while retaining the ethos of caring traditionally associated with nursing. In doing so, advocates envisioned a role that expanded work boundaries, specifically the work that was done by nursing. Significantly, they did not choose other options open to them, such as increasing the pool of people doing medical work by becoming physician assistants. By all accounts the negotiation of the role has been successful; it is now legitimized and no longer fosters strong resistance by physicians or nurses (Reay, Golden-Biddle, & GermAnn, 2006).

But has this new role altered or maintained the gendered arrangements of nursing as feminine and medicine as masculine? One view holds that the gendered arrangements have been maintained, in spite of successful negotiation of the NP role into the system. Maintenance has resulted because the NP role was developed as and is still regarded as a nursing role that has incorporated some medical responsibilities. It is not a medical role. Indeed, by sustaining the ethos of caring, advocates adopted a role that was gendered in very traditional ways even as they tried to shift gender boundaries of who does what work. As NPs they still occupy gendered (feminine) roles, doing more work

for not much more pay or higher status. Furthermore, there is no questioning of the dominance of medicine in the system or of the type of care fostered in such a system. NPs are not trying to get physicians to adopt a more caring approach. Because it is not a medical role, the gendered order was kept intact in spite of additional duties taken on by NPs relative to other nurses.

Adopting a cultural lens, an alternative view emerges suggesting that the gendered arrangements are being altered by the NP role. Precisely because the NP role was developed as a nursing, not medical role, it has produced possibilities for change in the gendered order. Incorporating medical work into a nursing position created space for the NPs to elude prevailing agreements about what and who is a nurse or doctor and gain authority for diagnosing and prescribing. The liminal character of the role mixes up and twists expected classifications and categories associated with the gendered nature of work. Nurses now do medical work, and medical work is done with caring. Holding the ethos of nursing and remaining identified with nursing while also treating patients has brought medical and nursing work into contact. No longer separate realms, the boundaries of these gendered jobs have become more malleable in contact, even in small, perhaps unnoticeable, ways. Experiencing NPs prescribe, consider the patient as whole person in diagnosis, and take time to integrate caring about the patient into curing, all small ways that the boundaries of gendered jobs of physicians and nurses have shifted. Significantly, it is through culturally liminal phenomena such as the NP role that individuals and groups are presented with opportunities to struggle over, negotiate, create, and come to consensus on new definitions of reality. It is in the interstices of organizational life—between job categories overlaid with gendered arrangements—that possibilities for change are produced.

It remains to be seen whether fundamental change in the gendered order and design of care can be negotiated from individuals working inside the very organizations they seek to alter. This issue emerged during one feedback session with some of the NPs who are part of this story. They are not sure—but what they are sure of is that their efforts have indeed altered the gendered arrangements and fostered consideration and some efforts in primary health care. The authors of this paper are similarly hopeful, though they recognize the tremendous challenges. It will be intriguing to track the negotiation of new roles and new systems of delivering care that emphasize primary health care and wellness, as well as other innovative micro-level efforts underway in health systems that mix up prevailing classifications to see if they can create change in the larger health system.

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