Nurse Practitioners' perspectives on the added value of nurse practitioners in the outpatient clinic in the Netherlands

a generic explorative qualitative study

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ABSTRACT

Title: Nurse Practitioners' perspectives on the added value of nurse practitioners (NP) in the outpatient clinic in the Netherlands.

Background: Many Dutch NPs work in outpatient clinics, together with physicians and specialised nurses (SNs). There is discussion about the added value of NPs among SNs and physicians. They believe that both professions do not differ in patientcare and that they perform similar tasks. For NP positioning and educational purposes, it is crucial to gain insight in the added value of the NPs in relation to the SNs.

Research question: What are the perspectives of nurse practitioners on the added value of the nurse practitioner in relation to the specialised nurse practicing in the outpatient clinic, based on the CanMEDS competences?

Methods: Explorative generic qualitative research was performed from March to June 2017. Data was collected through twelve semi-structured interviews with purposefully sampled NPs. Thematic analysis was used for data-analysis. Thereafter, the CanMEDS competences were used to compare the NPs and SNs practice.

Findings: Three main themes were derived from the data: 1) Nursing leadership was the most distinctive competence regarding the added value of the NP in the outpatient clinic. 2) Integration of care and cure, and performing on the expert level of nursing expertise was most mentioned added value, and 3) NPs competence in Knowledge and Science.

Conclusion: Driven by the NPs' competency in nursing leadership, the added value of NPs in relation to SNs is evident in integrating care and cure, practicing as nursing expert and knowledge in science. NPs and SNs must discuss the added value of both professions and how they can strengthen each other's practice. Moreover, NPs must propagate their added value and work together with physicians to make use of the NPs added value.

Key words**:** Nurse Practitioners; Nurse Specialists; Professional role; Qualitative Research.

SUMMARY (DUTCH)

Titel: Perspectieven van verpleegkundig specialisten op de toegevoegde waarde van de verpleegkundig specialist op de polikliniek in Nederland.

Inleiding: Veel verpleegkundig specialisten (VS) in Nederland werken nauw samen met gespecialiseerd verpleegkundigen (GV) en artsen op de polikliniek. Er bestaat discussie over de toegevoegde waarde van de VS ten opzichte van de GV. Om goede positionering van de VS te bereiken is het cruciaal om inzicht te krijgen in de perspectieven van de VS op de toegevoegde waarde van de VS.

Onderzoeksvraag: Wat zijn de perspectieven van verpleegkundig specialisten op de toegevoegde waarde van de VS ten opzichte van de GV op de polikliniek, gebaseerd op de CanMEDS competenties.

Methode: Deze exploratieve generieke kwalitatieve studie werd uitgevoerd van maart tot juni 2017. Data werd verzameld tijdens twaalf semigestructureerde interview met doelbewust geselecteerde VSen. Data werd geanalyseerd aan de hand van thematische analyse. Vervolgens werden de CanMEDS competenties gebruikt om de werkpraktijk van de VS en GV te vergelijken.

Resultaten: Drie zijn hoofdthema's afgeleid uit de data. 1) 'Verpleegkundig leiderschap' was de meest onderscheidende competentie van de VS en beïnvloed alle competenties van de CanMEDS. 2) Integratie van 'care' en 'cure' door klinische expertise van de VS, was de meest benoemde toegevoegde waarde en 3) de kennis en vaardigheden in wetenschappelijk onderzoek en zelfontwikkeling.

Conclusie: De toegevoegde waarde van de VS wordt aangestuurd door verpleegkundig leiderschap en is evident in de integratie van 'care' en 'cure', het verpleegkundig expert niveau van de VS en kennis in wetenschap en kwaliteitsverbetering. VSen, GVen en artsen moeten in gesprek om hun taakverdeling of elkaar af te stemmen, waarin de VS verpleegkundig leiderschap moet tonen om voor alle professionals recht te doen aan hun toegevoegde waarde.

INTRODUCTION

Healthcare systems around the world face the challenges of rising numbers of patients and increased complexity of care, leading to greater qualitative and quantitative healthcare demands and rising costs.[1] Complexity of nursing care is subsequently increasing and nursing roles are expanding.[1] To respond to the challenges in healthcare, task reallocation within the nursing and medical workforce was needed.[2-5] Task reallocation can improve the quality and organisation of healthcare, retaining cost-effective care without increasing the demand for physicians.[6-11] Subsequently, nursing education programmes are elevating to the bachelor and master level (European Qualifications Framework (EQF) level 6 and 7), and a new healthcare professional was introduced in the Netherlands in the 1990s; the Nurse Practitioner (NP).[1,6,12]

NPs have a nursing background and focus their work on care and cure within a specialty population, such as patients with breast cancer. The NP is a registered nurse with a Master of Advanced Nursing Practice (MANP) degree (EQF level 7). NPs acquire 'expert' status within their specialty population and integrate the medical and nursing domain into one role.[1,6,13-17] Before the NP was introduced in the Netherlands, the specialised nurse (SN) performed the highest educated nursing role. SNs focus their work primarily on care within a specialism, such as oncology. The SN is a registered nurse whom completed a registered subject-oriented advance training (EQF level 5 or 6). SNs training involves development of knowledge and skills primarily within the nursing domain.[1,16] NPs distinguish oneself from SNs with a unique mix of knowledge, skills and attitude, adopting a different nursing profile, and working in the medical domain.[1,16,18]

NPs and SNs work closely together in the outpatient clinics in the Netherlands. Since the NPs' introduction, the NP role develops continuously. NPs take over nursing and medical tasks that used to be carried out by SNs or physicians and conduct them in new ways.[17-19] For example in 2012, following a revision of the Dutch Individual Health Care Provisions Act, NPs obtained the legal right to independently carry out clinical procedures that used to be the preserve of physicians, such as prescribing medication.[17] Moreover, literature shows that the use of NPs expertise varies on the organisation in which the role is performed, and NPs develop and modify their role by doing different things and doing these things differently compared to SNs and physicians.[1,7-8,17] The continuous negotiation of boundaries and roles from and to NPs makes it unclear who is doing what exactly in the course of daily practice.[19] As a result, boundaries between occupational groups seem to be fading, resulting in a lack of distinction between NPs and SNs.[1,7-8] This sparks debate among SNs regarding the added value of NPs, which is impeding successful positioning of NPs in the outpatient clinic. Therefore, the NP role and added value should be clarified. An innovation dialogue with the

involved healthcare professionals can contribute to clarification of the added value of NPs.[17,20] To clarify the distinction in nursing professionals, improve suitability and quality of outpatient care in the Netherlands, it is crucial to first gain insight in NPs' perspectives on the added value of NPs in relation to SNs.[1,20-21] Because the Dutch NP and SN professional profiles have recently been redefined in V&V2020, and were based on the CanMEDS competences (Canadian Medical Education Directions for Specialists), this study will explore NPs added value in the outpatient clinic using the CanMEDS competences.[1] These insights would be invaluable for NPs' successful positioning and professional development in the outpatient clinic.[17,20]

Research Question

What are the perspectives of nurse practitioners on the added value of the nurse practitioner in relation to the specialised nurse practicing in the outpatient clinic, based on the CanMEDS competences?

METHODS

Design

This study was performed using a generic explorative qualitative design. No previous research concerning this topic has been performed in the Netherlands. Therefore, generic explorative descriptions are best suited to let interpretation emerge from the respondents' perspectives instead of established assumptions or methodology, to obtain a complex and detailed understanding of the phenomenon and explain the linkages within it.[22-24]

Sample

This study was aimed towards all outpatient clinics in the east of the Netherlands. The study was conducted on several outpatient clinics of one academic and one top clinical hospital in the Netherlands, including NPs with at least one year of post-graduate experience as SN and NP. NPs needed a background as SN in an identical specialism, to ensure they could describe the crucial differences between NPs and SNs. NPs were sampled purposively on variety in specialty population, hospital, post-graduate working experience and age.[7,25] Respondents were identified through experts in the field, and additional respondents were identified using snowball method. NPs were contacted by email by the first author, including an introductory letter and invitation to participate. Respondents who wished to participate were contacted by telephone to ensure respondents met all inclusion criteria and plan an interview.

Data collection

Data were collected through face-to-face interviews using a peer reviewed semi-structured interview guide. The interviewer used open questions, encouraging respondents to openly convey their perspectives and experiences. The initial interview guide topics were based on the CanMEDS competences (appendix 1).[1,25] Thereafter, the first author, study PI (AvV) and an expert in the field (JP), continuously adapted the interview guide in response to the emerging data.[26] Interviews were conducted and audio recorded from March to June 2017. Interview duration ranged from 36 to 59 minutes (mean = 50). Important perspectives and analysis ideas were documented using field notes and were written directly after the interview not to disturb the interview.[23-24] Field notes informed the data analysis parallel to the interview transcripts.[23,26] New themes and nuances stopped emerging after ten interviews. Two more interviews were conducted to ensure meaning saturation was reached.

Ethical considerations

The advisory committee of the University of Applied Sciences of Arnhem and Nijmegen confirmed that the Medical Research Involving Subjects Art (WMO)[27] did not apply (file number ACPO 49.11/16). Written informed consent was obtained prior to interviewing. No respondents refused to participate or withdrew from the study. The first author anonymised all information reducible to respondents or their working practice and assigned a random respondent number which they could not be linked to.

Rigour

Interviews were conducted by the first author; a 24-year-old male, registered nurse, and master's student in Nursing Sciences who was not experienced in interviewing for qualitative research. The first author had no professional relationship with the respondents before study commencement. The study PI evaluated several interview audio tapes to improve interviewing techniques, which enriched data collection. An audit trail was recorded throughout the data collection and analysis using field notes. Field notes were reviewed and discussed by all researchers, enhancing reliability of the findings.[23] One independent researcher and the study PI coded five transcripts independently from the first author. Coding decisions were compared and reflected upon, until inter coder agreement was achieved.[23] To challenge and complement the data-analysis, every phase outcome was cross-checked with the study PI and expert in the field.[26] The COREQ criteria were used for explicit and comprehensive reporting.[28] For clarification of the outcomes and reassessment of the study interpretations, the authors referred to a panel of experts to peer review the findings and interpretations.

Data analysis

Braun & Clarke's (2006) six phases of thematic analysis were performed, for its effectiveness eliciting the underlying meaning within respondents' perspectives.[26] Data were analysed inductively, to ensure the data fully directed the analysis process.[6,14-15,20,26] Analysis started with verbatim transcription of the audio recordings.[24,26] After four interviews were completed, the first author re-read the transcripts to identify meaningful fragments, and generated initial codes by collating meaningful fragments. Code names were formulated interpretatively using in-vivo coding with gerunds.[24,29-30] Themes were formed by analysing the relationships between codes, collating related codes, and combining codes into potential themes. To review and define the themes, the researcher re-read the entire coded data set, refined the coding and themes and described the essence of each theme. Themes were reviewed until meaning saturation was achieved.[26,30] To ensure the researchers were fully guided by the data, the researchers answered the research question by relating the finalized themes to the CanMEDS model, after all six data analysis phases were completed. NVivo© (version 11, QRS International) was used during the iterative analysis process. A database of codes, theme's and quotes were collated in Microsoft Word© and were revised during the final two phases of the analysis process.

FINDINGS

Twelve nurse practitioners participated in this study. NPs varied in experience as NP (range = 3 to 13 years), experience as SN (range = 2 to 30 years) and specialty population (Table 1). NPs' and SNs' role and scope of practice differed greatly. Wherein the following three themes were identified: (1) Nursing Leader, (2) Clinical Expertise and (3) Knowledge and Science.

TABLE 1 Baseline characteristics of the study population (N=12)

Nurse practitioner's role and scope of practice

Respondents perceived that NPs perform significantly different tasks and roles compared to SNs. Respondents found it hard to describe the differences in skills and attitude between NPs and SNs. However, respondents stressed that NPs and SNs differ in various competences and focus their working practice on different components of care (Quote 1 – Box 1). Although overlap in tasks remains, NPs perform these tasks with a different attitude on healthcare than SNs. NPs believed that their role focuses itself outside direct patientcare

and is aimed towards coordinating and improving the integrated care system, therein integrating care & cure for their specialty population. On the other hand, SNs focus more on direct patient care within the outpatient clinic. (Quote 2 – Box 1). NPs were convinced that they have a different perspective on nursing care and therefore provide a different care coordination care than SNs and physicians. This unique perspective and role in coordination of care makes NPs the best suited case manager in outpatient care (Quote 3 – Box 1).

BOX 1 Quotes related to the NP's role and function

Q1: "NPs are specialized within a specific discipline, so the specialized nurses can receive input of different types of NPs ánd a nursing scientist in order to spread their knowledge … the SN is broadly specialized, thus is more generic relative to that of NPs. There is a clear difference." (R05)

Q2: "Most tasks ... are performed by SNs. I assist them and educate them on this subject, however I do not perform those tasks myself anymore. I do point out however when errors are made or changes need to be implemented. So, it's more the coordinating aspect that I'm focused on, as opposed to the content." (R08)

Q3: "There's a gap between the physicians and NPs, who can, in addition to a variety of tasks using their underlying foundation as a nurse, take on the job responsibilities of a physician, and combine the two adequately. I think that has the potential to eliminate a very large grey area that used to be here … These NPs can perform a rather practical role that are difficult for a physician to take on …. And as SN you're simply not trained enough for that. Therefore, there is a definite distinction." (R12)

Theme 1: Nursing Leader

NPs add value with the implementation of nursing expertise in an elaborate leadership role. As a nursing leader, respondents take leading action in developments within outpatient care and outside direct patient care. NPs experience more autonomy in their scope of practice, because of the MANP education and legal entitlement. NPs work more independent than SNs and dare to take more decisions independently without supervision of a physician (Quote 1 – Box 2). Moreover, NPs feel they have more responsibility for clinical care. However, some respondents argued that they do not experience more responsibility neither take responsibility more often than they did as SN (Quote 2 – Box 2).

As NP, respondents regularly step out of their comfort zone to lead and organise important tasks (Quote 3 – Box 2). NPs were more committed and confident to initiate and participate in healthcare innovations and collaborations (Quote 4 – Box 2). These activities are more often performed on regional, national or even international level. For example, NPs attend international conferences routinely. NPs also share acquired knowledge more often and on a larger scale, for example during conferences or work groups (Quote 5 – Box 2).

Fulfilling the nursing leadership role as NP also includes promoting professional development and education. NPs promote professional development and patient interests better than they could as SN. NPs feel like a better advocate for the nursing profession and having more influence in organisational decisions. Resulting from unique expert knowledge

on their specialty population, more experience and knowledge of organisational structure and culture (Quote 6 – Box 2). Education is included in NPs role by providing education and developing curriculum for SN or medical students (Quote 7 –Box 2). NPs reported that their education is elevated to a higher level and they educate a wider audience that SNs, such as advanced nursing students, medical students and doctors. However, respondents felt that they could not invest enough of their time in specialty nursing tasks and competences outside direct patient care, and were focused too much on medical practice.

BOX 2 Quotes related to the NP's added value as a nursing leader

Q1: "I integrate the combination of the nursing and medical process, using clinical reasoning, in which I integrate the two, where I engage in a treatment relationship with patients and see them autonomously. And in cases of doubt, I can always request supervision. But I definitely did not do that type of work before I became NP … The experience you have gained as a nurse, you take that development with you as NP, in which many medical tasks … are added to that." (R05)

Q2: "Because I was the first NP in the field of immunology in the Netherlands, I felt quite responsible to start creating a network in the Netherlands … I do notice that you are addressed on a whole different set of skills, which is rather outside of my comfort zone … back then it was safer to stay in your own practice. Now I have become more daring … Because I feel I have to do it, because I am a NP now." (R11)

Q3: "You do it obediently, as a SN you adhere to protocols and agreements and you follow the physician. As a result of training as NP**,** you sort of step outside of that comfort zone. You get out of that mindset and discover a whole new world, so that makes the difference because you're challenged during the education … And you would not do that as a SN**,** so I think that is a really big difference." (R07)

Q4: "By taking the lead on a project. So not only participating in a project group but also being chairman. And also by being involved in a lot of things, actively involved. In other words, not just hanging back but being really actively involved, proactive." (R04)

Q5: "I see a big difference in terms of professionalization, that SNs tend to stay within their organization and sometimes visit a national congress, whereas NPs often attend international congresses and have international contacts … NPs are the leaders and the educators … So there is a big difference there too, because instead of taking up something from courses and congresses, you now actually bring something to the table." (R05)

Q6: "Well, because as a SN you're familiar with your generation, your peers, but now you're also familiar with what's beyond that… But you're an entirely different source of knowledge for others. Not only for referrals but also just for general support. Yes, that's an added value, because you're just so much more ahead of the source material than you were before." (R08)

Q7: "No, I'm a trainer now but I teach at the nursing pulmonary education as well, at the emergency department**,** for medical students. No, I never used to do any of those things." (R08)

Theme 2: Clinical Expertise

According to NPs, their added value in 'clinical expertise' encompasses integration of care & cure, improving continuity of care and improving inter-professional communication. Integrating care & cure and being nursing expert were the most frequently cited added values. NPs provide integrated medical and nursing care as one entity to their specialty population, in which they perform more elements of medical care than SNs, and have a broadened view on care & cure, compared to SNs and physicians. NPs perceive their expert

level knowledge and skills within the nursing domain as a crucial factor in the additional value of NPs in relation to SNs in outpatient care (Quote 1 – Box 3).

Because of their deepened knowledge in nursing domain and additional medical knowledge from the MANP, respondents perceived NPs as the best professional to fulfil the case manager role in the outpatient clinic. They universally felt that employment of NPs in the case manager role, results in higher continuity of care for both patients and professionals. Respondents reported that patients more often visit the same care provider when NPs are employed, which also contributes to more accessible healthcare (Quote 2 – Box 3). Communication and alignment with other professionals is easier because of better communicative skills and expertise in medical and nursing domain (Quote 3 – Box 3). Furthermore, respondents felt as a worthier interlocutor than before, especially towards physicians (Quote 4 – Box 3). Respondents perceive NPs as a better contact person for all professionals involved. Additionally, physicians more often ask NPs for advice regarding the nursing domain for their specialty population, considering the NP being more skilled in a certain domain (Quote 5 – Box 3).

However, a lack general of awareness among physicians about NPs' role and scope of practice is also an important influential factor. NPs mostly mentioned this challenge in working with physicians whom are unexperienced with working with NPs. Resulting in great differences among physicians in support for the role of the NP, some considering NPs' care as less quality and refusing to work together.

BOX 3 Quotes related to the NP's added value in clinical expertise

Q1: "Because that's where I think the NP differentiates from the SN or medical domain. They only focus on a specific part. One on care, the other on cure and that comes together perfectly in the NP role. That's when you get the holistic picture from a patient and I think that holds the added value." (R05)

Q2: "I think that especially for things like problems with medication, problems with sexuality, those are definitely issues where patients talk more comfortably about with me than with a surgeon. And it's often attached to something medical like therapy adherence, changing or adjusting medication, that's something a SN can't do." (R04)

Q3: "And the cooperation with the doctor also gets easier. It's like you're speaking the same language and you pick up on it fast. When a doctor tells you what he founds in a patient I understand it immediately. As SN it was more difficult, as if you're speaking different languages." (R10)

Q4: "I think it's because the NP function slowly became known, but also because of the know-how that I have gained, because of my role development, because you're lifted to a higher level … you exude that. It makes that you are considered a serious interlocutor and that you're asked to join in on many occasions." (R07)

Q5: "The difference I notice as NP is that you're in more of a coordinating role that guards the continuity of patientcare. I think that as a SN you're in more of an observing role … but as a NP I'm contact person for all parties involved with the patient and I'm the person that's up to date, ánd directing everybody … in both the nursing and medical domain." (R12)

Theme 3: Knowledge and Science

Respondents perceived realisation of optimal patient care as an important NP task. They felt that the MANP provided critical knowledge and skills on systematic thinking and practicing, utilising methodologies, and a scholarly attitude on scientific research and innovations. Respondents feel that NPs are better educated to prioritise, initiate and coordinate the qualitative innovations than SNs. (Quote 1 – Box 4).

NPs initiate, design and coordinate scientific research within the medical and nursing domain, herein incorporating their expert nursing skills and nursing perspective. NPs felt that their participation promotes research regarding nursing outcomes and establishment of evidence based practice (EBP) relevant to nursing care (Quote 2 – Box 4). Furthermore, NPs are better at implementing research and EBP in their practice than SNs, because they can interpret and evaluate research and protocols better (Quote 3 – Box 4). The incorporation of EBP and scientific research in their working practice results in improvement of patient care (Quote 4 – Box 4). Although NPs want to devote to optimising the quality of patient care, the outpatient clinical practice does not always allow to invest enough time to underpin the nursing domain with scientific research or EBP.

NPs reported that they self-steer their ongoing learning process more than they did as SN. Expanded knowledge and skills in scientific research supports NPs to acquire knowledge. NPs more consciously and actively research their working practice when they encounter a problem, because they have the will to learn and keep their knowledge up-to-date on their specialty population (Quote 5 & 6 – Box 4). Also, NPs perform more critical reflection than as SN, because NPs structurally use supervision and interdisciplinary reviewing to obtain feedback. Herein, NPs dare to take a vulnerable place because they view these moments as an invaluable addition to their learning process (Quote 7 – Box 4).

BOX 4 Quotes related to the NP's added value to knowledge and science

Q1: "I think that the SN could definitely do that but taking the lead, the initiative and taking things to the next level is hard. Because they don't have the tools for it that you get when learning to be a NP … I notice that those ideas are definitely there among SNs … But that transcendent thinking and seeing the bigger picture, that to me is a difference between NPs and SNs." (R09)

Q2: "Well, we simply weren't as active in that field back then. We did do scientific research, but it was medical research. Now we do nursing based research or projects to improve the nursing healthcare outcomes. We have managed to put that on the agenda, so that the cardiologists see as well that it's important." (R01)

Q3: "Learning to interpret protocols. Not just applying every protocol blindly but looking critically at what is necessary. Knowing when and how to do something different and arguing when to deviate from protocol. That's actually a very fun thing to do." (R11)

Q4: "In addition to that, as a NP you're also trained in other competence areas, scientific research, so you're much more engrained with the notion of evidence-based working and thinking… that as a result you won't act without having a scientific substantiation for your actions. This has a positive impact on patient care … Acquiring evidence based care." (R05)

Q5: “It’s not like you finish the education and then you stand still, definitely not as a NP. At a certain point it becomes like an oil spill, at first the difference isn’t that big but the difference gets bigger and bigger.” (R06)

Q6: “So you develop a critical attitude but also a milder attitude in the sense that you broaden your perspective, in a way of “is it right what I’m seeing, is it correct what I’m doing, is it the way it is supposed to be?” But also towards others.” (R08)

Q7: “The education ensures that you gain a vast basic knowledge and that it’s easier to find your way to specific information, and that has become easier all of a sudden. You share the experience, which is a major advantage as well, you stay in contact with the NPs with whom you have done several years of interdisciplinary reviewing, and you get tips in that area as well. You enter a different network, feeding your knowledge, pulling you out of isolation.” (R06)

DISCUSSION

This study describes NPs’ perspectives on NPs’ additional value in relation to SNs in the outpatient clinic. Respondents found it difficult to specifically distinguish the NPs and SNs expertise. However, NPs stressed that there is an undeniable difference in the implementation of their role, practice and unique set of competences. NPs’ added value is driven by the competency in nursing leadership and their added value is most evident in tasks and responsibilities outside direct patient care. The MANP education provided the vital foundation for the highly-developed nursing knowledge, skills and attitude required to perform the advanced NP role and practice.

The results of this study establish that NPs in outpatient clinics fulfil the nursing leadership role as defined by Vermeulen et al. (2017).[31] NPs have also been described as a key leadership position of influence for clinical and professional development.[32] Our results confirm these findings and adds to them by revealing the nursing leadership role as the encompassing link between the main competences in practice. All NPs practiced nursing leadership, influencing, the ‘Clinical Expertise’ and ‘Knowledge and Science’ competences by initiating innovations, improving healthcare accessibility, continuity of care, clinical practice using EBP, education and an ongoing learning process.

It is important to note that NPs do not represent a separate profession to SNs. NPs’ advanced practice nursing (APN) competences build on the foundations and core values of the nursing discipline.[16] The NPs in this study reported the performance of APN core competencies leadership, evidence based practice and collaboration, which interact with the central competency of direct clinical practice and the environmental competency of representing their speciality population in the integrated care system. The findings of this study confirm the differentiation as described by Hamric et al. (2014) and underpins the added value of NPs in relation to SNs in Dutch outpatient clinics.[16]

Confirming Elliott et al. (2010), NPs experienced lack of time for competences outside clinical practice as an important restrictive factor.[33] The NPs added value comes to full play when they precisely perform the tasks and responsibilities of their APN role outside direct patient care. The fact that NPs encompass all competencies from the APN role and blend them into daily practice, distinguishes NPs from SNs and physicians.[16]

Although respondents were purposefully sampled, the results from this study cannot be generalised because of the small sample size and sampling from one geographical region in the Netherlands. However, this study provides a very meaningful and novel insight in NPs' perspectives in this phenomenon, which could be transferable to similar settings.[26]

The sample in this study could possibly undervalue the real-world difference between NPs and SNs in their outpatient practice. Because NPs with a background as SN were probably more pro-active in performing their nursing role as SN. As in the fact that respondents did not feel more responsible after becoming NP than when they were SN. Moreover, multiple respondents reported that any SN becoming NP belongs to the top-level of SNs and therefore partly possesses APN perspectives and capabilities before becoming NP.

Medically driven configurations are not the best use of APN skills and both SNs and NPs are equally important to the overall nursing profession.[16] To improve NP positioning, it is important to state that NPs are a value-added complement to medical practice and not only a substitute for physicians.[16,19] This study adds to this theory that NPs are also a value-added complement to the nursing practice and not a substitute for SNs. NPs add value to both domains by practising APN tasks that would not be performed without the presence of a NP. NPs acknowledge that SNs' and NPs' competence areas are similar and overlap in tasks and roles remains, resulting in lack of clarity. Physicians' and SNs' lack of understanding of NP role and scope of practice was a reoccurring issue. Having to convince other professionals of their capabilities obstructs role development because APN roles require autonomy and authority to be fully enacted.[16] NPs should 1) act independently and take more autonomy to perform their tasks outside direct patient care, and 2) break free from medicalised roles and practice the unique combined nursing and medical role in which they excel.

Subsequently, nursing and medical professionals need to work together to not only utilize the added value of the NP with its APN role, but all team members'. Role clarification is extremely important to distinguish and strengthen NPs' unique role, scope of practice, and promote effective collaboration with SNs and physicians. Therefore, it is important that the roles and scope of practice of all team members are clear and well-understood, to increase physicians' and SNs' support and provide NPs with the trust and autonomy that is necessary for practicing the APN tasks and roles.[34]

Additionally, role clarification increases awareness and understanding of the NP role and scope of practice and results in less medicalised roles.[35] NPs are most often supervised by physicians and obligated to follow medical protols.[35] It needs to be clear that the APN role is embedded in the nursing discipline and is not the junior practice of medicine.[16] Therefore, physicians need to recognise the possibilities of an NP and let NPs practice their highly-developed nursing skills and perform select medical therapies. However, NPs also need take responsibility for their professional development and profile their expert nursing skills and leadership attitude to break free from medicalised roles.[35] As Lowe et al. (2012) described: "the valuable contribution of nursing roles will be lost, if the ability to clearly express their function does not exist".[36]

Overlap in nursing tasks is a prevalent problem which muddles the NPs' and SNs' role and scope of practice. NPs could reallocate tasks to SNs. As SNs educational level is increasing from EQF 5 to 6, SNs can perform former NPs' tasks within direct patient care.[1,12] Consequently, NPs can focus more of their time on the tasks and role outside direct patient care.

Subsequent research should focus on the barriers and facilitators towards NPs' added value, to determine critical areas of NP improvement and positioning in the Netherlands. Role clarification is extremely important promote effective collaboration in the outpatient clinic and fully utilise the added value of NPs. This study reports on the crucial differences between NPs and SNs. Providing generalizable results and a comprehensive description of the phenomenon, additional research should engage the conversation on role clarification involving the perspectives of all healthcare professionals in the outpatient clinics and using a larger sample.[34]

Conclusions

Driven by the competencies in nursing leadership, NPs' added value is most evident in tasks outside direct patient care, integrating care and cure, acting as nursing expert, and in knowledge and science. However, findings highlight that NPs cannot always invest enough in their specialty nursing role and practice medicalised roles. Therefore, increased awareness with NPs and role clarification in all team members working with NPs is necessary. Research into role clarifying perspectives of all team members, including barriers and facilitators, can strengthen all professions and improve positioning of NPs in the Netherlands.

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TABLES

TABLE 1 Baseline characteristics of the study population (N=12)

ID	Sex[a]	Age	Experience as NP	Experience as SN	Hospital setting	Registered specialty[b]	Specialty population
R01	f	52	10	3	University	4	Chronic cardiac failure (Cardiology)
R02	m	49	10	16	Top-clinical	3	Breast cancer (Oncology)
R03	f	65	12	15	University	3	Palliative care (Palliative care)
R04	f	44	5	20	Top-clinical	3	Breast cancer (Surgery)
R05	f	52	12	20	University	3	Lung cancer (Pulmonary oncology)
R06	f	53	4	4	University	4	Pituitary- & adrenal gland (Endocrinology)
R07	f	58	13	7	Top-clinical	3	Cardiac failure (Cardiology)
R08	f	52	8	5	University	4	COPD & asthma (Pulmonology & pulmonary rehabilitation)
R09	f	43	5	14	University	3	Bone tumour (Orthopaedics)
R10	m	47	5	2	University	5	HIV & suicide attempters (Psychiatry)
R11	f	56	5	30	University	3	Paediatric HIV & humoral immunodeficiency (Immunology & Infectious diseases)
R12	f	34	3	5	University	3	Paediatric acute lymphocytic leukaemia (Paediatric-oncology)

a Female (f); Male (m)

b 1: Preventative care for somatic conditions; 2: Acute care for somatic conditions; 3: Intensive care for somatic conditions; 4: Chronical care for somatic conditions; 5: Mental healthcare.

APPENDICES

Interview guide

Box 6 Interview guide

Background information:

- What is your:
  - Age?
  - Educational level?
  - Number of years working as NP and SN?
- Could you describe your outpatient clinic?
  - What specialism/patient category?
  - How many SNs and NPs?
  - When was the NP first introduced?

General question:

- What are the contrasts and similarities between the work of the nurse practitioner and specialised nurse in the outpatient clinic?

In-depth interview:

- Could you describe the changes in role and scope of practice from SN to NP?
  - How do you interpret the role of NP?
    - Knowledge/skills/attitude
    - Elaborate on overlap in role and tasks between SN and NP?
  - What was added to your competences, becoming a NP?
    - Could you elaborate on the additions in your role and practice since becoming NP?
- Could tasks or responsibilities form the NP be adopted by the SN?

- What has changed your role as SN/NP, following the MANP?
  - Differences in nursing/medical role?
  - How do you/patients profit from this?
  - Differences in competences as SN and NP?
    - Differences in knowledge/skills and attitude

- Can you describe the NPs scope of practice in relation to the SN?
- How do you describe the collaboration between NP and SN/other professionals?

- How would you describe the NPs practice, regarding:
  - Leadership/coaching role towards SN/nurses in general;
    - Feeling responsible
    - Autonomy & independent working
  - Organisation of care;
    - Accessibility of healthcare
    - Patient guidance
    - Clinical reasoning and practicing
  - Multidisciplinary cooperation;
  - Evidence Based Practice/endorsement in scientific research;
  - Which innovation or new practices does the NP introduce?
  - Do you feel the quality of care has improved, following the introduction of the NP?

- What makes the NP an added-complement to the outpatient clinic?
- Is the NP a necessary complement to the SN?

Critical environmental elements affecting APN
Figure 1 Hamric et al. (2014)[28]