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Abstract

The aim of the study was to examine the extent to which advanced nursing practice was evident in Jordan, with a particular focus on the contribution of Master's level nurses to advancing practice. It also aimed at understanding the drivers for developing its roles and the factors which might facilitate or hinder their implementation.

The study used an ethnographic design in which qualitative and quantitative methods of data collection were used. The study comprised two stages. The first stage involved interviewing key stakeholders and surveying M-level nurses. Stage two involved interviewing and observing M-level nurses working in clinical practice in five Jordanian hospitals and interviewing the main stakeholders with whom those nurses had contact.

Three themes emerged from the data: understanding advanced nursing practice, becoming am M-level nurse, and being an M-level nurse. The analysis showed that there was no clear notion of advanced nursing practice in Jordan, although participants did describe a number of different elements of advanced practice. The analysis also revealed that nurses undertake Master's degrees for professional and self-development reasons. The most frequently cited benefits from M-level education that reflected on practice were the enhancement of cognitive abilities, including critical thinking, problem solving and the questioning of practice, the use of research skills and in-service training. The area with least change was that of the development of new practical skills. The data also suggested that a change of job title or job description, after gaining a Master's degree, reflects the movement of M-level nurses away from direct patient care to non-direct patient care.

Several factors were identified as facilitating or hindering the development of the role of M-level nurses in practice. These were organisational factors, professional factors, and personal attributes. The most significant factors were lack of recognition of the M-level nurse, and the subservient role of the nurse in Jordanian society.

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List of tables and figures

List of commonly used abbreviations

ANP	Advanced Nursing Practice
CNS	Clinical Nurse Specialist
ICN	International Council of Nurses
ICU	Intensive Care Unit
JNC	Jordanian Nursing Council
JNMC	Jordan Nurses and Midwives Council
M-level	Master's Level
MOH	Ministry of Health
RMSs	Royal Medical Services

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Chapter 1

Introduction

1.1. Introduction

In 1982, the first Master's programme in education for nurses was established by the University of Jordan to prepare nurse educators. In 1998, Jordan University of Science and Technology established the first clinical Master's Programme with the intention of preparing clinical nurse specialists (CNSs) in three areas: critical care, community health nursing, and maternal newborn nursing. In 2000, the University of Jordan stopped its Master's in Education programme and launched a clinical programme in critical care. To date, there is no significant literature that documents M-level nurses' roles in practice in Jordan. The extant literature comprises the official description of these programmes as given by the universities in addition to anecdotal accounts and presentations in conferences. There are also a few published papers that provide a brief description of the availability of such programmes and express enthusiasm about advanced nursing practice (ANP). This made me realise that this topic had not been studied adequately in Jordan, and that little was known about the development of advanced nursing roles for nurses in Jordan and the drivers behind their establishment. Less was known about the practice of such nurses and the ways in which new nursing roles were being developed, practised, and implemented in clinical settings. This study was undertaken to address this gap in knowledge.

1.2. Biographical influence on the study

Exploring my personal biography as a Jordanian nurse-researcher seems to be important to shed more light on why I have decided to explore my research topic. I also believe that it influenced my epistemological and ontological stances, which subsequently influenced the research process.

I qualified as a registered nurse in 1990. I always thought of myself growing up to

become a physician. I achieved high grades at school, but this did not grant me a place in the School of Medicine. My decision to study nursing came out of frustration and the need to find an alternative to studying medicine. However, my passion for nursing grew quickly despite the hardship I faced with my colleagues as 'student nurses'.

Nursing education and training was intense and filled with rules and regulations. It was also shaped by western norms and idealised notions of nursing practice, which placed considerable emphasis on holistic care and the application of the nursing process. I liked and accepted what was offered to me and was filled with hope and enthusiasm to finish my studies and start my role as a professional nurse. After graduation, it seemed that much of what I learnt was a 'myth'; I experienced 'reality shock'. I found that nurses in Jordan barely communicated with patients. They were under pressure to finish many delegated non-nursing tasks. I also became conscious of how the skills and experience of nurses were undervalued in the society as a whole. Only a few nurses got promotion over time; the main route for promotion was through managerial posts. Physicians, on the other hand, were rapidly promoted from resident to specialist posts, through continuing education and board examinations.

As an undergraduate nursing student, I was introduced to nursing through a very directive way of learning where the teacher was the source of knowledge, and research at that level was relatively superficial. As a nurse, I found few opportunities for continuing professional development. My clinical practice was guided by policy and guidelines. I thought that some of these guidelines were outdated and not supported by the best evidence. My experience as a student and as a staff nurse in Jordan, Dubai and the UK made me realise the similarities and the difficulties nurses face within different social contexts.

My initial interest in M-level nurses in Jordan started while I was undertaking my Master's degree in ANP in the United Kingdom during the academic year 2003/2004. My knowledge then was limited to the fact that Jordan has a higher education system that qualifies nurses as CNSs. Preliminary research showed me that there is more to it. As a result, for the purpose of this study, I found it essential to map the process of

implementing these roles in practice to identify the barriers to and facilitators of their development and to explore the meaning of the new roles from the perspective of postholders and stakeholders.

To understand the concept and drivers behind the development of ANP and postgraduate programmes for nurses, I reviewed the international literature (the strategies used to search the literature are noted in Appendix 1). It was clear that the concept of ANP emerged in the early part of the 20th century in the United States as a response to socio-political and professional change (Duffield et al., 2009). Many factors have influenced the development of advanced practice roles in nursing in the global community, and these led to several attempts in different countries to define the concept. These factors include: the socio-political environment, the health needs of the society, the health workforce supply and demand, government policy and support for new role development, intra- and inter-professional collaboration, and the development of nursing education at postgraduate level (Ketefian et al., 2001).

Currently, it can be said that there is no consensual definition of ANP worldwide. However, international definitions share certain characteristics. ANP is recognised as a clinical career pathway for nurses wishing to progress in their careers whilst remaining in clinical practice (Furlong & Smith, 2005). It is agreed that advanced nursing goes beyond basic practice as it requires a high level of knowledge and specialised clinical skills with an expanded range of research-based interventions. Nurses assuming advanced roles are expected to function with autonomy and to establish the core functions of a nurse as an expert practitioner, researcher, educator, consultant and change agent (Manley, 1997; Hamric, 2001). The term 'ANP' encompasses multiple types of nurses in advanced roles. These roles may include nurse practitioners (NPs), certified nurse midwives, nurse anaesthetists and CNSs. Although these roles have developed individually at different points in the past century in different socio-political contexts, currently they are grouped together as APNs (Ketefian et al., 2001).

There is a considerable debate in the international literature about the appropriate level of educational preparation for the role of advanced practitioner. Educational

reforms, the desire of nursing professional bodies to bring together professional development with academic development, and a plethora of new nursing roles led university departments of nursing to develop Master's programmes which were oriented towards professional practice. In many countries, the movement of nurse education into the university sector has been associated with an increase in the numbers of nurses undertaking Master's level (M-level) courses.

Increasing the number of nurses with higher degrees has been argued to positively influence nurses' autonomy and increase their level of function and their status as practitioners. It is also argued that developing a unique theoretical knowledge through advanced education could enhance the professional status of nursing (Woods, 2000). Yet, the explicit nature of the contribution of postgraduate education to nursing practice is still problematic, and whether nursing is a 'profession' is still debateable. Nurses undertake postgraduate degrees to enable them to practise at advanced educational, managerial or clinical levels in order to meet changing demands in the healthcare system, yet few studies have been undertaken to investigate the impact of postgraduate education on clinical practice, and concerns have been expressed about the value of higher education for nurses (Davis, 1993; Hogston, 1995; Whyte et al., 2000; Gerrish et al., 2003; Pelletier et al., 2003; Spence, 2004a; Watson, 2006; Spencer, 2006; Pirret, 2007; Drennan, 2008).

In writing this thesis, I made sure that it follows a systematic order that presents the background of the study and the process I followed in gathering and analysing data. The following section introduces the structure of the thesis.

1.3. Structure of the thesis

This thesis is divided into nine chapters. Following this introductory chapter, chapter 2 and 3 provide the background and the literature review. Chapter 4 discusses the methodology. Chapters 5, 6, 7 and 8 provide the core findings of the study. Finally, chapter 9 is the discussion and conclusion chapter. Below I outline the structure of each chapter:

Chapter 2 examines the development of ANP from an international perspective; it also examines M-level education and its relationship to the professionalisation of nursing.

Chapter 3 provides a detailed description of the Jordanian context, including the historical background, health services in Jordan, and nursing education and practice.

Chapter 4 provides a detailed account of the research methodology, presenting the philosophical assumptions underpinning ethnography, a summary of its methods of data collection and analysis, and ends up with issues related to trustworthiness and increasing rigour.

Chapter 5 presents the findings of the survey and discusses these in light of the broader literature.

Chapter 6 examines elements of ANP in Jordan, participants' understanding of this concept, and the drivers for its development.

Chapter 7 examines nurses' motivation for undertaking a Master's degree, and presents different challenges that they encountered during their studies.

Chapter 8 examines participants' perspectives on the actual or perceived roles of M-level nurses.

Chapter 9 concludes the thesis by drawing together the main issues identified in the study and considers its overall contribution to and implications for nurse education and practice in Jordan.

Chapter 2

Advanced nursing practice and the professionalisation of nursing

2.1. Introduction

To understand the drivers behind the development of ANP, based on the reviewed literature, this chapter will firstly give an overview of the notion of professionalisation in nursing, focusing on advanced practice and M-level education as a professionalising strategy. Then, it will provide an overview of ANP in the international community (drivers, definition, impact of ANP on patient outcomes, and educational preparation). It will also introduce the factors that facilitate or inhibit the development of ANP, and of postgraduate education in nursing, focusing particularly upon M-level education.

2.2. Professionalisation and nursing

There have been three main phases of theorising evident in the literature relating to professionalisation. The first phase is exemplified in the seminal text of Flexner (1915), which is widely referred to as the basis of this particular way of understanding professionalisation, and the development of trait theories, which identified professionalism as a fixed set of attributes. From this perspective, a profession must demonstrate six attributes. Members of a profession:

- Are involved in essentially intellectual operations with substantial individual responsibility
- Derive their raw material from science and learning
- Work up this material to a practical and definite end
- Possess an educationally communicable technique
- Are self-organised
- Are increasingly altruistic in motivation (Flexner, 1915, p. 904)

Many trait theorists were unconvinced that nursing possessed the requisite qualities to deserve the title of profession. Flexner argues that nurses' activities are secondary in relation to physicians' activities, and that this subordination undermines nursing's claim

to be deemed a profession. According to Katz (1969) and Simpson and Simpson (1969), the core professional trait is the possession of a specialised, unique body of knowledge and autonomy of practice. Katz accepted that nursing had begun to develop a body of knowledge, but argued that simple possession is not enough: such knowledge must also be accepted as valid by those outside the profession, most crucially physicians and hospital administrators.

The second phase of theorising saw the development of critical theories, which were concerned with understanding the processes through which occupations could move towards professional status: the focus of such an approach is therefore on the ways in which groups are able to gain power through autonomy and dominance over other groups. Freidson (1970) places particular stress on the role of power in the medical division of labour and notes that the monopolistic power of the medical profession was such that it could subordinate adjacent and related occupations, keeping them permanently in the status of quasi or semi-professions. Freidson points out that Marxist writers adopted these perspectives on power to argue that professional dominance is of particular importance to capitalism, and that professional bodies under state protection have a peculiar contribution to make to the economic and political functioning of a capitalist system.

More recently, a third phase of feminist theorising explored the relationship between gender and professionalisation (Witz, 1992). Feminist writers criticised the medical profession as a privileged occupational group exercising patriarchal authority over subordinate social groups, especially over women. Despite major changes in legislation and political organisation, feminist writers assert that little has changed in reality with respect to female status, prestige and employment over the last fifty years of the twentieth century (Turner, 1995).

Nursing continues to struggle for occupational power; autonomy and control over practice, and organisation influence in the health care systems because of the bureaucratic context in which it is practised (Schwirian, 1998). Beetham (1987) adopted the sociologist Max Weber's definition of bureaucracy, which is characterized by: hierarchy

(each official has a clearly defined competence within a hierarchical division of labour and is answerable for his/her performance to a superior); continuity (full time salaried occupations with the prospect of regular advancement); impersonality (the work is conducted according to prescribed rules and a written record is kept of each transaction); and expertise (officials are selected according to their merit, are trained for their function, and control access to the knowledge stored in the files). Turner (1995) argues that, although the hospital has a bureaucratic structure, physicians retain considerable professional power and make decisions independently of professional administrators. Turner explains that the hospital has a dual system of authority: the governing body of administrators and the professional group of physicians. The medical profession remains autonomous and subject to few non-medical regulations. This is because medical practitioners enjoy considerable social status outside the hospital, and their professionalism is resistant to bureaucratic management (Turner, 1995). Being adjacent to such a powerful occupational group as medicine meant that nursing has long borne the burden of patriarchal professional dominance (Porter, 1995).

It is worth noting that these models derive from developed Western medical contexts, in which the concept of relationships carries particular cultural meaning which may not resonate with a Jordanian cultural context. For example, issues such as the relationship between men and women, and between professions and non-professions, are important issues to consider when exploring nursing and professionalisation in different cultural contexts.

Within a developed, Western context, nursing's professional standing was a reflection of its relationship to medicine. However, despite nursing's attempts to pursue the same strategy for professionalisation as the medical profession in terms of developing a unique knowledge base through a selective educational process, power and autonomy and professional organisations, it has not been regarded as a profession in its own right (Gerrish et al., 2003; Wade, 1999). Although education is perceived as a strong social force towards professionalisation (Rafferty, 1996; Keogh, 1997; Schwirian, 1998; Gerrish et al., 2002; Drennan & Hyde, 2008), the necessity for higher education for what is seen as a practical occupation is still subject to debate. Whether or not nursing is a profession

is still debated in the literature (Watson, 2006), and the understanding of 'professionalism' which underlies the development of M-level education for nurses is questioned (Gerrish et al., 2003). Debates therefore continue about the extent to which nursing can be considered to be a 'true' profession. Over time, nursing has attempted to claim professional status by focusing upon key attributes akin to those emphasised by trait theorists (Porter, 1992).

Despite the fact that nurse education is now situated within universities in several countries, its claim to a discrete body of nursing knowledge is contested (Narayanasamy, 2003); nursing has been argued to draw upon knowledge from different disciplines, with the main contribution coming from the medical sciences, (Keogh, 1997; Rutty, 1998; Woods, 2000). Nursing has, therefore, been seen by other professional groups to have failed in its attempt to articulate a unique knowledge base (Woods, 2000). In some countries, such as the USA, the UK, and South Africa, nursing has gained some professional recognition in terms of higher education that equips nurses with an enhanced knowledge base that legitimises their position in relation to medicine and current health policies. This higher education provides nurses with the opportunity to assume more prominent leadership positions and develop new and innovative roles in areas previously deemed to be the domain of medicine (Gerrish et al., 2003; Keogh, 1997).

In addition, nursing is still generally viewed as a practical occupation: nurses are trained as opposed to educated; they are controlled by physicians and are ultimately not accountable for what they do (Watson, 2006). However, Watson argues that nursing could actually be considered to be a profession on the basis of its accountability. Accountability is, in his analysis, the hallmark of a profession. In order to achieve this, nurses need to be properly educated in higher education and able to act beyond the level of mere competence in order to be capable of adapting to unfamiliar circumstances in unfamiliar contexts (Watson, 2006).

Others argue that, because traditional bedside nursing skills are contingent on the judgement of physicians, they cannot be the basis for occupational autonomy (Porter, 1992). Porter points out that nursing adopted a number of strategies to improve nursing's

status, and this started by developing the role of the nurse beyond traditional, medically dominated parameters. This required nurses to adopt a problem-solving approach, using scientifically derived knowledge and a holistic approach to patient care to enable active patient participation in care away from the biomedical model. Moreover, nursing attempted to increase the status of nursing through the development of an autonomous management structure. Nurses who wish to gain autonomy seek alternative routes either by moving up the nursing hierarchy in order to gain a position of status or by adopting different clinical roles such as those of consultant, change agent, counsellor, and leader (Porter, 1992). As the discussion of M-level education will show, these strategies are mirrored in the development of postgraduate nurse education both in Jordan and internationally. However, it is difficult to determine from the existing literature whether these strategies have prompted the development of postgraduate nursing programmes and improved the status of nursing, or whether postgraduate programmes have enhanced such strategies and consequently improved nursing status.

M-level education is seen as a strategy for professionalisation in nursing (Gerrish et al., 2003). Roberts and Vasquez (2004), Woods (2000) and Tosh (2007) argue that advanced practice nurses can improve the image and enhance the professional status of nursing and can be acknowledged as members of a profession through the use of power where they can have greater independence and influence over the matters of healthcare delivery where they work. Others argue that increasing the number of nurses with higher degrees might influence nurses' autonomy and increases their status as practitioners (Schwirian, 1998). Moreover, developing a unique theoretical knowledge through advanced education could enhance the professional status of nursing (Woods, 2000). This knowledge can be expanded and improved through nursing research, a skill that advanced practitioners are expected to perform, thus enlarging the body of knowledge and enhancing the status of nursing as a profession (Keogh, 1997). However, Woods (2000) argues that it is the way in which constructed knowledge is applied in nursing practice that will make the theoretical base of nursing unique.

In arguing for a professional status for nursing in Jordan, Oweis (2005) adopted the trait theorists' attributes of a profession. She concluded that nursing in Jordan is faced

by many challenges to meet the criteria for a profession. Firstly, nurses in Jordan have different educational backgrounds, and as Petro-Nustas et al. (2001).note, a long transitional period is required to standardise the level of education for nurses at the bachelor level (Secondly, there is a need for support from nursing professional bodies in Jordan. Thirdly, a profession is characterised by nurses' commitment. In Jordan the overall commitment is still in question (Mrayyan & Acron, 2004). Oweis (2005) explains that the attrition rate and migration rate are higher in nursing than in other professions in Jordan. This might be due to the negative social image of nursing and seeking better job opportunities with higher salaries outside Jordan. Finally, autonomy or freedom to make decisions and clinical judgments, within the nurses' scope of practice, is required. Many nurses in Jordan feel that the strong bureaucratic structures limit their autonomy and undermine their independent status (Mrayyan & Acron, 2004).

2.3. Master's level education: an international perspective

There is a considerable debate in the international literature about the appropriate level of educational preparation for the role of advanced practitioner. Moreover, the explicit nature of the contribution of postgraduate education to nursing practice is still problematic. Postgraduate education for nurses began at the Teachers College of Colombia University in the United States in the early 1920s, and evolved over time (Schwirian, 1998). Schwirian states that, in the USA, the importance of postgraduate level education for nurses seeking ANP roles emerged in the early 1970s and remains the focus in most contemporary Master's degree programmes in nursing. Schwirian also emphasises that clinical Master's degree programmes vary in scope, content, and goals but have common generic content. This content includes core theoretical courses (research methods, nursing theories), as well as speciality courses, and core clinical courses such as advanced pathophysiology, advanced physical assessment and advanced pharmacology (Schober & Affara, 2006).

A literature search identified few studies that specifically addressed M-level education in nursing and the motivation for nurses to undertake Master's degrees. In many countries, the movement of nurse education into the university sector has led to an

increase in the numbers of nurses undertaking M-level courses (Keogh, 1997), which suggests a supply-led demand. However, nurses are also undertaking postgraduate degrees to enable them to practice at advanced educational, managerial or clinical levels (Drennan, 2008) to meet changing demands in the healthcare system (Schwirian, 1998), which suggests a demand-led supply. It is difficult to determine by looking at the existing literature which has been more significant because both supply-led and demand-led change can be identified.

Nurses appear to be moving towards continuing education as a means of achieving personal and professional recognition and development (Redmond, 1991; Lash, 1992; Nolan et al., 1995; Boore, 1996; Dowswell, et al., 1998; Whyte et al., 2000; Davey & Murrells, 2002; Hardwick & Jordan, 2002; Pelletier et al., 2005; Chiu, 2005; Murphy et al. 2006; Joyce & Cowman, 2007; Gould et al., 2007; Cooley, 2008; Drennan, 2008; Hayajneh, 2009). In the United States, for example, the number of Master's programmes in nursing tripled between 1976 and the end of the 20th century, with the largest percentage of graduates coming from ANP programmes (Beck, 2000). Similar trends were reported in other countries (Davis, 1993; Gerrish et al., 2002; Pirret, 2007; Drennan, 2008). Gerrish et al. (2002) report that, in the last decade of the 20th century, considerable growth in the provision of M-level education for qualified nurses was witnessed in the UK. The authors stress that educational reforms, the desire of nursing professional bodies to bring together professional development with academic development, and a plethora of new nursing roles led university departments of nursing to develop Master's programmes which were oriented towards professional practice.

Studies in other disciplines such as physiotherapy, occupational therapy and librarianship identified a number of motivating factors that influenced students to undertake a Master's degree, including career enhancement and development (Carrington & Decker, 1997; Santos et al., 1998; Gosling, 1999 & 1997; Farley & Carr, 2003; Stathopoulos & Harrison, 2003; Green et al., 2008; Glover et al., 2008), and expectations of promotion and salary increment (Astin, 1993; Beeston et al., 1998). The need to acquire advanced professional and research capabilities (Atkins & Redley, 1998) and the desire to change career (Burgess, 1997) were also identified.

Though it is unclear how these motivations are reflected in the nursing workforce, few studies have been undertaken to investigate the impact of postgraduate education on clinical practice; moreover, concerns have been expressed about the value of higher education for nurses (Davis, 1993; Hogston, 1995; Whyte et al., 2000; Gerrish et al., 2003; Pelletier et al., 2003; Spence, 2004a&b; Spencer, 2006; Pirret, 2007; Drennan, 2008). Drennan (2007) notes that the majority of evaluations of Master's programmes for nurses tend to concentrate on students' satisfaction with the programme rather than measuring outcomes or the impact of the course on nurses and their professional practice. Draper and Clark (2007) also noted that studies conducted tended to be small scale and focussed on process and teaching strategies, rather than on the direct impact on practice.

The contribution of postgraduate education to advancing nursing practice was seen as providing nurses with certain outcomes. Some of these outcomes are 'enhancing clinical practice', 'thinking differently', and 'advancing the profession' (Spence, 2004a; Hogston, 1995). Other outcomes include enhancing the quality of patient advocacy skills, identifying research questions, acting as a role model, teaching colleagues, and making care decisions based on research findings (Pelletier et al., 2003). Whyte et al. (2000) emphasise that postgraduate education also opened up job opportunities, and it was perceived by graduates to enhance their clinical practice, develop a sense of personal achievement related to the acquisition of academic skills, and contribute to the individual's growth by broadening perspectives and developing advanced powers of reasoning. Other researchers identify as outcomes of postgraduate education generic and research capabilities including critical thinking, research awareness, leadership abilities, and the ability to apply what was learned to practice (Davis & Burnard, 1992; Barriball et al., 1992; Wildman et al., 1999; Hardwick & Jordan, 2002; Drennan & Hyde, 2008).

Little is known about M-level graduate nurses' career destinations. However, the majority of nursing graduates with a Master's degrees tend to be found in management and education (Gibbon & Luker, 1995; Sinclair et al., 1984; Hardy et al., 1984). However, Drennan (2007) and Joyce and Cowman (2007) note that, with the introduction of advanced clinical practice pathways within Master's programmes in Ireland, M-level

nurses view their M-level education as an integral part of their continuing education and clinical practice and they are seeking accreditation for an ANP role.

2.4. Advanced Nursing Practice

2.4.1 Defining advanced nursing practice

The concept of ANP emerged in the early part of the 20th century in the United States in response to a series of socio-political and professional issues. ANP was initially associated with some form of specialisation and was linked first with nurse anaesthetist and nurse midwife roles, and subsequently with CNS and nurse practitioner (NP) roles (Mantzoukas &Watkinson, 2007). Ketefian et al. (2001) and Bigbee and Amidi-Nouri (2000) explain that in the early 1900s in the USA, the large immigrant population's preference for midwifery services increased the government's awareness of poor maternal and child health in the USA. Moreover, lack of interest by physicians in obstetrics provided opportunities for nurses to expand and strengthen their role in midwifery. World War I and World War II also led to strong physicians' interest in surgery. Bigbee and Amidi-Nouri (2000), Ketefian et al. (2001), and Sheer and Wong (2008) explain that low pay and low status of anaesthesia practice at that time made it unattractive to physicians, which contributed to the development of nurse anaesthetists.

Nurse educators in the USA developed the concept of a CNS in an attempt to reduce the fragmentation of patient care that occurred after World War II. It was also in response to the knowledge explosion associated with the development of new technology and the increasing complexity of health care systems (Dunn, 1997; Duffield et al, 2009). Dunn also notes that the role of the CNS was envisaged as providing social and psychological support to patients, educating patients and their families, and serving as a role model to nursing staff. Nurses in this role were also expected to provide consultations to patients and conduct research. Dunn explains that nurse educators in the USA initially resisted the role of the nurse practitioner (NP) because it focused on technical activities that had previously been the responsibility of physicians (physical examination, laboratory tests, diagnosis and treatment of illness, and prescription of

medications). Dunn reports that despite this opposition, the NP role did develop in the USA in response to a range of drivers to meet the needs of changing health care systems and increased patient demands and expectations of quality of care.

Schober and Affara (2006) note that, although similar types of ANP roles existed in different countries, the development of these roles is either not documented or is not accessible for various reasons, and the authors had to rely on the information provided by key informants to explain how advanced nursing was evolving in each country. For example, the ANP roles emerged in the UK in the mid 1980s and in New Zealand and Australia in the 1990s (Paniagua, 1999; Pearson & Peels, 2002; Furlong & Smith, 2005; Sheer & Wong, 2008).

Two questions are usually raised when the concept of ANP is considered (Schober & Affara, 2006). While all nurses perform assessments and act in response to their conclusions, what is it about ANP that differentiates it from generalist nursing, and what are the drivers for practice development? Many factors have influenced the development of advanced practice roles in nursing in the global community, and these have led to several attempts in different countries to define the concept. Currently, it can be said that there is no consensual definition of the concept of ANP worldwide. One of the reasons why it is difficult to define ANP is because the nature of nursing practice varies greatly between different clinical contexts and settings. It has also been argued that the lack of a precise definition helps to facilitate creativity and innovation in clinical practice (Woods, 2000).

The American Nurses' Association (ANA, 1992) offered the following definition:

> Nurses in advanced clinical nursing practice have a graduate degree in nursing. They conduct comprehensive health assessments and demonstrate a high level of autonomy and expert skill in the diagnosis and treatment of complex responses of individuals, families and communities to actual or potential health problems. They formulate clinical decisions to manage acute and chronic illness and promote wellness. Nurses in advanced clinical practice integrate education, research, management, leadership and consultation into their clinical role. They function in collegial relationships with nursing peers, physicians, professionals, and others who influence the health environment (McLoughin, 1992, p. 23).

According to this definition, advanced nurse practitioners should demonstrate autonomy, be experienced, knowledgeable, and educated to at least M-level. They should be skilled in holistic aspects of patient assessment and the prevention and treatment of complex health problems. This multidimensional role could be more fully achieved in collaboration with other health care professionals. While this definition is comprehensive, it could be argued that only in exceptional circumstances would a nurse be able to fulfil such requirements and, as Woods (1997) has argued, the temptation to prepare a 'super nurse' should be tempered by the reality of clinical practice. Woods also explains that no one nurse can fulfil such a role and fully realise the multiple components: some advanced practitioners admitted to the author that their role, particularly with respect to the function of researcher, was impossible to realise due to clinical and administrative responsibilities.

A more recent definition was developed in the USA. This definition focuses on what nurses in such roles should do and what competencies they should have. The Advanced Practice Registered Nurses (APRNs, 2008, p. 7), in line with the ANA and National Council of State Boards of Nursing (NCSBN) definitions, define the APRN as a nurse:

- Who has completed an accredited graduate-level education programme preparing him/her for one of the four recognised APRN roles: certified registered nurse anaesthetist (CRNA), certified nurse-midwife (CNM), Clinical nurse specialist (CNS), or certified nurse practitioner (CNP)
- Who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification programme
- Who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care
- Whose practice builds on the competencies of registered nurses by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and a greater role autonomy
- Who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which include the use and prescription of pharmacologic and non-pharmacologic interventions
- Who has clinical experience of sufficient depth end breadth to reflect the intended license
- Who has obtained a license to practice as APRN

The United Kingdom Central Council (UKCC) (1994) defined ANP as being:

Concerned with adjusting the boundaries for the development of future practice, pioneering and developing new nursing roles responsive to changing needs and, with advancing clinical practice, research and education to enrich professional practice as a whole.

The UKCC's definition is therefore much more general and places a high responsibility on the advanced practitioners to be creative in developing practice (Woods, 2000). In 2005, the UK Nursing and Midwifery Council (NMC) revisited and revised the definition of ANP because of the growth in the number of titles that suggest an advanced level knowledge and competencies. The NMC (2005), in collaboration with the Royal College of Nursing (RCN, 2008) and the Association of Advanced Nursing Practice Educators (AANPE, 2006), proposed a framework to regulate advanced level practice. This proposal has been sent to the Privy Council and is still waiting for the necessary legislation to be put in place (NMC, 2008). The NMC agreed that ANP should be a registerable qualification in the UK. It defines advanced nurse practitioner as follows:

Advanced nurse practitioners are highly experienced and educated members of the care team who are able to diagnose and treat your healthcare needs or refer you to an appropriate specialist if needed. (NMC, 2005)

The NMC acknowledges that this definition has its limitations, and to provide more detailed information about what to be expected from an advanced nurse practitioner, it provided a list of competencies for the advanced nurse practitioners. Therefore, only nurses who achieve these competencies are permitted to use this title. Advanced nurse practitioners are highly skilled nurses who can:

- Take a comprehensive patient history

- Carry out physical examinations
- Use their expert knowledge and clinical judgement to identify the potential diagnosis
- Refer patients for investigations where appropriate
- Make a final diagnosis
- Decide on and carry out treatment, including the prescribing of medicines, or refer patients to an appropriate specialist
- Use their extensive practice experience to plan and provide skilled and competent care to meet patients' health and social care needs, involving other members of the health care team as appropriate

- Ensure the provision of continuity of care including follow-up visits
- Assess and evaluate, with patients, the effectiveness of the treatment and care provided and make changes as needed
- Work independently, although often as part of a health care team
- Provide leadership
- Make sure that each patient's treatment and care is based on best practice (NMC, 2005).

In Australia, Sutton and Smith (1995) agree that ANP differs substantially from other forms of nursing practice, such as expert and specialist practice. The authors suggest that expert and specialist nursing practice are terms often used synonymously to refer to ANP. However, they argue that ANP differs from expert and specialist nursing practice, and that this difference is evident in the ways in which advanced nurse practitioners think, see, and experience nursing practice. Sutton and Smith offer the following definition:

> Advanced nurse practitioners focus their efforts on the client and situations which enhance positive outcomes for the client. As such, the practitioner's actions are purposeful, directed towards excellence (in client terms) and pragmatic. In seeking to undertake practice, advanced nurse practitioners carefully consider and critically reflect on all aspects of care provided to the client …For advanced nurse practitioners, the client is the centre of that world…They recognise that their contribution to client care makes a difference…Because the client is central to their efforts they are willing to 'bend' the rules. However, this, like other aspects of their work, is undertaken silently and invisibly (p 1040).

Sutton and Smith (1995) place emphasis on direct patient care and a holistic approach to nursing practice, taking into consideration direct patient involvement in their care. They also note the ability of the advanced practitioners to operate outside of 'rules'. They do not need to refer to rules and regulations to determine what they do, and they are willing to break rules if they feel it is in the interests of the patient. Similarly, Mantzoukas and Watkinson (2007), the RCN (2008), and Duffield et al. (2009) suggest that specialisation is one element of ANP.

In a more recent definition, the Australian Nursing and Midwifery Council (ANMC) defines ANP as:

A level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, planning and implementation, diagnosis and evaluation of the care required. Nurses practising at this level are educationally prepared at postgraduate level and may work in a specialist or generalist capacity. The basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision making. (Ryan, 2009, p. 4)

The Australian definition emphasises the direct clinical role and minimal educational requirements at an M-level or higher. The generic features that underpin ANP include the use of knowledge in practice, critical thinking and analytical skills, clinical judgment, and decision making skills. The International Council of Nurses (ICN) also proposed a definition for advanced nurse practitioner. It states:

the nurse practitioner/advanced practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master degree level is recommended for entry level. (ICN, 2002)

This definition focuses on characteristics and competencies of advanced practitioners while leaving scope for each country to set legal and professional boundaries for the role. It also acknowledges that academic preparation is expected to be at M-level. Nevertheless, this definition is not without ambiguity as it does not offer a clear explanation of what is meant by 'expert knowledge' or 'expanded practice' nor does it define the clinical competencies that nurses need to acquire to practise at advanced level.

These international definitions share certain characteristics. The term 'ANP' encompasses multiple types of nurses in advanced roles (Duffield et al, 2009). Although these roles have developed individually at different points in the past century in different socio-political contexts, currently they are grouped together as APNs (Ketefian et al., 2001). ANP is recognised as a clinical career pathway for nurses wishing to remain in clinical practice (Woods, 1997; Furlong & Smith, 2005; Sheer & Wong, 2008, Duffield et al, 2009).

Most scholars identify that advanced nursing goes beyond basic practice as it requires a higher level of knowledge and specialised clinical skills to facilitate an

expanded range of theoretical and research-based interventions. Although it is not clear what is meant by a 'higher' level of knowledge, this could mean that advanced practitioners operate in a different way than non-advanced practitioners; they are able to assimilate a myriad of information, which they process in relation to their expert knowledge (Fulbrook, 1998). Nurses in these roles are expected to be able to function with autonomy and to establish the core functions of a nurse as an expert practitioner, researcher, educator, consultant and change agent (Manley, 1997; Hamric, 2001; Ketefian, et al., 2001).

It is noted that diversities still exist between different countries. Even within countries where ANP is established as a concept, it is difficult to reach a consensus definition, which makes it difficult to make comparisons between countries. It is also noted that some definitions were developed at specific points in historical time, and the recent attempts to re-define the concept focused on what nurses in these roles should do rather than defining the concept itself. This could also be related to the lack of coherence and clarity about the concept. Moreover, it is widely known that nurses have struggled to define nursing itself or to articulate what they do to non-nurses (Oberle & Allen, 2001; Darbyshire, 2009). Therefore, in the light of the international situation, it is not surprising to find a similar lack of clarity or definition in Jordan. It should be noted that no definition of ANP had been developed in Jordan at the time this study was conducted. However, the Jordanian nursing professional bodies developed a clinical career ladder that suggests competencies that equate to ANP roles (JNMC, 2005; JNC, 2008a). See section 3.4.2.2.

2.4.2 Drivers for the development of advanced nursing practice

It is widely accepted that various forces have shaped the development of advanced practice in the global community. Ketefian et al. (2001) proposed a framework for understanding the development of ANP in the international community. The authors consider various socio-political and professional forces that have shaped nursing roles in diverse cultural contexts in the United States, United Kingdom, Brazil and Thailand. These countries were selected because nursing in all of them was in a dynamic state; they represented different social systems, and they represented different geographical areas.

These forces include: the socio-political environment, health needs of the society, health workforce supply and demand, government policy and support for new role development, intra- and inter-professional collaboration, and the development of nursing education at postgraduate level.

Ketefian et al.'s (2001) framework draws attention to the organisation of health care within a particular socio-political context, and to forces such as healthcare reforms and economic structure within the country. It also draws attention to the extent to which consumers are involved in the development of advanced practice roles. Ketefian et al. also assert that unmet health needs and consumer demands and preferences have affected the development of advanced clinical roles in different contexts.

Health workforce supply and demand factors have also been critical forces in the development of ANP roles, and they have subsequently led to specialist nursing roles being forged to meet the needs of specific patient populations. Government policy and support can be seen as a significant precursor to such development. Government support may take the form of commissioning reports that explore the changing context of healthcare and outlining strategic target areas where developments in nursing practice can be made. These strategic policy documents can also give public recognition to advanced nursing roles (Woods, 2000; Drennan, 2007; Joyce & Cowman, 2007; Duffield, et al., 2009).

Ketefian et al.'s (2001) framework also draws attention to the extent to which active nursing organisations and collaboration can play a central role in such development. It is emphasised that, in formally recognising the concept of ANP, professional bodies provide an incentive for nurses to develop their practice and provide an impetus for universities to develop curricula that would provide the requisite educational programmes. Furthermore, this could allow employers to re-examine their service provision and explore ways in which ANP might be utilised in the delivery of healthcare (Woods, 2000).

Furthermore, the development of nursing education, and the move toward nursing becoming an academic discipline as well as a practical one, have provided nurses with

the opportunity to advance their practice. It is argued that formal recognition of advanced practice provided an incentive for nurses to develop their practice and undertake further education and training. Moreover, this also provided the impetus for universities to develop curricula that would provide the requisite educational programmes (Woods, 2000). These developments allowed healthcare organisations to re-examine their service provision and explore ways in which advanced practitioners might be utilised. These different elements explored through Ketefian et al.'s framework could be used to reflect upon the development of ANP in different cultural contexts and, therefore, I will draw upon this framework in seeking to understand the drivers for the development of ANP in the Jordanian context in chapter 9. Appendix 2 summarises features of advanced practice according to elements of the framework proposed by Ketefian et al. (2001, p. 157)

2.4.3   Facilitators and inhibitors of advanced nursing practice

There are multiple factors that can hinder or facilitate the implementation of an advanced nursing role. In her systematic review, Lloyd-Jones (2005) found that nurses in such roles encounter a range of factors that facilitate or hinder their role. The first is the practitioner's personal characteristics and previous experience which include factors such as confidence (or lack of), change management skills, flexibility and creativity. A second category is managerial and organisational issues that include clear role definition and the culture of the organisation. The third category is professional and educational issues such as clear career pathways and professional development, and induction to the role. The fourth category is the relationship with other health care professionals; this includes effective inter-professional relationships and support from others. The final category is the availability of resources. The author notes that few relevant studies came from the USA despite its long history of specialist and advanced nursing roles. Factors such as those outlined by Lloyd-Jones (2005) pose tremendous challenges for these nurses in advanced roles, as well as their colleague nurses, to implement their new roles in practice. Lloyd-Jones also notes that the absence of a facilitator might be a barrier. As I will demonstrate in the finding chapters, similar factors were reported in the current study (see chapter 8 for more details).

2.4.4 Developing new roles in practice

Due to the diversity of new nursing roles and the complexity of the contexts in which these are developed, there are many issues to be considered in relation to the introduction of new roles in practice. Lloyd-Jones (2005) draws attention to the importance of clear role definitions and objectives and the need to communicate these to relevant groups and, subsequently, to update them as necessary. The broader literature demonstrates that the development of new roles in various countries was guided by inconsistent policy. Hence, many titles were used to designate the post holder. In addition, educational preparation varied across different countries (Furlong & Smith, 2005). In the UK, several studies investigated the development of advanced nursing roles. For example, Gerrish et al. (2007) note that a recurring theme in the literature on ANP concerns the underlying tensions, mistrust, hostility and resentment both amongst nurses and between nurses and the medical profession (Wilson-Barnett et al., 2000; Collins et al., 2000). Bowler and Mallik (1998) report that medical staff viewed the function of advanced nurse practitioner as taking on mechanical tasks which anyone could be trained to perform. This view can be related to role ambiguity, which was cited frequently in the literature. It could also be due to the general view of nursing as a vocational or practical occupation, and the assumption that a great deal of what nurses do is learned on the job (Watson, 2006).

The United Kingdom Department of Health funded a study ('RSANP' 1996-1998) which reported a lack of clarity about the legal position of the NP role in the UK (Read et al., 2000). The authors explain that through a system of approval of institutions and accreditation of courses, a degree of standardisation and regulation of the educational preparation of the practitioner is assured. The respondents in the RSANP study raised issues of recognition, regulations, and standards of preparation. The findings also suggested that the current system of accreditation for the NP role was not adequate and, currently, recordable qualifications were not mandatory, an issue the NMC is still working on (NMC, 2008). A Further UK Department of Health funded study ('ENRiP', 1996-1998) illustrated a variety of clinical, legal, managerial, professional and educational implications of setting up new roles for nurses (Read et al., 2001). Also in the

UK, Carnwell and Daly (2003) illustrated variations between different disciplines in relation to the nature and focus of ANP. By contrast, in countries such as the United States, Canada and Australia, the scope of practice for APNs is defined in statute (Read et al., 2000).

Woods (1997) argues that those nurses in the UK undertaking roles such as CNSs, nurse practitioners, nurse clinicians, and nurse consultants who are prepared to M-level, and can demonstrate expert practice and skills in their particular discipline, should be eligible to be classified as advanced practice nurses. In setting the domains and competencies of advanced practice, M-level education is seen as an entry level for advanced practitioners in many countries (Woods, 1997; ICN, 2002, 2005; Castledine, 2003; Furlong & Smith, 2005; Schober & Affara, 2006; Hardcastle, 2008). Moreover, as discussed previously (section 2.3), there is an emphasis in nursing education on clinical Master's programmes that focus on the clinical advancement of practice (Schwirian, 1998).

2.4.5   Evidence for the impact of advanced nursing practice on healthcare Outcomes

Kleinpell and Weiner (1999) and Kleinpell and Gawlinski (2005) report that a variety of studies have been conducted worldwide to explore the effectiveness of outcomes of care provided by advanced nurse practitioners. The choice of outcome measure depends on the purpose of the outcome assessment, the type of patient groups involved, and the advanced practice nursing activities of interest. Studies have, therefore, variably, highlighted care-related outcomes (cost, length of stay, waiting time), patient-related outcomes (patient satisfaction, patient access to care, health maintenance), and performance-related outcomes (quality of care, interpersonal skills, employer satisfaction). Nevertheless, the authors point out that evaluating and choosing appropriate measures remains challenging. They need careful consideration of the purpose of the outcome assessment, outcomes of interest, study design and timing. Moreover, it can be difficult to identify relevant outcomes in areas where advanced nurse practitioners provide care as part of the healthcare team or in collaborative practice (Kleinpell & Gawlinski, 2005).

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In the UK, Gerrish et al. (2007) suggest that demonstrating the impact that advanced nurse practitioners exert through their evidence-based practice activities is, inevitably, difficult. The authors explain that the roles of such nurses are multi-faceted and complex. Many advanced nurse practitioners are part of a wider multi-disciplinary team and work in diverse clinical settings. Nevertheless, they were deemed in Gerrish et al.'s (2007) study to have had an overall positive impact on front-line staff, patients, and family members within the context of an enriched care environment. Similarly, in the field of adult critical care, Ball and Cox (2003) suggest that advanced practitioners in the UK, USA, New Zealand and Canada facilitate the restoration of patients' health and wellbeing by increasing patient satisfaction, enabling independence, and ensuring a trajectory of continuity. They also report that patients and relatives were prepared for transitions by advanced practitioners promoting a clear understanding in patients and relatives of their current condition and future abilities.

Evidence for the positive impact of ANP on patient care in the UK is also available. Byrne et al. (2000), for example, compared patients' satisfaction with care given by Emergency Nurse Practitioners (ENP) with the care provided by physicians and nurses working in a traditional Accident and Emergency (A&E) department. The findings indicated that patients were significantly more likely to have received health education and first aid advice from an ENP than from a physician; they were also significantly more likely to have been given written instructions to take home and told whom to contact if they needed more help and advice following discharge. The patients also reported that they were subsequently significantly less worried about their health, than patients seen in a traditional A&E. In Canada, Higuchi et al. (2006) report successful enhancement of the health of a rural older adult group by introducing gerentological APNs. In the USA, Brown and Grimes (1995) reported greater patient compliance with treatment recommendations made by nurse practitioners compared with those made by physicians. They also reported greater patient satisfaction with nurse practitioners.

2.5. Conclusion

This chapter shows how the majority of the extant literature concerning the development of ANP comes from western countries, in particular, the UK, USA and Australia. Reviewing the literature demonstrated a strong relationship between advanced practice and the professionalisation of nursing. The development of nurse education was seen as a professionalisation strategy; however, nursing is still struggling to gain the status of a 'profession'. Much debate within the literature concerned the necessity for postgraduate education for nurses and its impact on patient outcomes. Nurses in many countries are moving towards M-level education as a means of achieving personal and professional recognition and development, though the majority of graduate nurses with Master's degrees tend to be found in management and education.

This chapter has also reviewed the concept of ANP and illustrated a variety of definitions, conceptualisations, and roles that have emerged since the early part of the 20th century. Although ANP shares certain characteristics internationally, each country develops its own scope of practice and regulations, and no common definition of what constitute ANP is available. This lack of clarity sets the background for the current study.

As Ketefian et al. (2001) note, the development of ANP is culturally nuanced. The next chapter addresses this by providing a detailed description of the Jordanian context in which this study is embedded.

Chapter 3

The Jordanian Context

3.1.   Introduction

This chapter begins with a brief historical description of Jordan. This is followed by a discussion of the contemporary health care system. The past and current system of nurse education in Jordan and recent reforms are also discussed. Finally, the chapter presents issues related to nursing practice and the challenges faced by nurses in the Jordanian context.

3.2.   Historical background

Being in the centre of events in the Middle East (see Appendix 3 for a map of the region), Jordan has a complex history. Its political situation has affected, in particular, the development of its educational and health systems. Jordan is a small country (89,000 sq km) that has hosted many significant civilisations between 3200 BCE-622 BCE[1] (Before Common Era). The land was part of ancient Iraq; as a result, it was home to successive civilisations which included in turn the Sumerian, Akkadian, Babylonian, Assyrian and Mesopotamian empires. Equally important, Pharaonic Egypt stretched from the west, and extended its power and culture into Jordan. In addition to these great civilisations, the Nabateans, who migrated from the south of the Arabian Peninsula, managed to build their empire in Jordan and leave a legacy, Petra, that has put Jordan on the map in modern times as the home of one of the Seven Wonders of the Modern World. Subsequently, Jordan became part of the Persian, Greek, and Roman civilisations consecutively

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[1] Common Era, abbreviated as CE, is a designation for the calendar system most commonly used world-wide. The numbering of years using Common Era notation is identical to the numbering used with *Anno Domini* (BC/AD) notation. Dates before the year 1 CE are indicated by the usage of BCE, short for "Before the Common Era", "Before the Christian Era", or "Before the Current Era". Both the BCE/CE and BC/AD notations are based on a sixth century estimate for the year in which Jesus was conceived or born, with *common era* designation originating among Christians in Europe at least as early as 1615 (at first in Latin). Accessed from   http://en.wikipedia.org/wiki/Common_Era 19/08/2009

(332BCE-63BCE). This blend of cultures affected its population, as throughout history people of different origins inhabited the country ("The Hashemite Kingdom of Jordan," 1998; Holloway, 2004).

However, the year 622 CE (Common Era) was the beginning of a new era that would last for a long time in the region. Islam became the main religion in the Arab Peninsula, and spread rapidly throughout the Middle East and North Africa. To be more specific, since the mid-seventh century, Jordan has remained almost continuously in the hands of various Arab and Islamic dynasties of which the Ottoman Empire was the last. Nevertheless, during their four-century-rule (1516-1918 CE), the Ottomans could not control the Bedouin tribes, who were then the majority of the residents in Jordan, because of their style of living that had been the same for many generations. They remained living in the desert, moving from one place to another, looking for water and food away from civilisation; some continue this lifestyle today ("The Hashemite Kingdom of Jordan," 1998; Holloway, 2004). This unconventional life style meant that, during the Ottoman period, Jordan was not as prosperous as some of the neighbouring countries; its infrastructure was neglected, and the people suffered many injustices.

During the conflicts of World War I, the Islamic Ottoman Empire sided with the Central Powers against the Allies. The Ottomans banned the official use of the Arabic language (the mother tongue of the Middle East) and stopped teaching it in schools. They also arrested many Arab nationalist figures in Damascus and Beirut, and they started converting the Ottoman Empire into a secular one. As a result, many Arab nationalists started rebelling. Finally, in June 1916 and with the help of Britain and France, Sharif Hussein of Mackah launched the Great Arab Revolt against the forces of the Ottoman Empire in Hijazz which led to the empire's collapse in 1918. However, the long-awaited freedom came with a high price. In 1917, the Balfour Declaration promised a national home for the Jews in Palestine, and in 1920 Britain was given the mandate over Transjordan, Palestine and Iraq. France was given the mandate over Syria and Lebanon, which was the beginning of a long period of unrest in the region ("The Hashemite Kingdom of Jordan," 1998).

Meanwhile, Abdullah, Sharif Hussein's son, accepted to rule the emirate of Transjordan; financed by the British, he moved with a small force to Amman. On May 25, 1946, the Transjordanian parliament proclaimed Abdullah king and officially changed the name of the emirate to the *Hashemite Kingdom of Jordan*. On May 14, 1948, the British mandate over Palestine was ended, and the state of Israel was proclaimed with hundreds of thousands of Palestinians immigrating to Jordan and neighbouring countries. That year was another turning point, and the tragedy of Palestine had, and still has, the greatest effect on the history of Jordan. In 1951 King Abdullah was assassinated, and he was succeeded by his son, Talal. In 1952, King Talal was declared incapable, so his son, Hussein, took the oath and ruled as king for a period of almost fifty years (Dallas, 1998).

In 1967, the six-day war with Israel resulted in Jordan losing the West Bank. As a result of the war, more than 300,000 Palestinian Arabs became refugees and fled to Jordan. For many of them, this was the second uprooting in less than two decades, having been driven from their original homes in 1948. Jordan's economy was also devastated. Approximately 70% of Jordan's agricultural land was located in the West Bank, which produced 60 to 65% of its fruits and vegetables. Half of the Kingdom's industrial establishments were located in the West Bank, while the loss of Jerusalem and other religious sites devastated the tourism industry. Altogether, areas occupied by Israel had accounted for approximately 38% of Jordan's gross national product. In 1970, the Palestinian guerrillas (*fedayeen)* tried to create a state in Jordan. King Hussein, supported by America, ordered his army to expel them from Jordan. Wasfi Altal, the Jordanian prime minister, was assassinated by Palestinian guerrillas. That was the start of the bloody events of "Black September" and a civil war between the armed Palestinians and the Jordanian army (Dallas, 1998).

Jordan has witnessed an era of comparative security since then. In 1990, the Iraqi president, Saddam Hussein, invaded Kuwait. The American-led coalition forced the Iraqi army from Kuwait. The Iraqi conflict affected Jordan during the First Gulf War as well as the second one. With a population of only about three and a half million people at that time, the Hashemite Kingdom hosted over a million refugees from the conflict. About 300,000 became permanent "returnees" from the Gulf. Many of these "returnees" were

Palestinian refugees with Jordanian passports. The influx of these refugees led to an increased demand on the country's limited water supplies and infrastructure, rising poverty, and a sharp increase in unemployment to around 30% ("The Hashemite Kingdom of Jordan," 1998). Following King Hussein's death, his son Abdullah the Second took office and is now ruling as the King of Jordan ("The Hashemite Kingdom of Jordan," 1998; Dallas, 1998).

The political changes that took place in Jordan during the last hundred years brought with them numerous social changes, especially to Jordan's population structure. In addition to the Palestinians, Jordan has hosted immigrants coming from North Africa, Syria, and even Russia (The Hashemite Kingdom of Jordan," 1998). The Palestinians, in particular, benefit from the services of the United Nations Refugee Welfare Agency (UNRWA) which provides them with health services as well as education services at school and college levels (Reiter, 2002).

Due to a lack of high-school or higher education amongst indigenous Jordanians, King Abdullah and King Hussein mostly appointed educated Palestinians to senior positions. The Palestinians' society was also more urbanised and politically active while most indigenous Jordanians were Bedouin, rural, uneducated, and without political experience (Reiter, 2002). Reiter explains that, throughout the years that followed their emigration from their homeland, most Palestinians felt that their only opportunity for investment was in their education. This resulted in many of them getting high academic qualifications, initially from neighbouring Arab countries and later, after its opening in 1962, from the University of Jordan, and as a result obtaining senior positions, especially in the fields of health and education.

However, in 1970 the bloody events of 'Black September' created an ethno-national rift between indigenous Jordanians and Jordanians of Palestinian origin, which later led to the exclusion of Palestinians from public sector positions, directing them to the private sector or to attaining higher education qualifications which enabled them to seek employment in the rich Arab Gulf States (Reiter, 2002). The door was also opened to the indigenous Jordanians to catch up and achieve higher educational qualifications.

After the Iraqi occupation of Kuwait in 1990-91, many Palestinians and Jordanians (many of whom were originally Palestinians) who were working in the gulf countries returned to Jordan. The economic burden became very heavy with this rapid demographic growth and the very limited resources. As a result, the economy of the country was badly affected, and with sanctions imposed on Iraq, Jordan's main trade partner, the country was heading into a crisis. The return of expatriate Jordanians augmented the pressure to create additional spaces in universities and contributed to the growth of private universities (Reiter, 2002). The same scenario was repeated only recently with hundreds of thousands of Iraqi people fleeing their country and heading towards Jordan in the second Gulf war. This further incursion has had a negative impact on the socioeconomic and health development of the country.

3.3. The Jordanian health system

Jordan has survived many crises it has encountered, especially the ones related to education and health. Throughout the years, Jordan's health strategy has aimed at providing people with adequate health coverage; it also aimed at developing a comprehensive health system that includes the services of the public sector as well as the private sector to ensure preventative, tertiary and rehabilitative care for all (MOH, 2008). To achieve these aims, the government's policy has encouraged geographical complementarities in services. It has encouraged the private sector to invest in areas where people can afford higher costs. In contrast, it has concentrated public sector facilities in the relatively less-privileged areas, and a large portion of the Ministry of Health (MOH) budget is spent on secondary and tertiary health care. By 1999, the primary health care system reached 97% of the population (MOH, 2008).

3.3.1. Health care sectors

In the second half of the 20th century until the present day, a huge network of health care facilities has been formed in both the public and private sectors; these are seen as complementing rather than competing with each other even though there is limited collaboration between them. The health services in Jordan comprise the following:

1- The public sector:

- The Ministry of Health (MOH)
- The Royal Medical Services (RMSs)
- Two university hospitals: The University of Jordan Hospital in Amman and King Abdullah the First Hospital in Irbid

2- The private sector

3- The United Nations Relief and Works Agency for Palestine Refugees (UNRWA) in the Near East

The following is a summary of what these sectors do in Jordan:

3.3.1.1.   *The Ministry of Health (MOH)*

The MOH provides primary, secondary and tertiary services through a network of health centres, maternal and child health clinics, and hospitals. It runs 30 hospitals distributed throughout the country with 4333 beds, representing 38.7% of hospital beds in the country (MOH, 2008). It is responsible for all health affairs in the Kingdom. Its tasks and duties include:

- Maintaining public health by offering preventive treatment and health control services.
- Organising and supervising health services offered by the public and private sectors.
- Providing health insurance for the public within available means.
- Establishing and controlling the management of health educational and training institutes and centres according to relevant provisions of enacted legislations. (Hijazi & Al-Ma'aitah, 1999)

The role of primary health care (PHC) is evident in the areas of vaccinations, educational services and awareness campaigns, mother and child services, school health services, safety of food, environmental and occupational health, mental health services, and the prevention and treatment of infectious and non-infectious diseases (Hijazi & Al-Ma'aitah, 1999).

3.3.1.2.   *The Royal Medical Services (RMSs)*

The RMSs mainly provide secondary and tertiary services through eleven military hospitals with about 2129 beds, representing 19% of hospital beds in the country (MOH, 2008). It provides services and insurance to military and security personnel, staff of the Royal Court, Royal Jordanian Airlines, Aviation Academy, Mu'tah and Al-Albait Universities and staff dependants. The RMSs also receives referrals from the MOH and other health facilities.

3.3.1.3.   *University Hospitals*

The two university hospitals, King Abdullah Hospital (504beds) and The University of Jordan Hospital (522 beds), provide health insurance and services for the universities' employees and serve as referral centres for other health sectors (MOH, 2008).

3.3.1.4.   *The private sector*

The private sector provides primary, secondary and tertiary services through a network of private clinics and hospitals. The private sector has 60 hospitals with over one third of the hospital beds in the country (3642 beds). The majority of the private hospitals as well as private practices are in the capital Amman (39 hospitals) or in the major cities (MOH, 2008).

3.3.1.5.   *The United Nations Relief and Works Agency (UNRWA)*

UNRWA provides primary health care to Palestinian refugees who in 2007 amounted to 1,951,603 registered individuals (UNRWA, 2007). It has 23 primary health care facilities. Patients from these facilities may be referred to other hospitals (MOH, 2008).

3.4. Nursing in Jordan

3.4.1 Nursing education

In searching for literature on nursing in Jordan, few historical sources were located. One of the main sources, written in Arabic, was Sultan's book (1998). Sultan is a journalist and a researcher who is interested in nursing issues in Jordan (Dr. S. Almajali, personal communication, 4th Feb 2009). His book provides a comprehensive description and analysis of the development of nursing in Jordan.

Since its beginning, the development of nurse education in Jordan has been influenced by the medical profession. Physicians were involved in teaching nurses until the early 1990s when an increasing number of nurses with postgraduate qualifications, but with little educational and clinical experience, replaced them (Sultan, 1998; Shuriquie, 2006). Physicians also dominated the committees in the MOH which prepared and marked the comprehensive nursing examination. This continued until the Ministry of Higher Education introduced reforms for nursing education in 1998 and all nursing programmes at the associate degree and bachelor degree level started to be taught by nurses (Shuriquie, 2006). The Faculty of Nursing at the University of Jordan was founded as part of the medical faculty and was led by a British physician. The 4-year BSN degree was established by physicians and British Diploma nurses and was a combination of a nursing and medical sciences programme (AbuGharbieh & Suliman, 1992). In 1982, the Faculty of Nursing became independent of the Faculty of Medicine, and the curriculum became more related to the nursing model.

Many Palestinian women were part of the resistance against the British occupation and participated in nursing the wounded men in the battle field. Following the 1948 crisis and the emigration of Palestinians to Jordan, many Palestinian nurses emigrated to Jordan and participated in the development of nursing there (Sultan, 1998).

Until the mid 1950s it was common for women in Jordan not to work. Early marriage was the norm. Families were very large, and several generations used to live together in the same house. The hard work was in the house with a family of up to

thirteen or fourteen children to bring up; a woman would spend her day and night cleaning, washing, cooking and doing endless chores at home. Few families sent their children to school (Sultan, 1998). In addition, in war time people suffered from poverty and diseases (Mussalm, 1958). Until the mid twentieth century, people could not afford to pay the very few physicians who were available. The majority of people used to go to the barber or *Hakeem*, as he was called, if they became sick; women also relied on the services of untrained, self taught midwives or *Dayeh*. At a time when it was not acceptable for women to go out to work, nursing in particular was not considered a respectable occupation. Women who worked at night, an inevitable element of nursing, were stigmatised as contravening the cultural beliefs of the community.

However, at the same time, nursing was seen as an occupation for women rather than men. There were some women nurses visible through British nurses and the emigration of Palestinian female nurses into Jordan. The female nurse was perceived as someone who worked with men, cared for men, and stayed late at night, which was unacceptable by the conservative Jordanian society. Generally, females could not study against their family wishes, and because nursing was so controversial, women had to get formal written consent from their next of kin to allow them to study nursing. Nursing was not taught in schools, as it was subsequently, and the very few men who were called nurses used to go to hospitals to get training, which was minimal and given by physicians (Musallam, 1958; Cleveland, 1966; Sandford, 1985; Sultan, 1998). By contrast, in Palestine, nursing and midwifery education was delivered in schools of nursing which were situated in hospitals. For all the above reasons, nursing had a very low profile in Jordanian culture.

The difficulties faced by women are illustrated by Sultan (1998) who describes the journey of several Palestinian and Jordanian women to study nursing. Sultan (1998) points out that a 'Fatwa'[2] was issued by the Palestine Higher Muslim Council in 1925 so that Muslim families would allow women to study midwifery and nursing. This was first issued to allow the first Palestinian midwife (Mrs Anisa Shukair) to enrol in a six-month

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[2] Fatwa: a religious decree issued by a Muslim leader (Collins Dictionary, 2003)

course and graduate as a midwife in 1926. Mrs Shukair worked in Hebrow City, then moved to Amman in 1927 to work for the government until 1948. She then worked independently and was a private midwife for high profile families in Jordan. She also worked in Saudi Arabia for five years.

The first Jordanian nurse was Nabiha Alwar, who received support from her uncle to convince her mother and family (this took one whole year) to allow her to study nursing in Jerusalem. She enrolled in the course in 1929 and graduated in 1932 as a staff nurse. She worked in different hospitals in Palestine until she moved to Jordan in 1945. In 1965, she helped in establishing the first Maternity Hospital in Amman. She also worked in Kuwait, and became the president of the JNMC from 1980 to 1982. Another pioneer nurse was Adeebeh Musallam, a Palestinian who moved to Jordan in 1954. She was sent to the USA in 1955 on a scholarship, and was the first Jordanian nurse to get a bachelor's degree in nursing. Musallam became the director of the first school of nursing in Amman. In 1966, she became the Director of Nursing at the MOH and helped in establishing nurse education at university level.

In 1923, the first health authority was established in Jordan, and continued working until it was replaced by the MOH in 1950. In 1927, a hospital named the Italian hospital was established; this was funded and supported by western missionaries, and is still currently functioning. Only a handful of physicians were working at that time. Sultan (1998) states that the first government hospital was established in 1939 with 20 beds. Nursing in the armed forces started with two male nurses in 1942. In 1946, the missionary hospital in the city of Ajlun began training nurses, and it continued to do so until it was closed in 1979. In 1953, a Ministry of Health school of nursing was opened in Amman, awarding its graduates a diploma in nursing.

In the 1960's, the situation began to change, and the need for trained nurses was emphasised. There was an increase in the number of military personnel, and, to provide health services for all of them, the army realised the need for trained nurses. The army, in order to convince women to enrol in nursing, took the first steps to overcome some of the cultural barriers inhibiting the practice of nursing. It was noted that, though it was

acceptable to see foreign people doing work such as nursing, it was not acceptable when this work was undertaken by local people. Sultan (1998) affirms that the Jordanian army decided to do something about this by hiring seven retired British female nurses to work in the army hospital in Amman, allowing them to wear military uniform. Patients started noticing the difference in nurses' performance, and the army started a campaign to encourage women to work as nurses in the army. They emphasised sensitive cultural issues such as the fact that women were being treated in hospitals by men. Men in the community started to realise how culturally improper such conduct was, and gradually the idea of having women as nurses gained acceptance. Later, British nurses trained the Jordanian nurses and helped them to organise their work by introducing shift patterns instead of working for long hours.

The 1970's witnessed significant changes in nursing education and the development of several pathways for nursing education. Most nursing programmes were modelled after the American curriculum and taught in English (Thomas et al., 2000). Students were encouraged to enrol in nursing schools and colleges, and most of them were given grants to cover their expenses.

By the mid 1980's, students were competing for places at the university, and to enrol in university nursing education students needed much higher grades. In addition, they were mostly self-funded. By the end of the 1990s, there was a continuing growth in the number of students graduating from nursing programmes, demonstrating the extent to which the status of nursing was changing in Jordan. The following is a summary of nurse education programmes.

3.4.1.1   *The General Secondary School Certificate (Tawjihi)*

In Jordan, students who complete ten years of basic education are offered different branches of study depending on their preference and their overall marks. The different branches include art, science, agriculture, commerce, nursing and most recently Information Technology. After successful completion of such programmes students are granted a Tawjihi certificate which entitles them to apply for a place to study at a university or a college. The Tawjihi programme in nursing was established on the 5th of

June 1974 in collaboration between the MOH and the Ministry of Education (Sultan, 1998). It offered two years of a basic vocational nursing programme that included theory and practice after which students could sit for the national Tawjihi examination. After successful completion, students were issued with the Tawjihi nursing certificate and were able to take up work in hospitals as nursing aides (Shuriquie, 2006). Initially, 28 female students were enrolled. In 1987, this branch was opened to male students. By 1997, the number of enrolled students had expanded to 2059. However, after the establishment of nurse education at university level, the value of the Tawjihi nursing stream was questioned by nurse experts, and nurses holding this qualification faced poor employment prospects because the certificate came to be perceived, by nurse academics and Jordanian nursing professional bodies, as inadequate and as weakening the professional image of nursing (Shuriquie, 2006). As a result, this route into nursing was discontinued in 1998.

3.4.1.2   *Practical level nurse education*

Prior to the introduction of the practical level programme, assistant nurses learned their nursing skills at the bedside through practice. In 1960, the RMS set up the Military Services Training Centre and started to train male soldiers to become assistant nurses; they became known as practical nurses (Shuriquie, 2006). In 1963, a similar programme was established for women. Other programmes were also established by the MOH, the Islamic hospital, and University of Jordan hospital, with a total of 13 programmes throughout the country. In the early days, these programmes were as short as three months, and they gradually extended to 18 months; students could enrol after completing grade nine at age 14 or 15 years. In 1988, entry requirements were raised and students could only enrol after completing grade 12 (Tawjihi) (Shuriquie, 2006). These programmes offered practical nursing qualifications that aimed to provide nurses with technical skills.

There were several shortcomings with these programmes and considerable variations in the curricula as they were not regulated by the Ministry of Higher Education. They also offered no opportunity for nurses to continue their education at diploma or bachelor level because they did not provide accredited hours (Shuriquie,

2006). In 1998, these programmes were therefore discontinued and replaced by associate degree programmes which have a common curriculum and are accredited by Balka University of Applied Sciences. Shuriquie explains that students study for two academic years and then sit for a final national comprehensive examination, undertaken by all students on the same day; upon passing the exam, they are awarded an associate degree. The graduate nurse can then work as a practical nurse and can study for further two years at the university level to get a bachelor degree to become a staff nurse.

3.4.1.3 *Nursing education at Diploma level*

The MOH established a nursing school in 1953 which awarded a Diploma in Nursing. An American nurse ran the school, and most of the teaching staff were American or British. In the mid-sixties, Jordanian staff nurses who were trained in the United States and the American University in Lebanon replaced the American staff (Shuriquie et al. 2007). Shuriquie et al. note that students worked in the hospital and learned through apprenticeship as well as theory, reflecting the influence of the American nurse education system. It also indicates clear similarities with early nurse training in the UK, which can be traced to the Nightingale reforms (Roxburgh et al., 2008).

In 1962, the Princess Muna College of Nursing was established by the RMSs. The curriculum was based on the British model and taught in English. Nurse Instructors were British nurses; additionally, physicians who were trained in the United States and United Kingdom participated in the process of teaching. The students were awarded a diploma degree following graduation (Shuriquie et al., 2007). In 1983, the Supreme Jordanian Health Council formed the national nursing committee to study the nursing situation. This found an alarming shortage of qualified nurses. As a result, two further MOH colleges were established in 1984. Students could complete a three-year diploma programme. In 1998, educational reforms were introduced, and these colleges were linked with Balka University for Applied Sciences and started offering the two-year associate degree programme in nursing mentioned above. The RMSs College joined Mu'tah Military University, and, following curriculum and staff changes, a four-year bachelor of Science in Nursing was established. Such diversity has resulted in a work force equipped with varying levels of knowledge, skills and professionalism. The

graduates of the associate programme can apply to a bachelor university programme if they wish to further their education (Hijazi & Al-Ma'aitah, 1999; Thomas et al., 2000).

3.4.1.4 *Nursing education at the university level*

The first university education in nursing was started with the establishment of the Faculty of Nursing at the University of Jordan in 1972 (Sultan, 1998). It offers a four-year bachelor of Science in Nursing. The University of Jordan sponsored several graduates to obtain postgraduate education in the US. The majority of them eventually assumed faculty roles at the university. This educational background was highly influential in the continued emulation of American nursing practice and curricula together with the use of American textbooks (AbuGharbieh, 1993).

The Faculty of Nursing experienced a steady expansion and growth. In addition, it was the first faculty to offer a bridging programme for graduates of diploma and associate degree nursing programmes to complete their bachelor degree in nursing (similar to top-up degrees in the UK). The other nursing institution that has contributed to the advancement of nursing in Jordan is the Faculty of Nursing at the University of Science and Technology, which was established in 1983. It offers a four-year bachelor of science in nursing and midwifery, and a registered nurse bridging programme for diploma-prepared nurses that commenced in 1993. In addition, exchanges and collaboration between Western and Jordanian institutions have produced substantive outcomes in terms of faculty training, curriculum development, instructional design and enhancement. The newly developed midwifery programmes are being supported through an international educational link in collaboration with Middlesex University, Queen's University in Belfast, and the British Council (Shuriquie, 2006)).

Nowadays, the number of nursing programmes is increasing in both government and private universities. There are 29 colleges offering an Associate Degree in nursing and 13 universities offering a bachelor of Science degree in Nursing (Ministry of Higher Education, 2007).

Despite the negative image of nursing, opportunities for employment have encouraged male high-school students to enrol in nursing. The following table shows the number of nursing graduates from the University of Jordan: the number of nurses has increased over the years starting from 24 students in 1975 to 347 students in the year 2009. However, detailed information about the number of bachelor graduates from Jordan University of Science and Technology was not available.

Table 1: The number of nursing graduates from University of Jordan (bachelor degree) from 1976 to 2009 (University of Jordan, 2009)

Year	Female	Male	Total	Year	Female	Male	Total
1975/76	12	12	24	1992/93	115	66	181
1976/77	24	6	30	1993/94	110	69	179
1977/78	34	0	34	1994/95	114	59	173
1978/79	22	0	22	1995/96	98	59	157
1979/80	21	0	21	1996/97	92	49	141
1980/81	13	0	13	1997/98	90	47	137
1981/82	22	0	22	1998/99	64	51	115
1982/83	32	0	32	1999/00	85	57	142
1983/84	31	0	31	2000/01	62	72	134
1984/85	50	3	53	2001/02	76	76	152
1985/86	62	31	93	2002/03	77	113	190
1986/87	64	57	121	2003/04	80	75	155
1987/88	83	32	115	2004/03	54	110	164
1988/89	83	44	127	2005/06	103	170	273
1989/90	90	47	137	2006/07	90	254	344
1990/91	119	46	165	2007/08	130	190	320
1991/92	133	44	177	2008/09	171	176	347

The recruitment of male nurses became established in the mid 1980s and has expanded significantly since then. Male nursing students currently make up more than 55% of nursing students at some universities and community colleges, and the male nursing workforce is rapidly increasing. The majority of male nursing students entering

nursing programmes do so with mixed emotions since nursing is still identified as a woman's job (Hijazi & Al-Ma'aitah, 1999).

3.4.1.5   *Master's level nurse education*

Before presenting the state of higher education in nursing, a brief description of the social transformation in higher education in general is provided. The development of higher education in Jordan occurred in a number of stages, as a result of several factors (Reiter, 2002). Firstly, the opportunities available for Jordanians in the Arab Gulf States have created an enormous number of young people seeking higher education to benefit from higher salaries. Secondly, the demand for Jordanian academics in the Gulf States has meant that a university degree is the main prerequisite for finding work. Thirdly, a rapid growth in the number of students and higher education institutions occurred in the 1980s-1990s. Finally, for Jordanians of Palestinian origin, higher education became the main guarantee for their future, and was perceived as a means of changing their social status.

Nurse education evolved over a relatively short period of time. Jordanian nurses are becoming increasingly aware of the expanding role of nurses in developed countries. They have realised that their practice could be improved, not only in terms of new technology and skills, but also in terms of emerging new nursing roles (Al-Ma'aitah & Momani, 1999). This awareness was reflected in the new programmes that were opened and the number of nurses who enrolled in them. The first nursing education programme at postgraduate level was established in 1982. It offered a Master's programme in education to prepare nurse educators. This programme was discontinued in the year 2000 and was replaced by a CNS programme in critical care. Three Master's-degree programmes that prepare CNSs in adult health nursing, community health nursing, and maternal newborn nursing were then introduced in 1998 (Shuriquie, 2006). These were the first clinical nursing programmes offered at the Master's degree level in the Arab world.

Although there are no compulsory requirements from professional bodies, employers, or government for continuing professional development for nurses, the number of nurses undertaking Master's degrees is increasing.

This may reflect the desire of the nurses themselves to have better career development, suggesting a demand-led supply.

The growing demand for higher degrees was met by the different educational institutions in Jordan. According to their mission statements, these universities sought to equip nurses with a body of knowledge and advanced skills to improve patients' outcomes. In its mission statement, the Faculty of Nursing at the University of Jordan states that the professional nurse needs to be equipped with advanced knowledge and specialised skills in order to face the challenges of a changing health care delivery system, the continuing advances in technology, the increasing complexity of health services, and the changing health care needs of the population. It is to this end that the Faculty of Nursing has established nursing education at both the undergraduate and postgraduate levels. The bachelor programme prepares nurses for entry level professional practice, while the Master's programme builds upon these competencies and those developed during the process of professional practice. It also prepares professional nurses for leadership roles in both education and clinical specialisation. This again suggests a demand-led supply, in order to meet changing demands in the healthcare system. The University of Jordan also established the first doctoral programme in nursing in 2005. There are no formal records of the number of nurses with a Master's degree in Jordan; however, the following table provides an insight into the number of Master's graduates from the University of Jordan, one of the institutions providing nursing M-level education in Nursing. Graduates from the nurse education Master's programme can be seen from 1988 until 2001, whilst, from 2002 onwards they graduated from the critical care clinical programme. Detailed information about the number of Master's graduates from Jordan University of Science and Technology was not available.

Table 2: The number of Master's nursing graduates from University of Jordan from 1988 to 2008 (University of Jordan, 2008)

Year	Female	Male	Total	Year	Female	Male	Total
1988/89	9	0	9	1998/99	13	12	25
1989/90	8	1	9	1999/00	18	19	37
1990/91	2	0	2	2000/01	15	9	24
1991/92	3	2	5	2001/02	13	4	17
1992/93	5	3	8	2002/03	11	14	25
1993/94	7	7	14	2003/04	19	2	21
1994/95	6	11	17	2004/05	20	17	37
1995/96	11	6	17	2005/06	19	20	39
1996/97	1	4	5	2006/07	11	19	30
1997/98	5	13	18	2007/08	17	21	38

3.4.1.6 *Specialist training and continuing education programmes*

Clinical specialisation programmes are relatively new, and they were established through collaboration between the Jordanian government, the German Federal Republic (GFR), the United States, and the Italian Government (Shuriquie et al., 2007). The GFR project started in 1986 and focused on establishing hospital-based short and long term clinical courses in critical care. In 1988, the United States Agency for International Development (USAID) project established the Institute for Specialised Nursing which offered two postgraduate diplomas in teacher preparation and primary health care (Shuriquie et al., 2007). This was followed, as Shuriquie et al. explain, by the Italian project which established the Institute of Clinical Training in 1989 and offered a clinical instructor postgraduate diploma programme. These two institutes were linked with the Directorate of Training and Education at the MOH, following the cessation of foreign funding, and continued to run these programmes. The MOH established eight nursing development units to meet the continuing educational needs of nurses in its hospitals. The educational materials are supported by the World Bank and the World Health Organisation (WHO). Clinical specialisation courses in critical care and accident and

emergency nursing are amongst the courses run by the Jordanian MOH (Shuriquie et al, 2007).

The GFR project was later taken over by qualified nurses in the RMSs who had been trained abroad in the field of critical care. This provided a six-month course. In 2000, the critical care unit at King Hussein Hospital expanded to 30 beds, and, with increased demand or intensive care trained nurses, the RMSs recruited three American nurse specialists to organise and run two critical care programmes (Shuriquie, 2006). Shuriquie et al., (2007) note that these programmes adopted the core curriculum recommended by the American Critical Care Nurses Association, and continued to be run by RMS staff holding postgraduate degrees in clinical nursing. The authors outline such programmes: nine-month programmes which offer theory and practice in critical care nursing, midwifery, child health nursing, administration, and renal nursing. Several short-term continuing education courses such as advanced cardio pulmonary resuscitation (CPR), wound management, intravenous drug administration, infection control, and patient education are also offered. The RMSs provide nurses who complete these courses with certificates that are recognised by different health sectors but do not count as credits for further university education. Dependent on the needs of the hospitals, the RMSs also sponsor nurses to travel to the UK and USA for speciality courses (6-9 months). In addition, the private sector offers continuing educational programmes in the form of short courses through in-service education departments.

In 1997, collaboration with the WHO resulted in the establishment of the WHO collaborative Centre for Nursing Development located at Jordan University of Science and Technology (JUST). The centre aimed to develop education and human resources in nursing through continuing education and the promotion of post-basic nursing specialisation in the areas of critical care, oncology, community and primary health care, maternal and child health, midwifery, mental health, infection control, breast self examination, and CPR (JUST, 2008). Shuriquie (2006) states that the centre was not able to implement its second year plan, which included running long term specialist courses in critical care nursing, because nurse leaders preferred sending nurses to undertake Master's degrees rather than specialist courses of six-months duration. Shuriquie argues that this view of nurse leaders fails to recognise the importance of role adequacy in

specialist nursing, and highlights the need to enlist national collaboration for the advancement of nursing practice through specialisation as opposed to postgraduate education at M-level. She notes that M-level education is predominantly academically based and is offered to a limited number of nurses; moreover, it has little focus on the advancement of clinical practice and the development of role adequacy in clinical settings.

3.4.1.7   *Specialist training and continuing education requirements*

The Jordanian Nurses and Midwives Council has not set any requirements for continuing education at a national level, and there are no professional development requirements linked to the renewal of registration (Shuriquie, 2006). In 1994, the RMSs adopted a professional ladder programme for army nurses. The ladder provides a basis for minimum experience and continuing education at six levels: beginner, practitioner, assistant specialist, specialist, senior specialist, and consultant, with significant pay rises linked with the latter three posts (Shuriquie, 2006). Shuriquie explains that the years of experience required between each level ranges between two years of experience at the beginner level and five years at the other levels. She adds that requirements for attendance at and participation in higher continuing education increase with each level. Moreover, examinations relevant to the area of practice are only applicable at the first three levels, while conducting research, presenting papers and publication apply to specialist levels and upwards. At the consultant level a long-term specialist course (minimum nine months) or a Master's degree is required for the consultant level. In order to be acknowledged at a given level, nurses have to meet the entire requirement set for that level.

Shuriquie (2006) notes that this professional ladder does not take into account nurses who can fulfil the requirements within a shorter period of time or nurses who gain postgraduate degrees early in their careers. Promotion from one level to another does not necessarily correspond with actual promotion in practice as this is primarily linked with military rank. As a result, many nurses did not have the motivation to fulfil the requirements for each level because it takes a minimum of 15 years to reach the senior specialist level.

In the Jordanian literature on nursing, nurse scholars argue for the significance of postgraduate education and continuing education for nurses. Oweis (2005) states that both advanced education and certification in speciality areas are needed in Jordan to allow nurses to validate and maintain their knowledge and skills over time. Furthermore, she argues that these will increase the visibility and importance of nurses to the health care systems both for the general public and amongst other health care professionals. Al-Ma'aitah and Momani (1999) consider that Jordanian nurses holding advanced degrees can make a significant contribution to the profession by supervising and coordinating educational programmes for nurses in different health settings. These educational programmes are seen to contribute to professional accountability and autonomy. They are also essential for quality nursing practice.

Petro-Nustas (1996) argues that nurses who obtain higher academic degrees will augment their decision making and planning abilities, increase their self confidence and improve their self image. She also suggests that higher degrees will increase the trust of hospital employees and physicians in the nursing staff. Thus, nursing care is expected to improve. Petro-Nustas et al. (2001), therefore, argue that postgraduate education will promote the development of competent and skilled nurses who are able to meet the changing health-care needs of the society and adapt to overall complex healthcare systems. It will also ensure high quality nursing services to all clients. The authors suggest that advances in science and technology, greater emphasis on the promotion and maintenance of health, and the development of education have all led to an increased demand for qualified nurses.

Thomas et al. (2000) designed a framework for the development of human resources in nursing in Jordan in collaboration with the Jordan University of Science and Technology and the University of Windsor in Canada. The framework was initiated in 1995, and was designed to enhance the capabilities of faculty members in the north of Jordan to provide education for nurses enrolled in university programmes as well as nurses working in primary and secondary care in North-Eastern Jordan. The framework emphasised three main areas: structured programmes (BSN, RN-BSN, MSN), international activities (linkages, conferences), and staff development (training and

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continuing education). Following the implementation of this framework, the authors stated that this framework has benefited both practising nurses and nurse educators in North-Eastern Jordan. Staff nurses were able to access continuing clinical education and gain a Master's degree. The authors also reported that Jordanian nurses indicated they had become empowered to act as change agents as a result of their increased knowledge and confidence gained through education and training opportunities. Similarly, nurse educators were able to increase their academic and clinical teaching through graduate education and international collaboration. The researchers also found that international linkages and conferences provided nurses with a global perspective and raised the profile of the nursing profession in Jordan.

3.4.2 Nursing Practice

3.4.2.1   The professional regulation of nursing in Jordan

There are two nursing professional bodies in Jordan that are working on regulating nursing practice and education. These are Jordan Nurses and Midwives Council (JNMC) and the Jordanian Nursing Council (JNC). The following sections describe their role in further detail.

3.4.2.1.1   Jordan Nurses and Midwives Council (JNMC)

The JNMC (established 1972), formerly known as the Jordanian Nurses and Midwives Association (established 1959), is the professional body for nurses and midwives in Jordan. It is a member of the International Council for Nurses (ICN) and the Arab Nurses Council. It represents nurses and midwives, and its members are elected by nurses and midwives every three years. The JNMC is the professional body that issues nurses with a license to practise; it also requires nurses to be registered members to be able to practise. However, many employers did not require nurses to be registered, and their only requirement was a university or a diploma degree. Registration with the JNMC has recently been enforced, and many hospitals have started to ask for registration as a condition for employment. The introduction of the new pension scheme and benefits for registered nurses also motivated nurses to become registered members of the JNMC.

In addition to licensing nurses to practise, the JNMC also works on developing nursing standards to improve the profession of nursing and its practice. It organises a yearly conference and publishes a local nursing journal. Moreover, it recommends policies for nursing education and identifies the different levels of nursing education that are consistent with policies of higher education. It attempts to monitor and improve legislation governing nursing practice. Most recently, the JNMC established the National Institution for Specialist Nursing and the National Institution for Nursing Research, launched a research award, offered nurses a pension scheme and loans, and established the JNMC fund for higher education.

3.4.2.1.2 *The Jordanian Nursing Council (JNC)*

Although the establishment of the JNC was a highly political and contested process, it is poorly documented and therefore difficult to describe and understand in detail. However, the JNMC is seen as providing limited activities (Shuriquie, 2006). Shuriquie claims that the active involvement of Jordanian nurses in issues related to nursing practice and education only started recently with the development of the JNC.

Sultan (1998) describes the process of forming the JNC. In November 1975, with the help of American nurse experts, a proposal was put forward to establish the JNC to strengthen the role of the JNMC in setting standards for nursing education and practice in Jordan. In February 1979, another attempt was made to establish the JNC; this involved Queen Noor, the Minister of Health, the Dean of the Faculty of Medicine at the University of Jordan, and the Deans of Faculties of Nursing. In March 1985, members from the JNMC, the University of Jordan, and RMSs met to discuss its establishment. The president of the Jordanian Medical Council (JMC) suggested that the JNC might encounter financial and legal obstacles and therefore should be part of the JMC. This proposal was rejected, and it was agreed to establish the JNC independently from the JMC. However, the JNMC rejected the project on the grounds that they were not consulted. As a result, the project was frozen until 1987 when the High Health Council agreed in principle to establish the JNC. Despite all the efforts to establish the JNC earlier, it was not until 2002 that it was founded.

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The JNC works on developing standard competency measures and skill levels for registered nurses to improve the quality of care and promote continuing professional development. These measures include licensing exams for practice, job descriptions, work-based orientation programmes, continuing education, and accreditation of programmes (JNC, 2006). In January 2006, the JNC established professional standards for nursing and accreditation standards for nursing specialisation (JNC, 2006). A joint committee from The JNC and The Ministry of Higher Education and Scientific Research has been formed to address some obstacles concerning nursing education. One of the principal issues was the female/male student ratio at the Jordanian universities. Based on the joint committee's recommendations, the Higher Education Council determined that the ratio should be 70%:30% for the year 2008/2009 (JNC, 2008b), as explained in section 8.4.1.2.3.

3.4.2.2 *Standards of speciality certification*

In settings the standards for specialisation in nursing, both the JNMC and the JNC independently issued clinical career ladders for the professional nurse. Neither is yet implemented by hospitals, and it is left to the individual nurse to apply for them. The JNMC professional clinical career ladder classifies nurses as: general, qualified, assistant specialist, specialist, CNS, and consultant (JNMC, 2005). On the other hand, the JNC clinical career ladder classifies nurses as: beginner, practitioner, assistant specialist, specialist, senior specialist, and consultant (JNC, 2008a). This latter classification structure takes into consideration qualifications, clinical experience, participation in continuing educational programmes, research, ability to train nursing students, and distinguished practice. It is noted that both classifications are similar to the RMSs' clinical ladder, and they include challenging criteria for nurses in clinical practice, especially when it comes to conditions like undertaking research, publishing, participating and presenting at conferences.

The majority of nurses in Jordan, with the exception of those in the RMSs, are unaware of these career ladders (Shuriquie, 2006). However, as the findings of this study will reveal, the major issue surrounding the JNMC and JNC classification is that it leaves the nurses and their employers with confusion about different titles and to whom they

should be accountable. Nevertheless, common criteria can be seen between the different clinical ladders. The competencies of nurses in these levels suggest that, from the specialist level and above, nurse experts in Jordan are working towards criteria that equates to ANP in the international literature.

3.4.2.3 Challenges to nursing practice in Jordan

The development of nursing education in Jordan is not wholly congruent with the development of nursing practice. Nursing services are mainly provided in hospitals, and to a lesser degree in primary health care centres. The majority of nursing activities are embedded within a medical model of care or relate to carrying out medical orders, giving a rise to task-oriented care delivery (Shuriquie, 2006). Al-Ma'aitah and Momani (1999) note that nursing practice in Jordan does not emphasise discharge planning or communication skills such as counselling, teaching, and history taking; instead, the nursing role is limited primarily to the distribution of medications and basic nursing activities.

However, most of the literature on nursing practice in Jordan is anecdotal, and, in searching the literature, few studies that examined the role of Jordanian nurses in practice were identified. There was general consensus that nurses in Jordan lacked autonomy and decision making. The dominant methods of care delivery were task-oriented, operating within a team nursing approach, and a focus on holistic patient care has not, therefore, yet developed (AbuGharbieh & Suliman, 1996; Petro-Nustas et al., 2001; Mrayyan & Acron, 2004; Francis et al., 2005; Shuriquie, 2006). The limitation of the authority given to nursing leaders reduces the professional management of practitioners in health organisations. There are no developed roles comparable to those of the nurse practitioner or CNS in Western countries (Oweis, 2005; Shuriquie, 2006). Lack of clarity in relation to the roles of nurses and the absence of job descriptions are features of nursing practice in Jordan.

Hijazi and Al-Ma'aitah (1999) stress that the multiple entry levels to nursing are very confusing: nurses are seen as being at the same level regardless of their educational preparation. Recent reforms in nursing education have consolidated current training into

two levels: associate nurses and staff nurses. Practical nurses trained prior to the 1998 reforms constitute around 50% of the current nursing workforce: this level of training is similar to the enrolled nurse that existed in the UK in the past (Shuriquie, 2006). With time, the number of practical nurses will decline, and they will be replaced by associate degree nurses. The main functions of practical nurses include basic physical care, and clerical and portering duties carried out under the supervision of staff nurses. However, in reality, it is common for practical nurses to administer medicines, intravenous fluids and blood transfusions and thus to undertake the same duties as staff nurses even though it is widely known that practical nurses should not carry out such tasks (JNC, 2008a). This situation has been acknowledged by nurses in Jordan to raise concerns about safety of practice (JNC, 2008a). The JNC has, therefore, mandated that, to establish a safe practice environment, the professional nurse must hold a bachelor degree in nursing, a challenge that must be met by the year 2010 (JNC, 2008a).

Hijazi and Al-Ma'aitah (1999) also highlight several challenges to nursing practice in Jordan. Firstly, they note that there is a significant shortage of qualified nurses in Jordan due to the increase in the number of hospital beds and treatment units that have been commissioned as a result of expansion in the health facilities in the public and private sectors. This shortage comes as hospitals try to meet the needs of both local and international patients. Secondly, there is significant movement of health personnel: inside the country, staff move from the public sector to the private sector, and from one hospital to another within the private sector seeking better job opportunities and salaries. Staff also tend to move from rural to urban areas looking for a better life. Although this does not change the number of nurses in the system, it creates shortages at particular healthcare settings. Moreover, female nurses may leave the profession altogether for family reasons or because of inconvenient schedules and rotating night shifts (Petro-Nustas et al., 2001). Externally, nurses apply for jobs in other countries, especially in the Gulf region where more attractive employment packages are available (Hijazi & Al-Ma'aitah, 1999).

In an audit of the nursing workforce employed in Jordan in 2003, the JNC reported that the total number of nurses working in health sectors was about 16,095 (JNC,

2008b). This number includes foreign nurses (373), nurses working in pharmaceuticals (50), nurse academics (362) and midwives (1233). It excludes about 2,700 RNs working outside Jordan at that time. As differentiated by gender, there were 9,463 female nurses (58.8%) and 6,632 male nurses (41.2%). Of the total number of nursing personnel, there were 9,833 nurses (61%) who were working in the middle part of the country, 4,276 (27%) in the north, and 1,986 (12%) in the south. Table 3 shows the approximate number of Jordanian nurses according to health sector and qualifications excluding, nurse academics, midwives and foreign nurses.

Table 3: The distribution of nurses according to institutions and qualifications (JNC, 2008b)

	RNs	Associate	Practical	Aide	Master's	PhD	Total
MOH	2066	153	3012	1474	25	0	6730
Private	1606	229	815	933	25	2	3610
RMSs	953	684	618	0	13	0	2268
University hospitals	775	58	89	94	16	0	1032
UNRWA	44	22	85	54	1	0	206
Total	5444	1146	4619	2555	80	2	13846

The audit findings also showed that the ratio of nurses per thousand of population is similar to other Arab countries such as Syria, Egypt and Bahrain; however, when compared to developed countries, this ratio is low although it has been improving over years (JNC, 2008b). Although it had increased compared to 1982 (5:10000), 1994 (9.2: 10000), and 2003 (29.5: 1000) it is still very low as the population in Jordan is increasing; it is estimated that it will be 6,385,000 by 2010 (JNC, 2008b). This has implications for the quality of care provided by these nurses; it also influences the admission policy in nursing schools where more students are encouraged to enrol in nursing degrees.

However, it should be noted that many nurses do not update their registration. Moreover, not all hospitals responded to the survey conducted by the JNC, nor did all

provide accurate information about the nursing workforce; therefore, these figures do not represent the actual number of Jordanian nurses and should be interpreted with caution. Table 4 shows the number of Jordanian nurses registered with the JNMC by the end of 2007.

Table 4: Total number of registered Jordanian nurses in 12/09/2007: (JNMC, 2007)

Female nurses	6749	54%
Male nurses	5771	46%
Total	12520	100%

As in other countries, nurses occupy a subordinate position to administrators and physicians, and their working conditions are characterised by high workloads, nursing shortages, limited autonomy, dissatisfaction, conflicts with other health care professionals, and high rates of turnover and burnout (Maʿaitah & Momani, 1999; Petro-Nustas et al., 2001; Mrayyan & Acron, 2004; Mrayyan, 2005; Oweis, 2005; Mrayyan, 2006; Jonsson & Halabi, 2006; Mrayyan, 2007; Hamaideh et al., 2008). In Jordan, nurses' working conditions, salaries and benefits are controlled by each employing institution. There is no minimal wage legislation, and wages vary between institutions. In military hospitals, universities, and university hospitals, salaries are higher than in the private and MOH hospitals. In the MOH, there is no clinical career ladder, and the status of long-serving registered nurses is no different from that of new graduates (JNC, 2006).

Nurses in Jordan are continuously challenged by the increasing complexity of patient care. It is anticipated that improved standards of living and health care will result in a notable increase in the number of older people, and subsequently a higher incidence of chronic diseases. Consequently, there will be an increased need for more nurses to provide quality care for this client group (Petro-Nustas et al., 2001). Furthermore, the balance of care with cost requires nursing professionals to have an understanding of practice methods that improve quality, respond to clinical complexity, and are cost effective. Changing Jordanian demographics (high fertility rate and relatively low mortality rate) also affected nursing as a profession (Department of Statistics, 2003). Morbidity and mortality patterns such as the rise in non-communicable diseases, the

increase in the life expectancy of individuals with chronic and acute illness, the reduction in child mortality and morbidity in the last ten years are also factors that affect nurses. Furthermore, technological advances of the 20th century which have enabled the development of telemedicine and electronic medical records has put pressure on nurses to update their knowledge. Perhaps most importantly, Jordanian consumers are increasingly able to access information through the internet, and are becoming knowledgeable consumers of health care. This also puts pressure on nurses to provide quality health services (Hijazi & Al-Ma'aitah, 1999).

3.5. Conclusion

Jordan has a long and complex socio-political history. In this chapter, political changes from the mid twentieth century to current day have been discussed with particular reference to their impact on the Jordanian education system and the cultural super-valuation of higher education. Nursing has reflected these cultural changes, and several types and levels of nurse education have been established and reformed. Similar to other countries, higher education is expanding rapidly in Jordan, and new colleges with new programmes are being introduced at all levels. Yet, there are still many challenges ahead, and collaboration between all health care sectors is vital to shape the role of nurses and nursing in the future. The image of nursing, and of nurses, in Jordan reflects the role of women in society and their subservience to men. This also manifests in the relationship between physicians and nurses. Nurses in Jordan have attempted to improve the status of nursing through the development of nurse education, in particular M-level education. However, after the establishment of clinical Master's programmes which aimed to prepare CNSs, there are no studies conducted to investigate the actual performance of M-level nurses in practice. In this chapter, I explored the context in Jordan within which the current study is set. The next chapter will discuss the methodology employed in this study.

Chapter 4

Methodology

4.1 Introduction

This chapter considers the methodology chosen for the research and the methods of data collection. The philosophical issues underpinning positivist and naturalist approaches are mapped out, and the rationale for choosing an ethnographic approach for this study is presented. The principles underpinning ethnography, including consideration of a conceptual framework for the study, are also discussed. The process of gaining access and recruiting participants, in addition to the processes of data collection and analysis are also discussed. My role as a researcher and its impact on collecting, analysing and interpreting the data is also reflected on. Finally, issues of rigour and trustworthiness as they relate to this study are addressed.

4.2 Aim of the study

The aim of the study was to examine the extent to which ANP is evident in Jordan, with a particular focus on the contribution of M-level nurses. Specifically, the study sought to:

1. Identify factors that facilitate or hinder the development of ANP in Jordan.
2. Illustrate how the identified factors have shaped elements of advanced nursing in Jordan.
2. Explore the contribution of M-level nurses to the development of advanced nursing practice in Jordan.
4. Examine the nature of the roles adopted by M-level nurses in Jordan.
5. Consider the implications for future M-level nurse education and practice in Jordan.

4.3   Philosophical stance underpinning the study

4.3.1   Positivism versus Naturalism

In order to gain an understanding of M-level education and the development of new clinical roles for nurses in Jordan, it was necessary to decide which kind of methodological approach would be the most appropriate for the purpose of the study. There has been a long-standing debate and conflict between two competing epistemological approaches or paradigms about the nature of knowledge in the social world and the ways in which social reality can and should be studied; these approaches are naturalism, commonly associated with qualitative methods, and positivism, commonly associated with quantitative methods. Underlying both approaches are fundamental assumptions about what constitutes legitimate inquiry and justifiable knowledge about the social world (Gerrish, 1998).

The most important feature of scientific theories for positivists is that they are open, subject to testing, and can be confirmed or falsified with relative certainty. This requires either the manipulation of one variable and assessment of the effects on other variables (experiment) or statistical analysis of a large number of cases (survey). Other methods include the analysis of official statistics, and structured or non-participant observation (Topping, 2006). By using these methods, causal relationships can be identified and generalisations made on the basis of universal laws (Hammersley & Atkinson, 1995; Maykut & Morehouse, 1994). Positivism thus entails a belief that the methods and procedures of the natural sciences are appropriate for social sciences. Many accounts of positivism suggest that scientific knowledge is both inductive and deductive. In adopting this approach, positivists are only concerned with those phenomena that are observable either directly by experience or indirectly with the aid of instruments. Such a position rules out any possibility of incorporating metaphysical notions of 'feelings' or 'subjective experience' into the realms of social scientific knowledge unless they can be rendered observable and measurable (Bryman, 1988; Topping, 2006).

The naturalistic paradigm, by contrast, proposes that the social world should be studied in its natural state, undisturbed by the researcher who should adopt an attitude of

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respect or appreciation towards it (Hammersley & Atkinson, 1995, 2007). The researcher needs to discover the participants' definitions of the situation, which reflect their perceptions and interpretations of reality, and how these relate to their behaviour (Hammersley & Atkinson, 1995). It is argued that the social world cannot be understood in terms of simple causal relationships or universal laws. This is because human actions are based on intentions, motives, beliefs, rules, and values. As a result, the same physical stimulus or experience can mean different things to different people. As Hammersley and Atkinson, (1995) propose, phenomena can also mean different things to the same person at different times. Guba and Lincoln (1994) explain that the philosophical position of objectivity is based on realism and the idea that the world has an existence independent of our perception of it. By contrast, anti-realism holds that there are multiple socially constructed realities that are negotiated by individuals as they attempt to make sense of their experiences.

Deciding on which methodology to use in conducting any type of research is influenced by a number of factors such as the purpose of the research, the questions to be addressed, the time and resources available, the knowledge and experience of the researcher, the chosen theoretical framework, and most importantly, the researcher's epistemological beliefs (Woods, 1997). These beliefs will consequently have a considerable effect on the way the research is designed, undertaken, analysed and reported. All the previous factors guided me into adopting a qualitative approach for the present study, which in turn guided me in choosing the appropriate methodology. The next section will discuss the methodology chosen for this study and the philosophical stances that underpin this decision.

4.3.2 The study methodology

Preliminary inquiries indicated that little was known about the development of new clinical roles for nurses in Jordan and the drivers behind their establishment, which suggested that theory testing was inappropriate. I had a concern not to impose specific ideas about the development of the new clinical roles for nurses in Jordan; therefore, I decided that the major design of the study would follow a 'qualitative' approach, an in-depth ethnographic one in particular. To reconcile the tension between the two paradigms

(realism and anti-realism), I adopted what is called 'subtle realism'. The following section discusses this decision in more detail.

4.3.3 Interpretation of reality

Gerrish (2003) reports that in order for nurse researchers to justify the claims they make regarding their particular contribution to nursing knowledge, they need to make their epistemological and ontological position explicit. In this respect, I adopt Hammersley's (1992) position which proposes subtle realism as an approach to ethnography. This is discussed further below.

The implications of adopting a realist or anti-realist ontology for the research enterprise become clearer when one considers the relationship between these ontologies and the theories of truth which they imply (Murphy et al., 1998). Realists assume that there is a single, unequivocal social reality or truth which is entirely independent of the researcher and whose nature can be known. Realists also assume that the aim of research is to produce accounts that correspond to that reality, and that through our senses we are able to perceive the world as it is (Hammersley, 1992; Skene , 2007).

By contrast, anti-realism holds that there can be no absolute truth; the researcher assumes that there are multiple socially constructed realities that are devised by individuals as they attempt to make sense of their experiences; the researcher's account of the world is seen as one version amongst them. This is inevitably filtered through the researcher's language, gender, social class, and ethnicity. To this end, there are no truly objective observations of social reality; rather, there are observations that are socially situated in the worlds of the observer and the observed (Denzin & Lincoln, 1994).

In order to resolve the ambiguity in ethnography that lies between realism and anti-realism, Hammersley (1992) proposes "subtle realism", which is an attempt to represent reality rather than to attain the truth. Subtle realism, according to Hammersley, rejects the notion that knowledge must be defined as beliefs whose validity is known with certainty. In recognising that knowledge is provisional, the objective should be the search for knowledge about which researchers can be reasonably confident. Such confidence

will be based upon judgements about the plausibility and credibility of knowledge claims. Subtle realism maintains that phenomena exist independently of the researcher's claims which may be more or less accurate. Consequently, any claim about reality does not, in itself, change the nature of those phenomena in such a way as to make the claim either true or false. Finally, an approach grounded in subtle realism suggests that the aim of social research is the representation of reality rather than its reproduction, and any given reality can be represented from a range of different perspectives. Such representations inevitably reflect the assumptions that researchers bring to the research. Moreover, rather than engaging in futile attempts to eliminate the effects of the researcher, it is recognised that researchers are part of the social world they study. In addition, through a reflexive approach, attempts are made to try to understand these effects and how the researcher's values and interests may impinge upon the research.

In short, subtle realism accepts that there is no direct access to reality, but views, beliefs, and behaviour are seen as constructions that can provide information about the phenomena to which they refer (Mays & Pope, 2000). Mays and Pope also suggest that 'subtle realism' should be the philosophy of both qualitative and quantitative researchers, and that the two conflicting paradigms can be held together. From a subtle realist perspective, it is recognised that, in their search for truth, researchers will never grasp the whole truth. They strive through rigour and integrity to move closer to a more valid understanding of the truth of a situation (Gerrish, 2003). These philosophical stances helped me to gain a deeper understanding of the nature of my study. They also made me realise that subtle realism was appropriate for my study as it acknowledges my experiential and theoretical knowledge, which I believe to be of value in understanding different points of views. This philosophical stance underpins, therefore, the methodological approach chosen for this study. The following section discusses this approach in more detail.

4.3.4   The ethnographic approach

Qualitative research covers a broad range of approaches that are linked to different beliefs about what there is to know about the social world and how to find out about it (Snape & Spencer, 2003). Several qualitative research methodologies, located

within a naturalistic paradigm, have been reported in the related literature. These include grounded theory, phenomenology, life histories, and ethnography. The value of ethnography as a social research method is founded upon the existence of variations in cultural patterns across and within societies, and the significance of those variations for understanding social processes (Gerrish, 1998; Lathlean, 1994).

Ethnography is distinct from other qualitative research methodologies in that it focuses on culture (Holloway & Todres, 2006). It can be said that it originated in the work of nineteenth-century anthropologists who travelled to observe different pre-industrial cultures. Today, however, ethnography encompasses a much broader range of work, from studies of groups in one's own culture to studies of experimental writing and political interventions (Silverman, 2005). An ethnographic approach involves a long term association with a certain group, in their own territory, with the purpose of learning from them their ways of doing things and viewing reality (Holloway & Todres, 2006).

However, the definition of ethnography has been subject to debate. For some, it refers to a philosophical paradigm; for others it is a research method that one uses when appropriate (Atkinson & Hammersley, 1994). Despite the lack of a precise definition of ethnography, some researchers have attempted to describe its general features. For example, Hammersley and Atkinson (1995) describe ethnography as follows:

> A particular method or set of methods. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions, collecting whatever data are available to throw light on the issues that are the focus of the research. (p.1)

Atkinson and Hammersley (1994) suggest that ethnography entails the following features:

- A strong emphasis on exploring the nature of social phenomena, rather than setting out to test hypotheses about them
- A tendency to work primarily with 'unstructured' data, that is data that have not been coded at the point of data collection in terms of a closed set of analytic categories

- The investigation of a small number of cases, perhaps just one case, in detail
- Analysis of data that involves explicit interpretation of the meanings and functions of human actions

This summarises the two distinct characteristics of ethnography: firstly it focuses on understanding the perspectives of the people under study. Secondly, it focuses on observing their activities in everyday life (Baillie, 1995). It could be argued that this definition applies to all qualitative approaches; nevertheless, ethnography can be undertaken to understand the culture under study and, in order to do that, a prolonged engagement with that culture is needed. However, while these features outline the major characteristics of ethnography, they say little about the philosophical assumptions underpinning the ethnographic approach (Gerrish, 1998). Understanding these philosophical assumptions is crucial in judging the appropriateness of ethnography for researching the social world of nursing in Jordan.

An important aspect of ethnography is observation. Observation is a systematic selective way of collecting primary data. Atkinson and Hammersley (1994) explain that all social researchers are participant observers because they cannot study the social world without being part of it. They also suggest that researchers should not be overly concerned with attempting to make a rigid distinction between ethnography and other forms of qualitative research; rather, the focus should be on the common characteristics. In taking this pragmatic stance, ethnography is described as a form of social research which relies on first-hand knowledge of social processes gathered in situations by the researcher (Gerrish, 1998).

Savage (2006) argues that, within the qualitative paradigm, ethnography is particularly valuable because of its multi-methods approach and its attention to context; as Holloway and Todres (2006, p. 212) argue, "many cultures and subcultures exist within nursing, therefore, ethnography is particularly helpful in studying cultures linked to nursing." The research may seek to focus on the culture of a hospital or the subculture of a particular ward. According to Holloway and Todres, ethnography is therefore particularly helpful in:

- Studying cultures linked to nursing, with their rules and rituals and routine activities; this includes trans-cultural research which examines different ethnic groups, their interactions and meaning creation.

- Discovering the 'insider view' of patients and colleagues

- Explaining phenomena related to nursing

- Examining the conflicting perspectives of professionals within an organisational culture

Therefore, ethnography is thought to be well suited for studying previously unexplored areas and usually results in the collection of in-depth data and detailed accounts of specific nursing phenomena or experiences within their contextual circumstances (Baillie, 1995). Nurse researchers not only generate knowledge, which is seen as the goal for ethnography, but they may also wish to change and improve professional practice through understanding the culture under study (Holloway & Todres, 2006). In ethnography, there is no pre-determined framework or theoretical understanding of phenomena under investigation. The decision whether to use or reject a conceptual framework prior to conducting the study is explored in the following section.

4.3.5   Using a conceptual framework

Ethnographic research is inductive which means that it proceeds from the specific to the general (Holloway & Todres, 2006). Ethnographers often do not have a hypothesis neatly worked out before they enter the field; they allow their ideas to develop out of their observation and participation (Laugharne, 1995). Though role theory has been used by some nurse researchers to explore advanced practitioner roles in other contexts (Stark, 2006; Scott, 1998, Glen & Waddington, 1998), because ANP is, at most, still in its infancy in Jordan, such theories may not be suitable for this inquiry. It was also feared that, in imposing a particular theoretical perspective, there was a danger that the study could have been conceived too rigidly within this framework.

Ethnography generally starts with broad questions that are likely to change as the research progresses, responding to encounters and experiences in the field (Agar, 1986; Sharkey & Larsen, 2005). Silverman (2001) emphasises that, in research "data collection, hypothesis construction and theory building are not three separate things but are interwoven with one another" (p. 70). This process of interweaving different aspects of research is well described by using the analogy with a funnel suggested by Hammersley and Atkinson (1995): ethnographic research should have a characteristic 'funnel' structure, being progressively focused over its course. Over time, the research problem needs to be developed or transformed, and eventually its scope is clarified and delimited and its internal structure is explored. In this sense, it is frequently well into the process of inquiry that one discovers what the research is really about, and not uncommonly "it turns out to be about something rather different from the initial foreshadowed problems" (p. 206).

In this study, I recognised that I was inevitably influenced by my prior knowledge and understanding of issues of theory and practice in nursing and nurse education in Jordan. This was clearly important in a number of ways. Firstly, this knowledge and interest stimulated my desire to explore the phenomenon of ANP in Jordan. My prior understanding is related to the general context of nursing and nursing education rather than to ideas about what ANP and the role of M-level nurse in Jordan might involve. Secondly, it helped in setting down the parameters for the ethnographic study. The literature review was used in a general way to help focus the study as it proceeded, and particularly to contextualise and make sense of the emerging data. However, following Hammersley and Atkinson's (1983) suggestion that ethnographers should suspend a wide range of common sense and theoretical knowledge in order to minimise the danger of imposing misleading preconceptions about the setting and the people in it, I felt it was important not to impose preconceptions about the nature of ANP in Jordan, as they might not be based on the reality of the situation there.

4.4   Study design

4.4.1   Data collection methods

The adaptive nature of the ethnographic study design provides maximum flexibility in data collection, allowing for modification to the research schedule. An understanding of the phenomenon of ANP and M-level education in Jordan could best be gained through the in-depth study of the perceptions and experiences of those who had direct or indirect involvement in this development. This in-depth description could be complemented with a small scale quantitative study of all M-level nurses in the participating hospitals to provide baseline information on M-level nurses in practice and their understandings of ANP. The survey was also intended to provide a rich source of data that would enable purposive sampling for the qualitative stage of the study. Moreover, the aim and the objectives of the research dictated the use of a flexible and responsive research strategy through which an operational plan could be conceptualised to obtain appropriate data to address the research objectives. In order to maximise the data collected for this study, three principal methods were adopted: survey of M-level nurses, semi-structured interviews, and participant observation. The principles of each method, together with how these principles were made manifest in practice will be considered in the following sections.

4.4.1.1   *Questionnaire*

Descriptive surveys are used to obtain information on the current status of phenomena so as to describe 'what exists' with respect to variables or conditions (McKenna et al., 2006). Surveys are relatively easy to undertake (McKenna et al., 2006). They can also be a rich source of data to support refined purposive sampling (Marshall & Rossman, 1999). For the current study, the survey offered the opportunity to determine how certain variables were distributed within the study population before decisions about sample composition were finalised. The survey was also intended to act as a mapping exercise to identify the range and nature of new roles for M-level nurses and to find out more about their role and the extent to which M-level education had influenced their practice.

4.4.1.1.1 Content and Structure

The questionnaire (Appendix 4) was developed with reference to the research questions and was designed to explore issues raised by the related literature and existing international research in this field, drawing on previously validated tools which explored new nursing roles (Read et al., 2000; Read et al., 2001; Gerrish et al., 2007). Specifically, the questionnaire sought information on the current roles occupied by M-level graduates, their educational preparation, and their career progression. In addition, it sought information on the perceived impact of M-level education on nurses' practice, their scope of practice, and their working relationships with other health care professionals. It also solicited respondents' views on accountability and autonomy, and factors inhibiting or facilitating the M-level nurses' role.

The items included in the questionnaire were a combination of closed questions, open-ended questions and rating scales. Closed questions were included based on the recommendation that they can be used when researchers consider they know all the potential answers and only require respondents to select the one or ones that apply to them, such as demographic data (Murphy-Black, 2006; Parahoo, 2008). Closed questions produce data that allow ready comparison between respondents as all the responses are in the same format. They can be pre-coded, thereby making analysis relatively easy (Parahoo, 2008; Murphy-Black, 2006). In contrast, open-ended questions allow respondents to express their opinions in their own words. However, they can be time consuming and difficult to analyse. Likert rating scales, which are commonly used to measure attitudes, beliefs, opinions, values and views (Parahoo, 2008; Murphy-Black, 2006) were used for the generation of such types of responses, where considered appropriate.

4.4.1.1.2 Language

The questionnaire was administered in English because English language is commonly used in nursing practice in Jordan. It is also the language of instruction in nursing schools at the Jordanian universities. No problems were therefore expected to arise in this respect.

4.4.1.1.3 Pilot study

The survey questionnaire was piloted with three Jordanian nurses who were undertaking PhD degrees in nursing in the United Kingdom. The three respondents were chosen because they had similar characteristics to the population being studied; they also used to work in contexts similar to the study context. The aim of the pilot study was to check whether the questionnaire was understandable and user-friendly, to identify problems with individual items, and to check whether there were any consistent non-responses to items. This is argued to strengthen the face and content validity of the questionnaire (Parahoo, 2008). No difficulties with completing the document were identified. As a result, it was decided to use the survey without modifying any of its items. The preliminary analysis of these questionnaires aided later in the analysis and interpretation of the subsequent questionnaires. Data from the pilot questionnaires were not included in the final analysis.

4.4.1.2 Ethnographic interviewing

Using interviews gives a greater depth of data and enables the researcher to explore the perspective of the individual participant. An interview can be defined as a conversation with a purpose (Maykut & Morehouse, 1994) which helps in explaining the general picture. There are several types of interviews that researchers can conduct. Silverman (2005) states that the type of questions asked, and information sought, affect the structure of the interview. In structured interviews, the questions are preset and asked in a certain order. Interviews may also be semi structured, utilising a set of questions with an open format. Finally, there are unstructured interviews which are the most flexible as interviewees are not constrained by a set of pre-prepared questions (Kvale, 1996; Taylor, 2005). In semi-structured and unstructured interviews, the researcher is free to formulate the questions and raise issues on the spur of the moment (Kumar, 2005). In general, interviews are recommended (Tod, 2006) when the research purpose is to:

- Explore a phenomenon about which little is known
- Understand context
- Verify the results from other forms of data collection
- Illuminate responses from a questionnaire
- Conduct initial exploration to generate items for a questionnaire (p. 338)

Despite the rich data a researcher can generate by conducting interviews, interviewing has its own disadvantages. For example, it can be time consuming (Kumar, 2005). Researchers can spend a lot of time contacting the interviewees, preparing tapes, listening to tapes and transcribing interviews. For the purpose of this study, I used semi-structured interviews (see Appendix 5 for the interview schedule), which require the researcher to have in mind the main points that constitute the research problem and lead the discussion in the desired direction (Legard et al., 2003). The researcher must have the capacity to be responsive to the interviewee's agenda and views (Tod, 2006). Controlling the interview, though, is not easy as some interviewees may be uncooperative; others, on the other hand, may give endless data (King, 1994) and lead the discussion away from its main focus. The interviews I conducted were time consuming and costly, especially when they involved travelling to different areas in Jordan. In some cases, I travelled more than 100 km only to find that my appointment had been rescheduled. Some participants also changed the date of their interviews without prior notification, which inevitably affected my research plan.

In addition, interviews are influenced by the personal biography of the interviewer. Nunkoosing (2005) suggests that the use of self, building a relationship, awareness of the flow of conversations, awareness of the interviewer's theoretical and professional position, and awareness of the research question are all important in maximising data quality. However, the conversation that takes place is not the reciprocal interaction of two equal partners. Interviews are always characterised by a definite asymmetry of power (Kvale, 1996; Price, 2002; Donalek, 2005) which may be influenced by the interviewer's status (high, and/or novice), class, gender, and age (Taylor, 2005; Broom, 2005). Nunkoosing (2005) and Price (2002) state that the interviewer's power rests in his or her authority as a seeker of knowledge; it also rests in the methodological expertise which shapes the course of the interview. Furthermore, the interviewer's skill in observing and picking up non verbal clues and body language may also affect interviewees' responses (Taylor, 2005). In short, the quality of interaction between the interviewer and interviewee affects the quality of information obtained.

4.4.1.3 Participant observation

'Participant observation' and 'ethnography' have both been used to imply spending long periods watching people and talking to them to see how they understand their world (Delamont, 2004). In this research, I use the term 'ethnography' to indicate the overall approach taken to the research, and 'participant observation' as one method of data collection.

Using observation as a method of data collection is encouraged in ethnography because it is likely to provide thick and rich data and help the researcher gain an understanding of a social world from the perspectives of the members inside that social world (Wallace, 2005). It is important to recognise possible variations in the roles adopted by the observer. These range from the complete participant at one extreme to the complete observer at the other (Kumar, 2005). The remaining roles fall between these poles: nearer the former is the participant-as-observer; nearer the latter is the observer-as-participant (Gold, 1958). The complete participant's identity and purpose are not necessarily known to the observed. The researcher may engage fully in the activities of the group under study and act as an ordinary member of the group. In contrast to the complete participant, the complete observer has no contact at all with those he/she is observing; no one knows the researcher is there (e.g. by using CCTV cameras).

Both roles raise ethical issues of informed consent and covert observation. The participant-as-observer develops a relationship with the participants, and they are aware of his presence, whether as a researcher or a member of their group. The researcher spends more time participating than observing. Hammersley and Atkinson (1995) suggest that the researcher must decide on the sort of role to adopt depending on the nature of the setting and the purpose of the research, but they must acknowledge that changes in role can be made during the fieldwork. My role was primarily that of an observer-as-participant. Sometimes, I assisted in menial tasks (e.g. drawing screens around the patient's bedside, and helping the nurse to position the patient).

In order to understand people's behaviour, researchers must use an approach that gives them access to the meanings that guide that behaviour (Hammersley, 1995).

Bryman (1988) suggests that participant observers are rarely simply participant observers; they often also conduct unstructured interviews, examine documents, and carry out questionnaire surveys. This variation allows inferences drawn from one data source to be followed up by another, and it may also enhance the scope and breadth of the participant observation research. Hammersley (1992) warns that to rely only on what people say about what they believe and do without observing what they actually do is to neglect the complex relationship between attitudes and behaviour. On the other hand, relying on observation without talking to participants to understand their perspectives is to risk misinterpreting their actions. Moreover, participant observation is crucial to effective fieldwork (Fetterman, 1998) which requires the observer to interact with the participants and at the same time to spend time writing the field notes and testing the initial insights in the setting (Delamont, 2004).

Doing fieldwork may not go as smoothly as one may expect. Atkinson and Hammersley (1994) report four problematic features of fieldwork identity:

- Whether the researcher is known to be a researcher by all those being studied, or only by some, or none
- How much, and what is known about the research, and by whom
- What sorts of activities are and are not engaged in by the researcher in the field , and how this locates her or him in relation to the various conceptions of category and group membership used by participants
- What the orientation of the researcher is; how completely he or she consciously adopts the orientation of insider or outsider (p. 249)

Nurse researchers who seek to study nursing practice through observation are in a unique and privileged position. Their parallel status as researcher and nurse can assist them in gaining access to the research setting and in establishing rapport with participants. Their insights into the social world of nursing can inform their data collection (Lathlean, 1994; Gerrish, 2003; Arber, 2006). However, Baillie (1995) reports some difficulties which may arise when doing observation in a nursing setting. One is that the researcher's presence as a participant observer may lead to disruption of nursing care as nurses may feel that their practice is being judged or evaluated, and as a result change their behaviour. Furthermore, the nurse researcher may experience tension between the roles of researcher and practitioner during fieldwork. Nurse researchers

might also have a feeling of guilt for observing rather than doing the work themselves, and they may find it difficult to distance themselves sufficiently from the values and beliefs that underpin their own professional practice in order to understand the social world of participants (Gerrish, 2003).

In adopting a subtle realist perspective, I anticipated that I would exert some influence on the research setting and the behaviour of participants. Yet, it was difficult to predict the extent and the nature of this effect. Moreover, this made me aware of the need to take into account the personal and social identities of both myself and the researched. The next section provides further discussion of the implications of my role as a nurse-researcher.

4.4.1.4 Recording fieldnotes

The field, fieldwork and fieldnotes are concepts used in ethnography. The field is the physical environment in which the research is taking place, while fieldwork is the data collection process (Holloway & Todres, 2006). Fieldnotes are a record of the observations the researcher has made in the field and reflections upon these, which may be written in a notebook or recorded into a dictating machine (Watson & White, 2006). Researchers are also encouraged to keep a field journal or a diary in which they jot down their thoughts about their experiences in the field as an aid to reflection and to encourage reflection upon practice (Wong et al., 1997; Fonteyn & Cahill, 1998; Jasper, 2005, Holloway & Todres, 2006; Clarke, 2009). By keeping a research diary, researchers can be systematic in their examination of the experience of being qualitative researchers. This allows new insights and deeper understanding of the research process to surface. It can also help in providing opportunities to explore emergent themes from the data and compare these themes with the researcher's previous assumptions, thus helping to establish rigour in qualitative research (Koch, 1994; Taylor, 2005, Holloway & Todres, 2006; Clarke, 2009).

As Holloway and Todres (2006) explain, these fieldnotes are subsequently used by the researchers to help them remember important issues and questions raised during the research process and excerpts are used as data or extended descriptions in

ethnographic writing. Guided by the recommendations of many researchers in the field, I decided to keep a journal to record my own feelings and reactions to my activities, as well as the participants' activities, using a diary style of writing. I have used my diary throughout the research process including the interviews, observations, transcription and analysis.

4.5   The role of the researcher in ethnographic research

The way in which the researcher interprets her/his role as an ethnographer is clearly important (Lathlean, 1994). Agar (1996), Bryman (1988) and Gerrish (1997 & 1998) explain that the ethnographer should enter the field with few preconceived ideas in order to exert minimal influence on the nature of the data collected, the analytical process, and consequently the findings. When researchers study a culture that is different from their own, they are in the position of a stranger. However, the experience of the stranger is not restricted to those moving to another society; movement among groups within a single society can produce the same effects though generally in a milder form. Even where the researcher is in a familiar setting, he/she is required to treat this as 'anthropologically strange' in order to make explicit the presuppositions he/she takes for granted as a cultural member (Hammersley, 1992): this is what Agar (1996) calls a 'professional stranger'. There are clearly advantages in adopting this stance: the researcher tries to distance her/himself from those she/he is seeking to understand in order not to impose his/her own conceptions on the situation (Lathlean, 1994). However, Lathlean argues that, it is doubtful whether the researcher is capable of suspending awareness of relevant theories and concepts until a relatively late stage in the research process.

In traditional ethnography, the researcher enters the field as an outsider or stranger, whereas for the nurse ethnographer the research setting will never be totally unfamiliar (Baillie, 1995). The latter view represents my position in this study. I have worked in two of the study settings as a nurse, and I am familiar with the nursing culture in Jordan. My background as a Jordanian nurse was inevitably of relevance to the ethnographic process, and this needed to be made overt and reflected upon throughout the

study in relation to, for example, my relationship with participants; my potential to influence the research setting; and potential ethical issues which might have arisen. My situation was not unique; it has been frequently reported that nurse researchers find it difficult to separate the two roles of nurse and researcher, and this tension inevitably influences the research process (Lathlean, 1994; Too, 1997; Gerrish, 1997 & 1998; McEvoy, 2001; Bonner & Tolhurst, 2002; Hand, 2003; Pellat, 2003; Carolan, 2003; Dearnley, 2005; Arber, 2006; Skene, 2007; Darra, 2008; Wilson, 2008).

When I introduced myself to the participants, I wondered what social category the participants would assign to me. The role of nurse researcher is not well known in Jordan, so I could not assign myself to this role. I decided to introduce myself as a PhD student. I also decided to wear what postgraduate students from the faculty of nursing (Master's and PhD) wear and put on a white coat and a name tag as a PhD student from the University of Sheffield. Like Arber (2006) I did not want to be perceived as an expert as I feared that this might affect participants' responses. However, it is common for doctoral students to be ascribed such a status, and therefore many of the participants referred to me as Dr. Zainab.

When I began fieldwork, it became clear that some of the participants were known to me, some were colleagues that I had worked with a few years earlier. It was difficult for them to treat me as a stranger when they already knew me as a 'colleague', and as someone familiar with the world of nursing in Jordan. During data collection, there was a tendency for some of them to presume that I knew from my previous experience what was 'going on', rather than explain issues in more details. This was reflected in their tendency to say 'you know that', 'you worked here' 'you know how the situation is'.

Like Lathlean (1994), Gerrish (1998), Arber (2006), Wilson (2008), and Al-Makharmreh and Lewando-Hundt (2008), I had to carefully consider the extent to which I could or should act as a stranger. This dilemma was managed in three main ways: firstly, I tried to remain conscious of the desire to acknowledge my understanding of the general context of nursing, whilst suspending any preconceptions I might have had of the

phenomenon under investigation. At the same time, I adopted an attitude of ignorance in relation to contemporary practice by explaining to the participants that I had been outside the country for more than 10 years. Secondly, it was evident that in some senses I was an 'insider' to the situation through my previous knowledge and relationships. I used this in a positive way, especially in terms of gaining access. It made it easier for me, in some settings, to gain access to participants. In recruiting participants, the partial insider status meant that I had some credibility which facilitated access and made negotiation of access easier.

On the other hand, being perceived as a doctor is a two-edged sword. Not being perceived as having such elevated status might have allowed more collaborative and reciprocal discussion. Shared experiences may act as a catalyst that helps to open up and extend the depth of a discussion (McEvoy, 2001). Knowing about my background, most of them viewed me as an expert nurse who really ought to know what the nursing situation was like in Jordan. McEvoy (2001) and Hand (2003) explain that colleagues tend to avoid stating the obvious when they use statements such as 'you were in the practice area and know how things are'. Assigning this role (doctor) might have affected what they said or did not say to me. I was also aware that the situation might have changed since my departure from Jordan ten years ago, and because of this I took the opportunity to tell them that as I had been away from Jordan for a long time and I was grateful to hear more about it from them.

Lathlean (1994) warns that this familiarity with the setting could make the researcher take things for granted and make certain assumptions about the phenomenon under investigation. She advises that the researcher has to make constant checks on her/himself to ensure that she/he was 'standing back' sufficiently from phenomena in an attempt to understand participants' distinctive ways of thinking. Keeping a journal proved to be very helpful in such situations. The notion of the researcher as 'learner' or 'novice' was found to be helpful in achieving the necessary 'strangeness'.

The following extract from my diary provides an example of how data gathering and interpretation was influenced by my background:

"My first interviews were undertaken with nurse educationalists and nurse experts in Jordan (elite participants). I was very nervous and anxious to interview them especially that some of them were my teachers when I was an undergraduate student. I represented myself as a PhD student but they perceived me as already being a doctor. I was concerned this will make them think I know many things about advanced nursing practice in Jordan; consequently, this might stop them of revealing much of the badly needed information to me. I took advantage of the occasions when they were asking me about my life abroad. I told them I was away from Jordan for more than ten years and what I really knew about nursing in Jordan is what I kept hearing from my friends whenever I visited Jordan"

Subsequently, when I reviewed data transcripts, I found that these issues undoubtedly influenced the type and the quality of the data generated. Presenting myself as a student would imply that I am learning and that I could enquire about things that would be naïve in the expert eye. The interviewee might perceive the student's role as less dominant than the researcher's role. The notion of the researcher as a learner or novice might be a useful way of getting the participants to explain their perspectives without taking for granted the researcher's knowledge (Lathlean, 1994).

4.6   The data collection process

The study was carried out in two stages. The first stage involved gaining an understanding of the broader context by which elements of ANP and M-level education are evident in Jordan both by interviewing key stakeholders and by surveying M-level nurses. Stage two involved interviewing M-level and non-M-level nurses working in clinical practice in five Jordanian hospitals and interviewing the main stakeholders with whom the nurses had contact. Finally, observation of M-level nurses who agreed to be interviewed was undertaken. The stages are summarised in figure 1:

Figure 1: Stages of the research process

Ethical approval: The University of Sheffield

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Ethical approval: The participating organisations

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The pilot study

↓

Stage 1

Semi-structured interviews with nurse educationalists	Semi-structured interviews with professional body and MOH representatives	Survey of M-level nurses

Preliminary analysis

↓

Stage 2

Semi-structured interviews with M-level nurses	Semi-structured interviews with non-M-level nurses, physicians and nurse managers	Observation of M-level nurses

Analysis, synthesis and writing up

4.6.1 Stage one

The first stage comprised interviews with nurse educationalists and nursing professional body representatives and a survey of M-level nurses in each of the participating hospitals. The fieldwork was undertaken from December 2006 to April 2007. The aim here was to explore the development of new nursing roles from a national perspective. The interviews explored participants' views of factors influencing the development of M-level education in Jordan, drivers for the development of advanced clinical roles, factors that facilitate or hinder the development of ANP, and perceptions of the impact of M-level education on nursing practice in Jordan. Interviews were digitally recorded with the participants' permission and subsequently transcribed. Each interview lasted approximately one hour and was arranged at the participants' work place, at their request.

4.6.1.1   Study settings and gaining access

In December 2005, all hospitals in the main cities (Amman and Irbid) were identified. Initial inquiries revealed a total of 52 hospitals (private, public and university). An initial approach in writing was made to the director of each hospital to ascertain whether they employed M-level nurses, and to seek their support for the study. Six hospitals responded. One possible explanation for the poor number of responding hospitals could be that the invitation letters were sent from the UK, and, with poor post office services in Jordan, these letters might not have reached the hospitals.

Information was sought from each hospital on the number of M-level graduates and the number of nurses currently pursuing Master's programmes. To assess the willingness of hospitals to participate in the study and identify the number of nurses working with M-level education, I visited Jordan in April 2006 and had preliminary discussions with the directors of nursing in the six consenting hospitals. All gave general approval for the study. However, the two M-level nurses in one of the participating hospitals had left by this time, which meant that the total number of hospitals which could be included in the study was reduced to five: one MOH hospital, three private hospitals, and one university hospital.

Following ethical approval for the study in the MOH hospital, I visited the Director of Nursing in that hospital who introduced me to the General Director of the hospital. Both were encouraging and hoped the findings would improve nursing services and patient care in the hospital. In the other hospitals, approval was gained by writing to the Director General. One of the private hospitals had a similar process for ethical approval to the MOH. Hospital directors who were supportive of the study were asked to identify someone within the organisation who could act as my point of contact in terms of accessing and recruiting participants and facilitating other aspects of the research. In all participating hospitals, the facilitator was a member of the in-service education department. Nurses were asked to indicate in the questionnaire whether they were interested in participating in the interview/observation for the second phase of the study. At the time of interviews, they were asked if they were willing to identify relevant health care workers (other nurses, physicians) who might be interested in being interviewed for the study.

Elite groups are also powerful in terms of knowledge, position, and influence, and they enjoy considerable authority (Harris et al., 2008). Fortunately, I was successful in gaining access to all elite participants that I identified except for one director of nursing with whom it was impossible to identify a mutually convenient time. Although I received general approval from the General Medical Director, I was concerned about whether I would gain access to the M-level nurses working in this hospital and their colleagues, but fortunately, access to them was not problematic.

When I visited the wards to introduce myself to the nurses, senior nurses were very interested in the study and introduced me to the other staff. Arber (2006) emphasises that gatekeepers have the power to grant or block access within a setting, and they have expectations about the researcher's identity and intentions. I was warmly welcomed by all except on one occasion when I went to meet a charge nurse who was formal and quite unfriendly when I introduced myself and the purpose of my visit to her. She was the only person who proactively asked me to show the approval letter from the hospital. Her attitude might be explained by the fact that, as a teaching hospital, many students and researchers continue to undertake their research within its settings and this might be seen

as a disruption to work. I explained the purpose of the research and assured her that I would not cause any disruption to their work. We met several times after that, and I felt that her attitude changed as she started smiling and talking to me.

4.6.1.2   Survey sample

The survey was planned to generate descriptive data from all M-level nurses in the five participating hospitals. With little known about the work of these nurses and the ways in which their new roles were being developed, practised, and implemented, the questionnaire provided important baseline data and enabled the identification of potential participants for the ethnographic study with a small sub-set of nurses. The hospital sample included university, government and private hospitals. Military hospitals were excluded from the study (see section 9.2).

The number of M-level graduates working in clinical practice in Jordan is small. The total number of such nurses in all participating hospitals was 44, of whom 31 nurses returned the questionnaire. The most appropriate means of distributing and returning the questionnaires was negotiated with each hospital. Three hospitals provided the names of M-level nurses to whom the questionnaire could be sent. The other two hospitals preferred to distribute the questionnaire to all M-level nurses on my behalf. Each participant was provided with an envelope in which he or she could put the completed questionnaire, seal it in person and hand it back to me. Return of the completed questionnaire was deemed to indicate participants' consent to participate in the survey. The limitations of the questionnaire are discussed in section 9.2.

4.6.1.3   Key stakeholders' interviews sample

The Deans of the Faculties of Nursing at the University of Jordan (Amman) and Jordan University of Science and Technology (Irbid) were approached directly to seek their support for the study and to identify educationalists who might be invited for interview. These are the only Jordanian universities that offer Masters programmes in nursing. The sample consisted of nurse educationalists involved in developing and teaching M-level education. These included the course leader and two lecturers in each university. Other key people involved three professional body representatives and the

MOH representative. These key informants were chosen because they were directly involved in setting standards for nurse education and practice in Jordan. In addition to this, selecting participants was also based on practical considerations such as who was available to take part in the study. A letter was sent to all participants outlining the purpose of the study and inviting participation. A participant information sheet was included providing full details of what involvement in the study would entail.

4.6.2 Stage two

The second stage comprised interviews with two M-level nurses in each of the participating hospitals. Data were also collected by observation of M-level nurses and by interviews with key stakeholders with whom the nurse had contact (e.g. director of nursing, other nurses, physicians). This stage of data collection took place between July 2007 and November 2007. The purpose of this stage was to obtain information about the role of M-level nurse with respect to working relationships, accountability, daily responsibilities, autonomy, authority, available resources and role evaluation. Moreover, I wanted to gain a more in-depth understanding of factors influencing the development of ANP and of the contribution of M-level education to such development. Finally, I wanted to explore the extent to which M-level education had influenced their practice, to identify managers' perspectives and expectations of these roles, and to obtain information in relation to educational preparation.

As noted earlier, the English language is commonly used in nursing practice in Jordan. However, the participants were given the chance to choose the language they wanted to use, so interviews were conducted in their preferred language (Arabic or English). All participants, except nurse educationalists, preferred to be interviewed in Arabic and to use English language where appropriate such as in using technical terms. The interviews took place at a venue convenient to the participants (all participants preferred their work place). They were digitally recorded, with the participants' permission, and supplemented with detailed field notes.

4.6.2.1 *M-level nurses' interview and observation sample*

Prior to this first phase, pilot interviews were carried out. No difficulties were

identified and no changes were made to the interview schedule. The piloting process is described in Appendix 6. The plan was to undertake semi-structured interviews and periods of observation with a purposive sample of two M-level nurses in each of the participating hospitals, resulting in a maximum overall sample of ten M-level nurses.

I approached those nurses who had indicated, in their questionnaire, that they were willing to be interviewed in a subsequent phase of data collection in order to ask them if they were still happy to take part in the study. However, as a novice researcher and due to time constraints, I decided to interview the first ten nurses who returned my calls at the beginning of stage 2 of the study, thus recruiting an opportunistic sample. I felt I owed a debt of gratitude to those participants who had indicated that they were prepared to give their time and did not want to reject any nurses who were willing to participate. The sample, therefore, consisted of the ten nurses who agreed to be interviewed. Nine of these nurses happened to be working in the ICU and one in the in-service education department. The limitation of this sampling strategy is discussed in chapter 9.

4.6.2.2   *Local stakeholders' interview sample*

Interviews were also undertaken with a range of stakeholders who had direct or indirect influence on the way the roles occupied by M-level graduates were conceptualised and operationalised in each hospital. The sample included the nurse managers and other health care professionals with whom the M-level nurses had contact. I interviewed three senior physicians, two directors of nursing, two deputy directors, two nurse supervisors, one charge nurse, two practical nurses, and five non-M-level nurses (staff nurses). Again, the decision for selecting participants was based on who was available and consented to take part in the study.

4.6.3   **Conducting the semi-structured interviews with all participants**

Broom (2005) states that inexperienced researchers need guidance on how to design an interview-based project, how to run an effective interview and how to analyse the data. I could not agree more! In the course of the interview, I needed to be aware of the participant's body language as well as pay attention to what he or she said as recommended by Arber (2006). Most importantly, I had to be careful not to lead the

interviewee into giving certain responses by asking leading questions (Wilson, 2008). Mason (2002) indicated that, to develop the skills of the researcher as an interviewer, it is advised that the researcher should practise in everyday social situation by listening to people, remembering what people have said, what he or she has asked them and observing and picking up verbal and non verbal clues. I tried to do that whenever I had the chance, trying at the same time to make people feel at ease.

As an interviewer, my aim was to establish an in-depth understanding of my interviewee's experiences and the meanings within her/his accounts of a particular action or process. To overcome my lack of confidence in conducting interviews, I sought the advice of my supervisors who recommended reading about the subject, in particular the studies that used reflection as a learning tool. She also advised me to use the digital recorder to record our meetings and then reflect upon them. After that, both of us discussed them as guided reflection. This helped me in accomplishing the practicalities of interviewing, note taking and handling the audio recorder. Bulman (2004) advises that finding someone to reflect with, such as a colleague, a mentor or a supervisor, can provide a sounding board, open up different perspectives, and provide support and guidance. I also enrolled in a two-day course on qualitative interviewing and attended several workshops on interviewing and the associated ethical issues. This prepared me to some degree and provided me with baseline information on how to conduct the interview. The two interviews I conducted for the pilot study were also extremely helpful.

It is important to remember that each participant is different, and the key to being a good interviewer is to realise that there is no right way of doing an interview (Nunkoosing, 2005). A good interviewer picks up on what motivates a person to participate and seeks to address the needs of the participant as well as the objectives of the study (Broom, 2005). In my case, all participants were welcoming and cooperative during the time of the interview. M-level participants, in particular, appeared to be keen to talk about their experience, and they were happy that someone was interested in their role. They also hoped that the findings could have an influence on shaping their role in practice. For example, one of the participants expressed his feelings about the study:

"I would like to thank you because you raised such an important issue for us; we want this subject (M-level nurses' role) to be raised and hope that your research findings will help in the development of the role"

Time was one of the vital aspects that I had to consider. Interviewing busy people and asking them to give up their time to be interviewed made me appreciate them so much. All interviews were carried out during the participants' working day, which was an important concession that the hospitals made for me as these times were the only ones during which the participants were willing to be interviewed. On two occasions, the interviews only lasted thirty minutes because of the participants' busy schedules; this might have affected the potential for in-depth clarification of issues that were raised. On three other occasions, I had to wait for two hours to meet with interviewees. Two directors of nursing in two hospitals and one professional body representative had forgotten about our meeting. The following diary extract provides an example of how strongly I felt about my study. Of course, I fully understand that other people might not have felt the same way. My frustration at any possible cancellation made me aware of how important the data collection had become to me.

"I was asked to come between 2-4 pm. I arrived at 2:30pm; there was a meeting and I had to wait till they finish. No objection as long as I have my interview. I waited till 4pm and I was afraid that the interview will be cancelled (it took me long time to get the appointment). I knew they finish work at 4pm. I think the secretary got fed up with me as I kept asking him if there was any chance of cancellation. Thank God he said that there was time and no need to worry. I was so relieved to hear that. I did not stop worrying till I shook hands with my participant. The interview went well. What a relief!"

One of the concerns about interviews is that participants might give short answers (Taylor, 2005). This, however, was not the case in my research; the participants did most of the talking. I wondered whether it was an advantage to be an active listener and give the participant more time to express their views, or if it was a sign that I lacked experience in handling interviews. Legard et al. (2003) stress that researchers need a degree of humility when interviewing senior professionals or peers. Melia (2000) suggests that less from the interviewer is more, and I think that my awareness of some of the participants being nurse researchers and experts in their area made me give them the freedom of speech. I also realised how strongly I felt about the topic, and on some occasions, as a nurse who had experienced disagreements with nursing management, I

was sympathising with the nurses. I found myself compassionate with nurses and their problems.

As a novice researcher I was concerned that I might make assumptions through my closeness to the participants, thereby missing valuable data. However, I had always to step back and remind myself of my role as a researcher. I would also record my worries and hunches in my journal so that I could look at them later from a more objective perspective. Recording and acknowledging all my worries in my diary and reflecting upon them in addition to discussing them with colleagues and supervisors made me aware of my influence, a thing I considered while I was analysing the data. I also made sure to indicate the possibility of such influence in writing the thesis to ensure that the reader knows my views and as a result can look out for signs of any potential personal influence on the study's outcome

4.6.4 Building rapport

Before the interviewer begins the interview, he or she must establish a good relationship with the interviewee to facilitate the interviewing process as well as to ensure trust, acceptance, and mutual respect (Taylor, 2005; Clarke, 2006). Holloway and Todres (2005) and Kvale (1996) suggest that researchers should begin the interview with background information or introductory questions to yield spontaneous, rich descriptions; then, they can move to more complex or sensitive questions. I began with asking the participants to tell me about their role in general. Starting with such a broad question was important to give the participants the chance to talk freely.

Gaining access to the participants' narratives was an ongoing process rather than a one off event. It involved multiple interactions over a period of time. For example, I contacted them first by email to set an appointment for the interview. Then, I visited their work place on a number of occasions to introduce myself, discuss the aims of the study, and hand over the information sheet and the consent form. By the time the data collection had started, I was known to them, and I felt that a trust relationship was developing between us. This was evident by them welcoming me and being keen to answer my questions. In addition, they declared themselves to be looking forward to the findings of

my study.

The participants' willingness to communicate with me was linked with an interest in my qualifications and my personal experience as a PhD student in the UK. Many of them asked me about how I got the offer of a university place and how I was managing my life in the UK. My availability and willingness to answer their questions seemed to encourage them to share with me their personal accounts in subsequent stages. This reciprocal interaction and my willingness to share my own accounts also seemed important in order for them to build a trusting relationship with me. Booth and Booth (1994) state that building rapport demands a measure of intimacy that goes beyond the normal relationship between the interviewer and the interviewee. Researchers are encouraged to share information about themselves and their lives in order to produce non-hierarchal relationships (Oakley, 1981; Clarke, 2006).

In most research contexts, it is frequently assumed that the interviewer is anonymous to the interviewee, and that they do not belong to the same groups and will not meet again. This, however, is not always the case as, for example, when interviewing a colleague (Platt, 1981). McEvoy (2001) emphasises that an interview with a colleague is framed in the context of an ongoing relationship. Oakley (1981) describes the research interview as a collaborative process where the researcher and the participant work together to generate the research data. Zeilani (2008) encourages researchers to show empathy, both verbal and non-verbal, not to rush the interview, to give respondents time to answer (allow silences), to have an attentive listening posture and a degree of eye contact, and to use non-verbal communication. For example, when participants talked freely about their views, I used some uttering sounds like 'hmm' 'uhh' and maintained eye contact to indicate that I was listening and was interested in their views. I also allowed silence to give them time to express their views and found that they tend to break the silence themselves and continued talking.

4.6.5   Ending the interview

Legard et al. (2003) state that about five to ten minutes before the end of the interview the researcher can signal the approach of the end of the interview to allow the interviewee gradually to return to the level of everyday social interaction. For example, I finished the interview by saying "As we are coming to end our discussion I just want to see how your role really enhanced your job satisfaction." Then, I asked them if there was anything else they would like to add, or if there was anything I had not covered that they thought was relevant. Lastly, I thanked them for their time and the rich data they had provided me with.

In general, the participants thanked me and said they were happy to participate in my study and that they were looking forward to seeing the results of my study. They also expressed their hopes for improving the situation of nursing in Jordan, especially in relation to issues discussed in the interviews. Some participants also offered their help in the future in case I needed any further information or had any enquiries. The length of the interviews varied, with a maximum length of one hour. Some researchers argue that ninety minutes is required for qualitative interviewing, while others found that participants find it hard to tolerate long interviews and feel reluctant to continue the interview when they feel there is no new information to share (Elliot, 2005).

4.6.2.3   *Observation of M- level nurses*

The fieldwork was undertaken in the five participating hospitals. In order to complement data collected from the interviews, a period of observation of the M-level nurses was undertaken. I spent 3-4 days shadowing every nurse that I interviewed, observing their day to day practice in order to gain an understanding of their role in action. The aim of the observation was to learn about the structure of the working day and provide more understanding of the role of M-level nurses from the perspective of the nurses themselves. No information was sought directly from the patients or relatives with whom the nurse had contact. I used an unstructured approach to observation by recording detailed fieldnotes of periods of observation. One of the difficulties faced by researchers is when to record fieldnotes. Ideally, notes should be recorded as quickly as possible to

avoid any loss of information. However, taking notes while observing may result in incomplete observation. I recorded the fieldnotes as soon as possible after observing an event to ensure accuracy, usually during break time. If it was not possible to record the full detail during the episode of observation, I made short descriptions at the time which I extended as soon as possible after the period of observation or interview.

In order to clarify issues raised through the period of observation, I addressed them directly with the nurses by informal discussion with them and their colleagues in their free time or at the outset of an event, asking about how and why they acted in this way, about their relationship with their colleagues and vice versa, and about their relationship with nursing management. For example, discussions concerned how they legitimised their role in practice, having their job title and job description changed.

The observation mainly took place in the ICU where the majority of nurses who agreed to be interviewed were working, with the exception of one nurse who was working in the in-service education department. On planning for the fieldwork, I wanted to collect data with minimum disruption to work routine. I was also concerned that my presence as an observer would be a nuisance for staff and patients. Consideration of what to observe from an ethical or comfort point of view, when nurses were involved in certain activities with patients deemed to be confidential or sensitive, was vital. It was made clear to nurses and patients that they could ask me to withdraw at any time or in situations where they were uncomfortable with the presence of an outsider. Clarke (2009) describes diary keeping as a personal activity and cautions that care has to be taken regarding which extracts from the diary and how much should be revealed to the reader in a way that does not compromise the confidentiality and anonymity of the participants.

Initially, I was unclear of how the role of the M-level nurse was different from that of other nurses. Working in teaching hospitals, the staff were familiar with the presence of students around them, and they were asking me what I needed to observe. Some non- M-level nurses thought I was evaluating the M-level nurses, so they were very careful when they were talking around me. I did not want them to alter their behaviour for any reason, so I kept reminding them of the purpose of my study. I also felt that they

later became more relaxed and friendly. I did feel uncomfortable, however, when observing distressed relatives and patients. One of the experiences the researchers go through is the tension between their role as researchers and their role as practitioners (Gerrish 1997). The following personal experience explains my feelings in one such situation:

"In one ICU, a child was admitted following a road traffic accident and was unconscious with his family crying around him. They were so distressed and kept asking about his prognosis. I wondered what to do. Should I try and offer some comfort to the relatives as a nurse would do? There was tension between my role as a researcher and my role as a nurse. Yet I felt I could cause some embarrassment to other nurses if I intervened, and the relatives might ask me questions that I might not be able to answer as I knew little about their child. I decided to step back and maintain the role of the researcher even though I was not entirely comfortable about this decision"

4.7   Data analysis

4.7.1   Quantitative data analysis

In the first instance, each item in the questionnaire was coded and entered into an Excel spreadsheet. Microsoft Excel enables efficient storage and organisation of data and basic statistical manipulation. Free text data were subject to separate content analysis and were entered into Microsoft Word files.

Quantitative data can be analysed by a variety of statistical methods. For the purpose of this study, descriptive statistics were used to describe various aspects of the sample of respondents. The data were divided into categories and presented as frequency tables. The first step in analysing these categorical data was to count the number of observations in each category and express them as percentages of the total sample size. An initial approach to analysis was to describe the mean and the standard deviation of each variable.

4.7.2   Qualitative data analysis

Data analysis in ethnography is not a distinct stage of the research. It starts in the pre-field work phase and continues through the research process (Hammersley & Atkinson, 1995, 2007). In general, ethnographers deal with unstructured data which take

the form of open-ended verbal descriptions in fieldnotes, transcriptions of audio/video recordings, or extracts of text from documents. Hammersley and Atkinson report that the process of analysis involves, simultaneously, the development of a set of analytic categories that capture the relevant aspects of these data, and the assignment of particular items of data to these categories.

Qualitative analysis requires rigour and investment in time and energy for training (Roper & Shapira, 2000; Broom, 2005) in order for the researcher to develop what are often underestimated skills (Ingleton & Seymour, 2001). Analysis involves interaction with the data, which are scanned and organised from the start of data collection, enabling the focus on particular issues to become clearer as the research progresses (Holloway & Todres, 2006). Qualitative analysis also involves a pivotal process of reflection and creative interpretation (Ingleton & Seymour, 2001).

Ingleton and Seymour (2001) argue that qualitative analysis is fundamentally a creative endeavour, involving an intuitive process that cannot easily be clarified to others. It is also argued that the analysis is not linear but an iterative, back and forth, process which can sometimes be experienced as unfocussed and messy (Holloway & Todres, 2006; Roper & Shapira, 2000). Throughout the early stages of this research, I continued to read what other people had written about data analysis to gain an understanding of the process and was, ultimately, guided by the work of Mason (2002).

Mason (2002) outlines three broad approaches to sorting and organising qualitative data. They are: cross-sectional and categorical indexing, non-cross-sectional data organisation, and the use of diagrams and charts. For the purpose of this study I used the first approach for several reasons. Firstly, cross-sectional indexing is most readily applied to text-based data such as interviews and field notes. Secondly, I was able to obtain a systematic overview of the data and develop a clear idea of their coverage and scope. In this way, I was able to distance myself from memorable elements, and therefore gain a more measured view of the whole. Thirdly, when I got a sense of the scope and coverage of my data, this helped me in my conceptual, analytical and theoretical thinking.

The development of analytical categories must be driven by the research design and the epistemological and ontological stance (Mason, 2002). Ontologically, I needed to be clear about what kinds of phenomena my categories were supposed to represent. In my study, for example, the categories represented different participants' accounts and understandings of the concept of advanced practice and the role of the M-level nurse in practice. Nevertheless, in acknowledging the importance of context in understanding events and meanings, I also took into account the effects of myself and the research strategy on the findings. Epistemologically, I needed to think carefully about how these indexing categories represented instances of these ontological phenomena, and what kind of knowledge they constituted. For example, producing interpretative and reflexive categories meant that they were likely to be based on what I thought they implied. This would involve reading not only what a text actually contained, but the implications of what was not present literally in the text, including its context. However, before doing so, Mason (2002) emphasises the need to know how to recognise and read the data. She proposes three different ways to do this: reading data literally, interpretively, and reflexively. The following discussion illustrates how each form of reading manifested in my study:

Literal reading was undertaken by reading and re-reading the transcript, listening to the tape, and comparing the transcript with the tape. Ingleton and Seymour (2001) describe this mode of reading as a mechanical process which involves labelling, categorising, and collapsing data into themes. However, most qualitative researchers do not stop there; many would also suggest that purely literal reading is not possible because the social world is always already interpreted and because what we see is shaped by how we see it (Mason, 2002). Whilst this process required a considerable investment of time, I found it productive as it allowed me to recall my experiences and aided my familiarity with the interview data and started to highlight important issues and areas for further research attention. Each script was then re-read, and specific words were highlighted to produce codes. The codes were the participants' own words, and provided the basic building blocks of the analytical process. As the coding developed, analytical notes were made with reference to repeated words, compared for similarities

and differences, contrasting issues that were raised, or areas for exploration with the current literature. This was done with constant reference to the research questions.

Interpretive reading involves an attempt to look into the underlying significance, or to go beyond the meaning of words and actions (Mason, 2002). Interpretive reading involves constructing a version of what these data might mean or represent, or what the researcher thinks she/he can infer from them. In other words, reading is done through or beyond the data in some way. For example, reading a section of an interview transcript may tell something about the implicit norms or rules with which the interviewee is operating, how his/her narratives are affected by social actions, and how they make sense of social phenomena and what interpretation they have. Alternatively, there may be more emphasis on my own perspectives and interests.

Reflexive reading locates the researcher as part of the data and seeks to explore the researcher's role in the data generation process. It involves a process of self examination, specifically relating to how the researcher's past experiences, beliefs and values impact on the setting and phenomenon being studied (Ingleton & Seymour, 2001; Mason, 2002).

The first stage of analysis began with transcribing the interviews. I transcribed the interviews myself. Maclean et al., (2004) suggest that this can help to ensure the anonymity of the participants. It also increases the exposure of the researcher to the data. I typed the transcript by listening to the recordings in small sections and reviewing them more than once following the recommendations of Johnson (1995). Similar to Zeilani (2008) I found this process to be laborious and time consuming. It involved listening to the recording several times, rewinding repeatedly to get a clear understanding of what had been said. Dearnley (2005) and Johnson (1995) suggest that a one-hour interview might take five hours to type verbatim. A thirty minute interview took me six to eight hours to transcribe. I transcribed the interviews immediately after each interview and made no attempt to correct the spoken English of participants. I transcribed the Arabic interviews word-by-word. This helped me to examine the perspectives of participants and examine my involvement in them. Similar to Darra (2008), I listened carefully to the

recordings and discovered that how I chose to phrase questions could reveal my values and areas of interest. This has been acknowledged throughout the research process and the interpretation of findings.

I also sought support from another researcher who read some of the transcripts and compared them against the original. The involvement of another person as Jasper (1994) describes might defend against the researcher's subjectivity. It also meant that I had someone with whom I could discuss the interviews. This might raise ethical questions about the confidentiality of participants. However, the fact that I made the transcripts anonymous and that the other researcher is from a totally different field and had no idea about hospitals in Jordan helped in securing their confidentiality.

In relation to those interviews carried out in Arabic, the first major task before the interviews was to translate the research questions and meanings to a form understood by participants. The second task after transcribing the interviews was to translate their narratives in a way that could be understood by others. Translation usually involves translating the source language (Arabic) to a target language (English) and back translation (Twinn, 1997; Esposito, 2001). I decided to translate the transcript based on the whole meaning of narratives and not word for word. I also made the decision to translate the transcripts myself. I found that, in addition to being very expensive, professional translators in Jordan tend to translate texts word for word, and are not familiar with health care terminology. I then asked an independent researcher who is fluent both in Arabic and English to check some of translated data. We discussed our translation and clarified any differences. I learnt that the translation process is also laborious and time consuming and can result in many grammatical errors. One of the issues that arose with translation is that nurses in Jordan use a mixed vocabulary of English and Arabic. This is due to the fact that nursing is taught in English and some terminologies are not translated into Arabic.

My main concern in analysing the data was whether I was doing it properly, and if I was making enough sense of the data. I was encouraged by my supervisors during the analytical process to think conceptually, to develop a coding framework, and to become

alert to the emerging categories and themes. I continued to read what other people had written about data analysis to gain an understanding of the process. I was also concerned about the potential for the identification of some participants through their narratives and made it clear that anonymising participants could not guarantee the protection of their identities. This was particularly evident in the case of some elite participants. This did not seem to be a concern to the participants, and they freely expressed when they wanted their narratives to be 'off the record'. Such data were not included in the analysis.

The main steps in my data analysis were:

1. Listening to the recording and comparing the transcript with the recording and data checking (familiarisation).

2. Reading the transcript intensively to get implicit and explicit emergent meanings,

3. Underlining key words or elements in the text, isolating them and giving them code numbers. The process of underlining the key words that seemed to represent the feelings of the interviewee and looking for relations achieved a series of labels relevant to the aim of the interview. I also referred to my research diaries.

4. Developing categories and coding by breaking down the data, identifying common issues, looking for similarities and differences, and giving each important section a descriptive label.

5. Writing a short summary

6. Once coding was completed, codes with similar meaning or themes linked to the same area of analysis were grouped together (Categories were those relevant to research objectives and those highlighting other issues that were not considered previously). This stage also involved reducing the interpretation to a number of general and sub themes, and assigning data to these themes. Each piece of data related to a category was lifted from the transcript and put onto a sheet of paper. To ensure anonymity and confidentiality no names, or profiles of participants, participating hospitals were included.

7. Exploring the role of the researcher in the data generation process by considering the reflexive notes (self-examination, how the researcher's past experiences, beliefs, and values influenced the setting and phenomenon being studied)

8. Coding to reflect the substantive issues emerging from the general and sub themes. This entailed interpretation of meaning.

9. An independent researcher was asked to cross reference some of the data, and any discrepancies between my analysis and hers were discussed and resolved.

10. Presenting the findings in several chapters under general headings. Quantitative data were presented as a discrete chapter. Qualitative data from the survey were integrated with those from the interviews and observational data.

4.8. Ethical considerations

There is no national ethical approval system in Jordan, so ethical approval had to be gained separately from each hospital, each of which have different ethical approval protocols (see Appendix 7 for ethical approval documents). However, the MOH recently established an ethical committee which reviews all research projects to be conducted in any MOH settings. An application form was completed with all documents attached (proposal, information sheet, cover letter, consent form, and ethical consideration). The MOH ethical committee reviewed the research project and approved it. Ethical issues were not confined to specific stages of the research. They started at the moment of choosing the topic of the research. Moreover, participants were recruited only if they were willing to participate. Gaining and retaining consent was an on-going process throughout the research project. Each participant was asked to sign a consent form to take part in the study, except for the questionnaire, where return of the completed questionnaire was held to indicate consent.

Participating in the study was voluntary, and each participant was asked to sign a consent form prior to the interviews, and where relevant prior to observation. Signing the consent form was not a straightforward process, and I was concerned that participants were not worried about signing, especially when I heard a lot of comments such as 'there is no need; I trust you'. Before the interview, I checked if the participants had read and understood the information sheet and the purpose of the study. To avoid embarrassing them, I asked them first about what they thought their involvement in the study would be like. I found that many of them had not read the information sheet. Therefore, I felt a

responsibility to go through the information sheet and explain the purpose of the study before initiating data collection.

With all the interviews I sought the permission of all participants to use the digital recorder. On two occasions, I felt that participants felt anxious about recording their interviews. I assured them that all the information they shared with me would be kept confidential and anonymous, and that they could stop the recording whenever they wanted. I also encountered occasions when the participant was talking and then would say 'off the record'. I respected their wish not to share that part of their account and did not use it as part of my data despite it being recorded.

The following ethical considerations were addressed:

1. The research proposal was approved by the Research Ethics Committee of the University of Sheffield, UK and the Ethics Committee in each hospital before the study commenced.

2. Informed consent was sought from all research participants. Each potential participant was provided with an information sheet which explained the purpose of the study and the involvement it would entail. It also stressed the voluntary nature of participation.

3. Return of the completed questionnaire indicated participants' consent to participate in the survey. Written consent was obtained from all participants who were interviewed. Participants were free to withdraw from the study at any time.

4. Every effort was made in advance to draw the research to the attention of the patients and health care staff with whom the nurse being observed might interact. This was done, for example, by displaying posters about the study in clinical areas and attending ward meetings. The nurses were asked to seek verbal agreement from the people with whom they interacted so that they would agree to the researcher being present. This was done to reduce the risk of people feeling pressurised by the researcher in being observed. I told the nurses that I would withdraw from any situations that the nurses, patients, or other health care staff might feel they did not wish to be observed in.

5. It was possible that cases of unsafe practice which had not been remedied might

be observed. In these situations it was agreed that I would act in accordance with the requirements of local hospital policy and my honorary contract with that hospital; standard procedures specified in the contract would be instituted. This might involve reporting to appropriate authorities. Should this situation arise, it was agreed that it would be discussed with the nurse before any action was taken. In the event this did not prove necessary.

6. I had to be sensitive to cultural issues related to gender. In some hospitals it was not possible for a female nurse to be present with male patients.

7. The primary data collected during the course of the study were kept confidential and were not shared with any other parties. Only the researcher and her supervisors had access to the data. At later stages, an independent researcher had access to selected, anonymised data. Every effort was made to ensure that the individuals and organisations that participated could not be identified. Pseudonyms were appropriate to preserve anonymity and to safeguard confidentiality.

8. All raw data were stored securely in a locked cupboard and electronic data were stored on a password-protected computer and made available only to the researcher. Transcripts of recordings were anonymised, and no information that could identify individuals was recorded. Personal details relating to participants were stored separately from transcripts.

9. The reports arising from the study will not identify any individuals or organisations that have taken part. In order to ensure that individuals from participating hospitals cannot be identified in the reports, information obtained were brought together and reported collectively rather than in relation to each hospital or health sector.

10. Although anonymity was a general principle, in some cases, the anonymity of the participants might be threatened by detailed description of the research process and the participants' roles as well as by the excerpts from interview and observation data. Elite participants were given the choice of revealing information that might disclose their identity. They stated clearly, during the interview, that information they did not wish to share with others should be kept 'off records'.

4.9   Trustworthiness and rigour

There has been considerable debate over whether qualitative and quantitative methods can be assessed to the same quality criteria. Given the assumption of multiple, constructed realities, anti-realists argue that qualitative research represents a distinctive paradigm, and therefore should not be judged by conventional measures of validity, generalisability, and reliability (Mays & Pope, 2000). Murphy et al. (1998) argue that this position is unnecessarily constraining, and is likely to render qualitative research of very limited usefulness in applied fields. The advocates of subtle realism argue that there is an underlying reality which can be studied with an attempt to represent that reality rather than to attain the truth. From this position it is possible to compare the different perspectives offered by different research processes with each other and against the criteria of quality common to both qualitative and quantitative research, particularly validity and relevance (Murphy et al., 1998; Mays & Pope, 2000).

The validity and reliability of qualitative research are often referred to as 'rigour' (Ingleton & Seymour, 2001). There is a range of methods which may enhance rigour in qualitative research. I used reflexivity as a way of enhancing rigour in my study. Acording to Ingleton and Seymour (2001), the success of these methods depends on the extent to which the researcher is able to gain access to and immersion within the fieldwork setting, and the degree to which he/she is able to enter the lived world of the participants). Trustworthiness means the research process has been conducted fairly, and its product represents as closely as possible the experiences of those being studied (Baillie, 1995).

Ethnography has been challenged on its claims that ethnographic accounts represent reality. The critics claim that this is not possible because researchers have no access to an independent reality and the ethnographer's account is just as much an interpretation as those of the people he/she is studying. In order to represent reality, ethnographers rely on rhetorical devices (Hammersley, 1990). These critics do not reject the use of rhetorical devices, but what they want is more honest rhetoric, or rhetoric that

does not pretend an unattainable realism. For example, texts can incorporate the voices of the researched in a more substantial and less controlled way

Large sample size has little significance in qualitative research. By choosing small samples, ethnographers usually study cases in depth rather than in breadth. Furthermore, ethnographers are often not concerned with empirical generalisation. Instead, they are concerned with making theoretical inferences, and this does not require the case studied to be representative. Finally, replication is not always possible in social science. The fact that it may not be possible does not detract from the validity of ethnographic findings.

Given the purpose of this study, trustworthiness was achieved through reflexivity which is further described in the following section.

4.9.1 Reflexivity

To increase the rigour of ethnographic research, it is suggested that researchers include a reflexive account in their report (Koch & Harrington, 1998). One strategy involves the use of an audit trail: a record of the researcher's decisions about gaining access, selection of field role, choice of participants, ethical consideration, and analytical methods (Holloway, 2005). The effects of personal characteristics such as age, sex, social class and professional status on the data and on the distance between the researcher and participants need to be pointed out and later discussed (Mays & Pope, 2000). Sharkey and Larsen (2005) state that the interpersonal nature of ethnographic research requires a reflexive approach to acknowledge the process and the content of the data. Finlay (2002) sees reflexivity as "a confessional account of methodology or as examining one's own personal, possibly unconscious, reactions. It can also mean exploring the dynamics of the researcher-researched relationship and how the research is co-constituted" (p.536). As a result, it can be assumed that the research process is influenced by the researcher's characteristics and personal values. In other words, the researcher and the research cannot be separated where reflective writing contributes to the trustworthiness of a research study (Mason, 2002; Taylor, 2005; Jasper, 2005).

Hammersley and Atkinson (1995) argue that both positivism and naturalism fail to take into account the fact that social researchers are part of the social world they study,

suggesting that both are concerned with eliminating the effects of the researcher on the data. They continue to argue that there is no way in which we can escape the social world in order to study it. Ethnographers recognise that they are unable to put their own knowledge of the social world to one side in the hope of achieving objectivity (Pellatt, 2003). Savage (2000) explains how ethnography is viewed as contextual and reflexive: it emphasises the importance of context in understanding events and meanings, and takes into account the effects of the researcher and the research strategy on the findings.

It is evident from the literature that most students and practitioners initially find reflexivity difficult, and sometimes fail to demonstrate critical analysis of situations (Atkins & Murphy, 1993; Jasper, 1994; Fonteyn & Cahill, 1998; Spencer & Nowell, 1999; Duke & Appleton, 2000; Glaze, 2001; Paget, 2001; Kember et al., 2001; Liimatainen, 2001; Taylor, 2003; Clancy, 2007). However, they later find acknowledging and accepting feelings and emotions useful; they also show improvement in critical analysis. To stress the importance of reflection, some researchers conveyed their own reflective insights in conducting qualitative research (Dearnley, 2005; Perry et al., 2004; Wall et al., 2004; Pellatt, 2003; Carolan, 2003; Hand, 2003; Hodgson, 2001).

When I decided to undertake my Master's degree, I hoped to develop new skills in research and critical analysis. It was not easy for me to return to education after thirteen years of clinical work, and I experienced difficulties in writing assignments. Amongst the skills that were introduced to me was reflection. Reflection helped me to deal with several issues I encountered during my years of study in the UK, and I think it will always be part of my practice whether as a nurse, an educator or a researcher. However, a full-time one-year course was not enough for me to develop my critical analysis skills further. When I first started learning about reflection, I tended to be (and still am) more descriptive and found it difficult to integrate theory with practice. Making reflection public was a concern for me as I was not used to sharing my feelings and thoughts with others. With time, I realised the benefits of disclosing reflective writing for me and for others.

Atkins and Murphy (1993) found in their literature review on reflection a lack of

clarity and definition of the concept of reflection. They identified three key stages in the reflective process. The first stage is an awareness of uncomfortable feelings and thoughts. Here, the practitioner realises that the knowledge one is applying is not sufficient to explain what is happening in the unique situation. The second stage involves a critical analysis of the situation, which is constructive and involves an examination of feelings and knowledge. The third stage involves the development of a new perspective on the situation leading to learning from experience. As a researcher, I strove to be fully aware of my effect on the study.

4.10 Conclusion

In this chapter, I have discussed the philosophical stances underpinning the chosen research methodology. The main aim of the study was to examine the extent to which ANP is evident in Jordan, with a particular focus on the contribution of M-level nurses. By choosing ethnography, I sought access to the 'insider view' of participants with the intention of investigating the culture under study by means of interviewing and observation. I wanted to gain in-depth accounts on different perspectives. However, the application of this approach has its limitations. The subjectivity of the researcher in qualitative research is seen as weakening the credibility of the findings. One way of resolving this problem is by using reflexivity to raise awareness of the ways in which self affects both the research process and outcomes, and to rigorously convey to readers of the research an account of how this happens. By acknowledging my role and influence on the research process, I have striven to understand more clearly the deeper meaning of the phenomena under investigation.

In order to judge the quality of quantitative research, researchers normally use the concepts of reliability and validity. However, the appropriateness of using these concepts in qualitative research is questionable. Therefore, different criteria are required to assess qualitative research based on the concept of trustworthiness. I have argued for the adoption of a more tentative position referred to as subtle realism. Following discussion of the methodology, study design and data collection, subsequent chapters will present the findings of the study.

Chapter 5

Survey of M-level nurses

5.1. Introduction

The purpose and the conduct of the survey have been described in chapter 4. This chapter presents the findings of the quantitative data from the questionnaire, and discusses these in light of the broader nursing literature.

5.2. Findings

5.2.1 Response rate

Out of 44 questionnaires sent to respondents, 31 were returned. A low response rate can have a significant impact on the usefulness of findings (Murphy-Black, 2006). The level of response varies considerably in published research as it depends on the nature of the study. However, the response rate for this survey was 70%, which can be considered to be good (Murphy-Black, 2006).

Researchers are encouraged to use certain strategies to improve the response to questionnaires (Parahoo, 2008). In this case, the fact that each participant was sent a personalised questionnaire and a personal letter may have helped in getting a response from them. Moreover, all respondents provided free text data, indicating that they were interested in the study and were willing to spend time recording their opinions. Feedback to me personally from the nurses who completed the questionnaire indicated that they were interested in the study and keen to see the findings disseminated to policy and decision makers in Jordan.

Although the literature on surveys suggests that a personally delivered questionnaire has the advantage of a better response rate (Murphy-Black, 2006), I received a good response rate from hospitals who chose to distribute the questionnaire on my behalf. It was not possible to determine the characteristics of non-respondents, and the potential for some biasing of responses is, therefore, acknowledged; for example, it is

possible that those who did not return the questionnaire held particular views, or were more unhappy with their work than respondents (The potential of bias is explored in section 9.2).

5.2.2   Demographic data

Demographic data were generated in relation to the respondents': sex, age, general nursing experience, experience after earning the Master's qualification, and the nature of their Master's qualification. These data were subjected to descriptive analysis.

5.2.2.1   Sex

Nineteen (61%) respondents were female, and 12 (39%) were male nurses. This does not reflect the current gender distribution amongst registered nurses in Jordan, where 54% of registered nurses are females and 46% are males (Table 3). It is possible that the gender distribution of M-level graduates may not reflect that of the general population of nurses, but this cannot be verified as there are no formal records of the number of nurses with a Master's degree in Jordan. The gender distribution seen in this study is likely to reflect the sampling strategy utilised (see section 9.2).

5.2.2.2   Age

Respondents' age ranged between 24-42 years (Mean = 30.7, Standard Deviation = 5.58 years). The nursing workforce in Jordan is known to be relatively young, and Mrayyan (2005), Mrayyan and Al-Faouri (2008), and Hayajneh (2009) reported similar age ranges in their studies of Jordanian nurses. The average age of qualified nurses in these studies ranged from 22-36 years. My observation in different participating hospitals also indicated a relatively young nursing workforce. This age-profile could be related to the fact that nurses, particularly married nurses and female nurses, may leave nursing for family reasons or because of inconvenient work schedules and rotating night shifts (Petro-Nustas et al, 2001). In addition, many experienced qualified nurses, in particular male nurses, leave the country looking for better work opportunities and higher salaries outside Jordan (Petro-Nustas et al, 2001). This is discussed further in section 8.4.1.4.

5.2.2.3 Length of professional experience

Respondents' experience ranged from 2-22 years since they first earned a nursing qualification (Mean = 9.6 years, Standard Deviation = 5.97 years), indicating an experienced nursing workforce, as would be expected with M-level nurses.

5.2.2.4 Length of time in current job

The respondents had experience in their current jobs (at the time of data collection) that ranged from 1-15 years (Mean = 4.7 years, Standard deviation = 3.4 years), which suggests that these nurses not only have experience of general nature in nursing, but also they are relatively experienced in their particular settings.

5.2.2.5 Time since obtaining a Master's degree

A maximum of eight years had passed since the respondents had received their Master's degree (Mean = 1.65 years, Standard Deviation = 2.1 years). A mean of 1.65 years suggests that the majority of respondents had received their Master's degree very recently.

5.2.2.6 The Master's qualifications

All respondents were awarded their Master's degrees from Jordanian universities. There are no official records of the number of Master's graduates in the country, nor are there records of where they earned their qualifications. However, it seems likely that most M-level nurses would have pursued higher studies in Jordan because of the attempt by the sponsoring organisations, including the Jordanian government, to encourage nurses to undertake their Master's degree in Jordan to reduce the costs of studying (MOH, Personal communications, 1st Feb 2007). Moreover, it is convenient for those who cannot afford to study overseas or who do not want to leave their jobs or their families.

Nine (29%) respondents earned their Master's degree in disciplines other than nursing such as speech therapy, public health, administration, and quality management (table 5). Factors influencing choice of Master's degree are explored in section 7.2.

Table 5: Master's qualification (speciality) in the survey sample

	Frequency	%
Critical care	22	71
Education	2	6
Public health	2	6
Administration	2	6
Speech therapy	1	3
Quality management	1	3
Community health	1	3
Total	31	98[3]

However, 22 (71%) respondents held a Master's qualification in critical care (table 6), reflecting the large number of students graduating from this specific programme. The dominance of critical care over other specialities in the sample might also be attributed to the fact that the study was conducted in hospitals rather than clinics, and may have been further influenced by the sampling strategy utilised (see section 9.2).

Robertson (2004) attributed the emphasis on acute care in the United States to medical innovations in the twentieth century, whereby the biomedicalisation of the health care system greatly influenced nursing education and practice. Similarly, in Jordan, there has been a rapid expansion of medical technology and an increase in complex diagnostic and therapeutic procedures with a number of highly specialised hospitals opening in the last decade. These hospitals not only meet the needs of the Jordanian population but also provide diagnostic and therapeutic management for patients from the neighbouring Arab countries who come for treatment and undergo major operations such as open heart surgeries and kidney transplants. In Jordan, community care is less well emphasised in undergraduate curricula, leading to the powerful influence of acute care on nursing students' career and graduate education choices (Petro-Nustas et al., 2001).

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[3] Totals do not add up to 100% due to rounding

Petro-Nustas et al. (2001) note that educational reforms in Jordan are essential to meet the changing health care needs of society and to adapt to the complex health care system. Dunn (1996) explains that an increase in the 'acuity' of hospital populations, and in the technological nature of care, has implications for the nursing profession. It creates an increased demand for nurses who are able to provide effective nursing care for critically ill patients within a highly sophisticated technological environment. The skills and knowledge required for the critical care nurse are beyond the scope of undergraduate programmes. To be able to possess a variety of advanced nursing skills and function effectively in the critical care environment, the nurse must have access to postgraduate education. Consequently, it can be said that the acute care of individuals remains the dominant focus of nursing education, and hospitals continue to be the practice setting of choice for most nursing graduates in Jordan.

5.2.2.7   *Job title*

Fifteen (48%) respondents described themselves as 'staff nurses' (table 6). In a few cases, titles were specific to practice areas; for example, those who worked in in-service education departments were called 'education co-ordinators' or 'clinical instructors'. This suggests that the majority were in direct patient care posts equivalent (in title) to non-M-level nurses.

Table 6: Respondents' self- reported job title

Job title	Frequency	%
Staff nurse	15	48
Education co-ordinator	5	16
Charge Nurse	3	10
Head Nurse	3	10
Supervisor	2	6
Quality nurse co-ordinator	1	3
Chief of Respiratory Dept	1	3
Clinical instructor	1	3
Total	31	99[4]

[4] Totals do not add up to 100% due to rounding

Eight (26%) respondents reported a change of job title after completion of their Masters' degree. Table 7 shows the transition they made from their previous job title to the job title at the time of data collection.

Table 7: Respondents' changes of job title

From – to	Frequency	% of those with changes of job title
Staff nurse to education co-ordinator	3	38
Senior nurse to area supervisor	2	25
Charge nurse to quality nurse co-ordinator	1	13
Staff nurse to clinical instructor	1	13
Respiratory therapist/staff nurse to chief of respiratory department	1	13
Total	8	102[5]

Changes in job titles suggest a tendency to move towards 'non-direct' patient care: educational, administrative, and managerial posts rather than 'direct' patient care ones. Francis et al. (2007) state that the clinical focus in postgraduate education in Jordan reflects the need to develop advanced clinical nursing practice. However, Shuriquie (2006) has argued that hospital administrators do not yet recognise nurses with Master's qualifications, or their potential impact on clinical practice. She points out that nurses with Master's or higher qualifications in Jordan are expected to undertake tasks related to education or management. While Master's graduates may be valued with respect to such specific domains of practice, their contribution to direct patient care in Jordan may not be fully realised. These findings find resonance in the broader literature. For example, in the UK, Gibbon and Luker (1995) report a tendency for teaching and management to dominate academic nursing development. These findings were also emphasised by Hardy et al. (1984) whose study findings showed that the majority of their respondents in the UK moved to more senior but non-clinical posts on gaining their Master's degrees.

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[5] Totals do not add up to 100% due to rounding

Read et al. (2004) emphasise that, in the UK, nurses with higher education are generally expected to step back from hands-on involvement with patient care and assume a managerial and educational role. Hardy et al., and Sinclair et al. (1984) agree that academic study can only serve to take nurses away from practice, and this appears to be reflected in the experiences of Jordanian nurses with Master's qualifications. This issue will be explored in section 8.4.1.4.

However, in a recent work in Ireland, Drennan (2008) reported contrasting findings, where the majority of M-level nurses in his study continued to take up clinical posts. This trend was seen in relation to the Irish Government recommendations for a career pathway for nurses which resulted in creating promotional opportunities for them (Drennan, 2007; Joyce & Cowman, 2007). Drennan stresses that this is a reversal of the trend seen in Ireland and England in the mid to late 1990s where the majority of graduates from Master's programmes left clinical practice to take up posts in nurse education, with a few obtaining senior management positions.

In the current study, respondents who had no change in their job titles were asked, in a free text question, to give reasons why no change had taken place. Table (8) shows the reported reasons. 'Hospital policy' was most frequently reported by the nurses as a reason for not having their title changed. There are, of course, a number of possible interpretations of respondents' reference to hospital policy. The apparent lack of any clear consensus about the role of M-level nurses in hospitals is a matter of concern. It is customary to find some strong bureaucracies within health care and hospital policies that may hinder or restrict nurses' contribution to practice (Shuriquie, 2008; Mrayyan, 2004; Oweis, 2005).

Table 8: Respondents' reasons for not having their title changed

	Frequency	% of those without title change
'Hospital policy'	11	48
'The ANP role is not accredited in Jordan'	5	22
'I am still new graduate and I am not entitled to title change'	3	13
'I did not have approval from hospital to undertake Master's degree'	2	9
'No vacancy for ANP role'	1	4
'I do not know'	1	4
Total	23	100

Discussions with nurses and managers indicate that hospitals' policies in Jordan require nurses to apply for permission to study and to get approval from their work place to pursue higher education. When nurses are not granted this approval, any promotion or incentive that an M-level nurse could be entitled to as a result of undertaking Master's education may not be available.

Of all the respondents, five (22%) reported that they had not had their title changed because the role of advanced practitioner is not yet accredited in Jordan (see section 8.4.1.1). This lack of recognition leaves hospitals to set their own policies. Three (13%) respondents suggested that, as they had only graduated recently, they anticipate that over time some changes in their job title will eventually take place.

5.2.3   Job description

When respondents were asked if they had a job description, 20 (65%) indicated that they had, nine (29%) reported that they did not, and two (6%) indicated that they were not sure. Twenty five (81%) respondents stated that gaining a Master's qualification did not result in a change to their job description. The respondents were also asked to explain how their job description had changed, or why it had not changed. Two (6%) respondents stated that their job description changed from being involved with direct

patient care to administrative, managerial and training responsibilities. Three (10%) respondents had their job description changed to being members of the in-service education department.

Respondents who had maintained the same job description following completion of their Master's degree cited a variety of reasons for this continuity (Table 9). There are clear similarities between this data and the reasons given for continuity in job titles.

Table 9: Respondents' reasons for not having their job description changed

	Frequency	% of those who did not have their job description changed
Hospital policy	6	24
I am still a new graduate	4	16
Job description is the same for all nurses	3	12
Did not have approval from hospital to undertake Master's degree	2	8
The role is not accredited in Jordan	2	8
No vacancy for ANP role	1	4
Not answered	7	28
Total	25	100

Using pre-determined categories, only eight (26%) respondents indicated that this job description reflected their current role (Table 10). Mrayyan (2004) and the JNC (2006) report two issues in nursing practice in Jordan which relate to job descriptions. Firstly, job descriptions are written in unfamiliar terminology using complex sentence structures: this may be part of the reason why nurses do not know if their job description reflects their role. Secondly, job descriptions are often not reviewed and updated periodically to keep them current. These findings reflect findings reported by Read et al. (2001) in the UK in which few respondents felt that their job description reflected their current role. The authors warn that this has serious implications for nursing practice in

general, when nurses are unable to define their role, duties, responsibilities and performance.

Table 10: The extent to which job description reflects current role

	Frequency	%
Very well	1	3
Reasonably well	7	23
Not very well	11	35
Not at all	5	16
Not sure	2	6
Not answered	5	16
Total	31	100

5.2.4   Respondents' areas of practice

Eighteen (57%) respondents worked in intensive care units (medical, surgical, coronary, and neonatal). These nurses had been working in these units prior to undertaking their Master's and continued to do so afterwards, including one nurse holding a Master's in community health who was still working in intensive care. Francis et al. (2005) report that the primary health care sector in Jordan finds it difficult to recruit and retain registered nurses. Mrayyan (2004) further states that many nurses do not value primary care nursing practice, and therefore do not consider practice in these settings as a career option. Furthermore, although primary health care is repeatedly said to be a priority for the MOH, hospital services continue to absorb the majority of the Ministry's staff and expenditure (Huddart, 2005). It was also noted that, amongst respondents working in in-service education departments, only one nurse held a Master's in education while the rest had their Master's qualifications in critical care (Table 11).

Table 11: Respondents' areas of practice

	Frequency	%
Intensive care	18	58
In-service education	4	13
Orthopaedics	2	6
Surgery	2	6
Respiratory therapy	1	3
Emergency	1	3
Renal	1	3
Quality assurance	1	3
Medical oncology	1	3
Total	31	97[6]

5.2.5   Respondents' practice responsibility

Twenty-two (71%) respondents had single ward responsibility (e.g. charge nurse). Two (6%) had responsibility for several wards (e.g. area supervisor), and seven (23%) had responsibilities relating to the whole hospital (e.g. in-service education).

5.2.6   Differences between previous and current role

When I asked about any changes in their job titles, I was trying to find out if these nurses were recognised as advanced practitioners or CNSs in their area of practice. On the other hand, job descriptions give indications of what the organisation think they should do in practice. What M-level nurses suggest is that they do not have a job description, and if they have one, it does not necessarily reflect what they do in practice. Therefore, respondents were asked to state if there were any differences between their previous roles and their roles after they had earned a Master's qualification. Twenty one (68%) respondents stated that there were differences between their previous role and their current role. Their current roles were very varied, as were the factors that they assigned significance to. In addition to working clinically and providing direct care, new aspects of

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[6] Totals do not add up to 100% due to rounding

their role included: developing clinical practice; working with and supporting other nurses; and teaching and assessing students in clinical areas.

It was not clear whether these new aspects resulted from changes instigated by their line managers or whether they were self-initiated. Despite the fact that the majority of nurses did not have a change in their job title or job description, the majority did feel that they had assumed more responsibility since they had completed their Master's course. Similar to Hogston's (1995) who investigated the impact of continuing professional education on the quality of nursing care within an NHS trust in England, respondents in this study perceived it as important to share their new knowledge with others. This was reflected in their new ways of working; mentoring, supervising, and developing practice. Nurses with an M-level qualification were articulating elements of the multifaceted role of the CNS which incorporates clinical practice, education, research, and management. In contrast, those respondents (32%) who felt that there had been no change to their role since they had earned a Master's qualification gave similar reasons to those offered to explain role continuity in job titles and job descriptions.

5.2.7   Respondents' perceptions of the appropriateness of Master's level education

When asked about their education and training, all respondents stated that a Master's qualification equipped them with specialised skills and knowledge. This was articulated, on the one hand, in terms of skills that had significance for their own professional development such as updating knowledge, expanding new knowledge, and changes to self and, on the other hand, in terms of skills that would benefit their colleagues such as instructing others, involvement in policy making, and participating in conferences.

5.2.8   Barriers to continuing education/training beyond Master's level

Twenty-seven (87%) respondents reported that they felt that the education they had received had prepared them for their job after gaining their Master's qualification. However, 29 (94%) felt that further education and training beyond M-level would be important in order for that role to change and develop. It was evident that respondents felt a need to be kept up-to-date and to continue their personal and professional development.

In a free text question, respondents were asked to state what sort of education/training they felt they might need. Their responses indicated that training in research skills, specific clinical procedures, leadership, evidence-based practice, teaching skills, and patient and family education would be of value. Respondents were presented with a pre-defined list of potential barriers to furthering educational opportunities and were asked to tick all that applied. Twenty-two (71%) respondents felt that there were one or more barriers to accessing further education and training following completion of their Master's degree (Table 12).

Table 12: Barriers to further education/training beyond Master's level

	Frequency	% of total respondents
Cost is too high	18	58
Funding is not available	14	45
Hospital unable to cover my absence	14	45
Lack of time	12	38
Hospital does not think it is relevant	9	29
Long distance/need to travel	6	19
No appropriate course available	6	19
Other	4	18

Respondents added other factors they perceived as barriers. One of these barriers was the 'lack of computer resources and database access' in their work place. Other barriers are related to their perception of their employers. One of these, 'institution trends and beliefs', is probably related to the policy of the institution, and the other one, 'opinion of the administrator', is related to the lack of support in the work place. An important barrier that was repeatedly mentioned was 'heavy work overload'.

The broader literature highlights similar barriers to continuing education in countries such as Australia and the UK. These include time, money, availability of sufficient opportunities, staff shortages, release from workplace, workload pressures, and lack of encouragement from managers (Hogston, 1995; Bousfield, 1997; Mills et al., 2002; Woods, 1998a; Nolan et al, 1995).

5.2.9 Respondents' perceptions of knowledge after gaining a Master's degree

Respondents were also asked to respond to a range of 'knowledge'-related items. In general, they perceived themselves to be up-to-date with current research knowledge in their field, to have a good understanding of evidence-based practice, and to be confident in using research to inform clinical decision making (Table 13). These findings were emphasised regardless of the working area of the respondents.

Respondents working in education also agreed strongly with items related to being confident in using research and professional judgment to inform their clinical decisions. It is perhaps surprising that these nurses, who were not providing direct patient care, perceived that they could make clinical decisions. This response tendency may reflect a weakness in the questionnaire design. For example, in the knowledge items, respondents were provided with more positive than negative statements. This may have led respondents to preferentially select response categories thought to be desirable.

Table 13: Respondents' perception of their knowledge after gaining a Master's degree

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	No answer
I am up-to-date with current research knowledge in my field	13 (42%)	15(48%)	1(3%)	1(3%)	1(3%)	0(0%)
I have good understanding of evidence-based practice	19 (61%)	10 (32%)	1 (3%)	0 (0%)	0 (0%)	1 (3%)
I am confident in using research evidence to inform the clinical decisions I make	16(52%)	12 (39%)	2 (6%)	1 (3%)	0 (0%)	0 (0%)
I am knowledgeable about guidelines and protocols relevant to my field	20 (65%)	10 (32%)	0 (0%)	1 (3%)	0 (0%)	0 (0%)
I actively seek out evidence based information	11(35%)	16 (52%)	2(6%)	2 (6%)	0(0%)	0(0%)
I am confident in using my professional judgment to inform the clinical decisions I make	15 (48%)	12 (39%)	3(10%)	1(3%)	0 (0%)	0 (0%)

5.2.10 Research undertaken after gaining a Master's degree

Only 11 (35%) respondents reported having undertaken research in their current role. This research was undertaken either as an integral part of their Master's degree or as part

of research conducted at their hospitals where they acted as members of larger research team. Some nurses reported that the research which was undertaken as part of their Master's degree was considered to be part of their work as M-level nurses. None of the respondents had published their research. However, 12 (39%) had presented papers related to their role or work at conferences (see section 6.2.2 for further discussion).

5.2.11   Respondents' ways of working after gaining a Master's qualification

Respondents were provided with a list of activities and were asked to indicate the extent to which these activities featured in their current role. As Table 14 shows,

Table 14: The extent to which the following activities feature in respondents' current role

	Major component	Minor component	Does not feature
Providing direct care to patients	22(71%)	3(10%)	6(19%)
Teaching staff	27(87%)	4(13%)	0(0%)
Health education (patients)	18(58%)	12(39%)	1(3%)
Health education (families)	15(48%)	13(42%)	3(10%)
Function autonomously	23(74%)	4(13%)	4(13%)
Undertaking research	16(52%)	11(35)	4(13%)
Bringing about change in your workplace	22(71%)	8(26%)	1(3%)
Developing policies and protocols	15(48%)	13(42%)	3(10%)
Developing your own practice	27(87%)	3(10%)	1(3%)
Developing practice in general	21(68%)	9(29%)	1(3%)
Assisting other nurses to solve clinical problems	29(94%)	1(3%)	1(3%)

Acting as a resource to other nurses for clinical information	28(90%)	2(6%)	1(3%)
Discussing research findings (in general) with other staff	20(65%)	9(29%)	2(6%)
Examining patients	10(32%)	14(45%)	7(23%)
Undertaking ECGs	18(58%)	5(16%)	8(26%)
Cannulation	19(61%)	3(10%)	9(29%)
Venepuncture	18(58%)	3(10%)	10(32%)
Defibrillation	14(45%)	6(19%)	11(35%)
Ordering X-rays	5(16%)	8(26%)	18(58%)
Catheterisation	12(39%)	7(23%)	12(39%)
Making referrals to other professionals	12(39%)	13(42%)	6(19%)
Assuming leadership and management responsibilities	22(71%)	8(26%)	1(3%)
Ordering different tests	8(26%)	9(29%)	14(45%)
Interpreting different results	19(61%)	7(23%)	5(16%)

the majority of respondents indicated that developing practice (by assisting other nurses to solve clinical problems, acting as a resource for other nurses, developing their own practice, teaching other staff, bringing about change in the workplace, assuming leadership, and taking management responsibilities) were major components of their role. Twenty-two (71%) were providing direct care to patients. Interestingly, around half of the respondents were undertaking activities that are considered core and specialised skills for nurses in advanced roles (Read et al, 2000): defibrillation, ordering X-rays, making referrals to other professionals, ordering different tests, and examining patients. However, anecdotal accounts indicate that many of these clinical tasks were also performed by the majority of non-M-level nurses; it is a common nursing practice in Jordan to perform procedures such as electrocardiogram (ECG), cannulation, venepuncture and catheterisation. These tasks were more frequently noted by nurses working in intensive

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care units who comprised the majority of participants in this phase of the study. This finding is also, therefore, likely to have been influenced by the sampling strategy for this study.

It was also noted that only half of the respondents reported that they provided health education to patients and their families. This is significant because nurses have a legitimate role to play in the area of health education. The relatively low number of nurses reporting such activity is probably because of the preponderance of ICU nurses in the sample, and of the large number of respondents with a Master's degree in intensive care. It might be also a reflection of the low value attached to health education in the Jordanian health care system. It may also, potentially, highlight gaps in programmes of Master's education: the Master's programmes may not have been designed to create such outcomes in practice.

Another important issue that emerged from the findings concerns the examination of patients. Although physical examination is taught as part of their clinical Master's courses (see Appendix 8 for course modules), only ten (32%) respondents felt that examination of patients was a major component of their current role. This will be explored further in relation to the qualitative data in chapter 8.

Twenty-three (74%) respondents felt that autonomy was a major component of their current role. This was surprising and contradictory in the light of the qualitative findings (see section 8.4.2.2.2). The five respondents who provided in-service education or who were in managerial posts were most likely to indicate that they had no autonomy, or that their autonomy was very limited. This autonomy varied within the same hospital. It was not clear why this was the case. It might be related to the nurses' personalities and their abilities to negotiate and influence decision makers in their organisation. Some nurses might also be working in hierarchal or procedure-driven units which do not leave much room for autonomy.

Some respondents indicated that they were able to order and interpret a variety of tests. Initiating these tests appeared to depend not just on the role of the M-level nurse but also on the area of practice. For example, the extent to which these are indicative of

'autonomy' depends on where the nurses are practising and whether they are responsible for direct patient care. The view of these nurses is reflected in the broader literature and the debate around nurses assuming advanced roles by undertaking physicians' tasks and whether these tasks indicate autonomy. On the whole, respondents who worked in education and management did not perform these tests. Only one respondent who worked as an educational co-ordinator reported ordering and interpreting different tests. The qualitative data indicated that nurses, especially those who worked in the intensive care units, were expected to order different tests (although it was not in their job description). The most frequent tests identified by respondents in the free text questions are shown in Appendix 9.

5.2.12 Respondents' perceptions of their impact on quality of care

Respondents were asked to indicate the extent to which they agreed with the statements provided regarding their perceived impact on the quality of patient care. The majority of respondents indicated that they felt that they influenced the quality of care positively, either by influencing colleagues' patient care practices or through their own direct patient care activities (Table 15). Not surprisingly, there was a strong view amongst respondents that Master's education has a positive impact on quality of care. The perceived impact of M-level nurses on care is explored further in section 8.3.

Table 15: Respondents' impact on quality of care

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	No answer
Information and advice I provide to nurses influences how patients are managed/cared for	8(26%)	23(74%)	0(0%)	0(0%)	0(0%)	0(0%)
Information and advice I provide to patients influences their approach to managing their condition	8(26%)	19(61%)	4(13%)	0(0%)	0(0%)	0(0%)
Information and advice I provide to patients influences how nurses manage their care	7(23%	21(68%)	3(10%)	0(0%)	0(0%)	0(0%)
Nurses and other health care professionals actively seek information, support and advice from me	4(13%)	23(74%)	3(10%)	0(0%)	0(0%)	1(3%)

I have helped create a culture in which nurses feel able to challenge and question care	4(13%)	14(45%)	12(39%)	0(0%)	0(0%)	1(3%)
I actively draw upon experience of patients in making decisions to inform their care	8(26%)	22(71%)	1(3%)	0(0%)	0(0%)	0(0%)
My work load is too heavy to be able to carry out a holistic nursing assessment of patients	13(42%)	14(45%)	1(3%)	2(6%)	1(3%)	0(0%)
I am not permitted to initiate and lead practice development	0(0%)	15(48%)	3(10%)	13(42%)	0(0%)	0(0%)
I am not permitted to make decisions without reference to medical practitioner	4(13%)	17(55%)	2(6%)	7(23%)	1(3%)	0(0%)
I lack the authority in the work place to change practice	8(26%)	13(42%)	2(6%)	8(26%)	0(0%)	0(0%)
There are not sufficient resources to change practice	7(23%)	16(52%)	1(3%)	7(23%)	0(0%)	0(0%)

5.2.13　Respondents' working relationships

When the respondents were asked about their work relationships, 18 (58%) felt very well integrated with other nurses, and 11 (35%) felt reasonably well integrated. In addition, 12 (39%) described their relationships with other health care professionals as very well integrated, and 17 (55%) as reasonably well integrated.

5.2.14　Factors that M-level nurses perceive to be important in enabling them to work effectively in their current role

Respondents were asked to identify the factors that they perceived to be important in enabling them to work effectively in their current role (Table 16). 'Other' factors were 'support of their boss' and 'expanding knowledge base through relevant educational workshops and lectures.

Table 16: Factors that M-level nurses perceive to be important in enabling them to work effectively in their current role

	Frequency	% of respondents selecting this item
Increased knowledge and confidence	26	84
Support of nursing staff	24	77
Support of nurse managers	24	77
Increased autonomy	24	77
Expanding the range of skills possessed	22	71
Good staffing levels	20	65
Support of medical staff	15	48
Other	2	6
Not answered	0	0

Support from nursing staff and nurse managers was highly appreciated by respondents in this study which is consistent with Woods's (2000) findings. In terms of environmental context, factors such as good staffing levels (Mills et al, 2002) and autonomy were cited as being of help in implementing new roles. All these factors may be relevant to understanding the Jordanian situation. Bousfield (1997) states that lack of support has a negative effect on an advanced nurse's practice, while Mills et al. (2002) report that one of the most common difficulties experienced by advanced nurse practitioners is poor professional and peer support. Read et al. (2004) noted that supportive working relationships were essential for nurses in innovative roles. They also acknowledged the support of medical staff as an important factor. The dominance of medical practitioners within the health care system in Jordan makes it necessary for nurses to get support from them. Medical practitioners might object to nurses developing new roles which they might see as overtaking their roles.

5.2.15   Factors that M-level nurses perceive to be important inhibitors of effective working in their current roles

Respondents were asked to identify the factors affecting their ability to work effectively in their current role (Table 17).

Table 17: Factors that M-level nurses perceive to be important inhibitors of effective working in their current role

	Frequency	% of respondents selecting this item
Being expected to develop advanced role whilst being counted in the nursing staff	20	65
Lack of understanding of the role by others	19	61
Lack of resources (IT, computer, library)	16	52
Not be graded/financially rewarded for the job	16	52
Conflict with nurse managers	16	52
Absent/incomplete protocols	16	52
Opposition by medical staff	13	42
Poor levels of nursing staff	12	39
Nursing colleagues' feelings threatened, resentful and non accepting the role	11	35
Being used as junior physicians replacement	6	19
Other	5	16

Read et al. (2004) note that supportive working relationships are essential for the development of advanced roles. Woods (2000) notes that resistance and resentment from nursing colleagues were the most common inhibiting factors. Respondents were also expected both to utilise their skills and knowledge as Master's graduates and at the same time to undertake similar roles, as staff nurses, to their colleagues in the hospital. In the current study, 'other' factors were related to the environmental context such as low levels of nursing staff and lack of resources (IT, computer and library). These responses were reflected in many of the issues which were subsequently brought out by the interviews (see chapter 8 for more details).

5.2.16 Respondents' perceptions of the effects of their Master's education on their career development

Twenty-eight (90%) respondents felt that Master's education had enhanced their career development. It was noted, though, that those who thought Master's education had enhanced their career development saw this as happening either through developing personal attributes or through professional and practical development rather than through opening up opportunities for career progression. The acquisition of knowledge and skills was identified as bringing added value to their work. Such skills included expanded knowledge, critical thinking, and skills in undertaking and utilising research. Some respondents felt that a Master's degree improved their professional status and helped them to teach others.

5.2.17 Respondents' perceptions of the effects of their Master's education on their job satisfaction

Twenty-six (84%) respondents felt that Master's education enhanced their job satisfaction and personal sense of achievement. Mrayyan (2005; 2006; 2007) reported that, in general, nurses in Jordan were neither satisfied nor dissatisfied with their jobs, and in a sense were neutral in reporting their intent to stay in their current posts. However, job dissatisfaction has been reported in the Jordanian nursing literature; researchers in Jordan identified factors that lead to dissatisfaction such as low pay, lack of career opportunities, lack of nursing and hospital administrators' support, lack of transportation, and poor child care facilities (Hijazi & Al-Ma'aitah, 1999; Al-Ma'aitah et al., 1999; Armstrong-Stassen et al., 1998)

5.2.18 Respondents' perceptions of the effects of their Master's education on their clinical practice

More than 90% of respondents indicated that they felt that Master's education had affected their clinical practice in a positive way (Table 18). This overwhelmingly positive response may be the result of respondent bias or poorly formed questions as participants were asked to respond only to positive statements.

Table 18: Respondents' perceptions of the effects of their Master's education on their clinical practice

	Yes	No	Not answered
I am better able to apply research to practice	29 (94%)	1 (3%)	1 (3%)
I am better able to plan patient care	29 (94%)	1 (3%)	1 (3%)
I am better able to give quality care	30 (97%)	0 (0%)	1(3%)
I am more able to evaluate care	29 (94%)	1 (3%)	1 (3%)
I am better able to apply wider knowledge and skills to practice	31 (100%)	0 (0%)	0(0%)
I am better able to improve my teaching skills	31 (100%)	0 (0%)	0 (0%)
I am better able to question/challenge practice	29 (94%)	2 (6%)	0 (0%)

However, the current response profile suggests that M-level education was perceived as enabling nurses to integrate theoretical and clinical skills effectively. The likelihood of receiving positive responses means that these findings should be interpreted with caution.

5.2.19   Respondents' views of their future career plans

Respondents were asked to indicate where they saw themselves in five years' time in terms of their future career plans ticking one response category only (Table 19). Despite this instruction, some respondents ticked multiple responses. Nurses who ticked the 'other' box stated that they were hoping to do things like 'becoming a business woman', 'continuing in higher education', or 'becoming a clinical nurse specialist'. However, the majority of respondents (71%) in this study indicated that they were likely to move into education (This is explored further in chapter 8).

Table 19: Respondents' views of their future career plans

	Frequency	% of respondents selecting this item
Still in this post	1	3%
In a similar post elsewhere	1	3%
In a more traditional professional role	0	0%
Moving into clinical management	4	13%
Moving into general management	3	10%
Moving into education	22	71%
Taking a career break	1	3%
Leaving the profession altogether	5	16%
Retired	0	0%
Don't know	2	6%
Other (Please specify)	4	13%
Not answered	0	0%

Oweis (2005) has demonstrated that highly educated nurses in Jordan have high expectations, which include working in a supportive work environment with adequate and equal professional opportunities for career progression. If such supportive environments are not available, they may opt to leave clinical practice in Jordan and seek opportunities in other educational settings or outside Jordan. Clinical career ladders, which offer an opportunity for promotion based on education, experience, job performance and research participation, are limited in Jordanian hospitals and limited career progression is, therefore, a significant cause of dissatisfaction (Mrayyan, 2004; 2006).

In the UK, Read et al (2001) report that a few respondents in their study also gave several reasons for leaving their profession: lack of career prospects or financial reward, stress, lack of support, lack of recognition, and heavy workloads. These findings are also congruent with the findings of other studies in the UK; for example, that having a Master's or PhD degree does not entitle nurses to any special recognition in clinical practice. Spencer (2006) reviewed the perceptions of nurses, midwives and health visitors of the impact of higher education on professional practice, personal and professional development. The author suggests that graduate nurses do not receive more rapid

promotion when compared to non-graduate nurses, although the graduate nurses have greater career aspirations and expectations. Moreover, the academic qualifications are necessary but not sufficient for promotion. Whyte et al. (2000) note that teaching was the dominant career pathway for nurses with higher education.

5.3 Conclusion

This survey was designed to gain background information about M-level nurses in clinical practice. The findings indicate a dominance of critical care Master's courses and respondents working in intensive care units (ICU) over other specialities. Some responses may reflect weaknesses in the questionnaire design or sampling strategy. Therefore, some of the findings should be interpreted with caution. Nevertheless, the data suggest that a change of job title or job description, after gaining a Master's degree, reflects the movement of M-level nurses away from direct patient care to non-direct patient care. This raises questions about the deployment of M-level nurses in practice. The majority of nurses reported differences between their current and their previous role, and felt that a Master's qualification had equipped them with specialised skills and knowledge, although they acknowledged that these could be further developed to enhance their role in the future.

This chapter has also discussed factors that M-level nurses feel can either hinder or facilitate their roles. The most frequently cited factors were hospital policy and support from nursing colleagues and nurse managers. In highlighting nursing support, these nurses might be calling for more understanding and sharing at inter- and intra-professional levels. An interesting finding was that the majority of these nurses reported moving to education as a future career plan. This also raises the question of why nurses who had undertaken a clinically oriented Master's thought of themselves as future nurse educators. The following chapters will discuss the main themes that emerged from the qualitative data and try to address some of these questions.

Chapter 6

Understanding advanced nursing practice

6.1. Introduction

The primary aim of the study was to examine the extent to which elements of ANP are evident in Jordan, with a particular focus on the contribution of M-level education. The aim of this chapter is to look at how different groups of participants (nurse educationalists, professional body representatives, M-level nurses, nurse managers, nursing co-workers, and physicians) perceive the concept of ANP and to consider commonalties and differences between these participants and relate them to the existing literature. The participants were asked, in the survey and in the interviews, to describe the term 'advanced nursing practice' so that an understanding of what this term meant to them could be gained. The collected data were analysed thematically. This analysis shows that the participants described ANP in terms of its generic features and core competencies. The themes which emerged from the data (survey free-text, interviews and observation) were: core competencies, specific practice area vs. generic practice, beneficiaries of ANP, and drivers for educational change.

6.2. Core competencies

The majority of participants found the concept of ANP very difficult to describe. However, although a variety of perspectives were evident, there were many areas of consensus. In this chapter, ANP is discussed in terms of the characteristics attributed to, or expected of, M-level nurses by participants. These characteristics can be categorised under cognitive-related competencies and research-related competencies.

6.2.1 Cognitive related competencies

In the survey data, M-level nurse respondents defined ANP in a number of ways. Cognitive competencies were described in relation to: depth and breadth of knowledge,

application of knowledge and skills to practice, and critical thinking and problem solving skills. The following M-level nurse's understanding reflects a complex and holistic picture in which ANP is characterised in terms of a focus on the individual, his family, and the larger community. Advanced nurse practitioners are deemed to be significantly experienced and knowledgeable. This knowledge should be gained through postgraduate education. They should be able to conduct a comprehensive health assessment and treat complex problems, 'actual' or 'potential'. To do so, they need 'depth' of knowledge and the ability to critically apply what has been learned to professional practice. ANP was articulated as a:

"High level of expertise in the assessment and treatment of the complex responses of families, individuals and communities to actual or potential problems using greater depth and breadth of knowledge, complex interventions and skills and high degree of synthesis of data, so it needs Master's or doctoral level of education." (M-level nurse 1 /survey data)

Some M-level nurses stated that they acquired 'new knowledge', which was also gained through postgraduate education. The result of this new knowledge is enhanced practice:

"it means to me that increasing the quality of practice depends on new knowledge that we can acquire from our study in Master's." (M-level nurse 2 /survey data)

However, few M-level nurses actually defined higher educational qualifications, such as M-level degree, as an essential requirement for ANP. Nevertheless, though this requirement was not categorically stated, this omission should be interpreted with caution. Having already acquired a Master's degree, they recognise that knowledge and skills have to be formally taught through postgraduate education. Thus ANP was described as:

"Developed nurse role based on special knowledge and skills gained through further education and practice it means also expand nursing role, needs special certification and education." (M-level nurse 24/ survey data)

Some M-level nurses defined the advanced nurse practitioner as a nurse who employs critical thinking and problem solving skills, emphasising that they should be linked with practice:

"ANP means more knowledge and skills, critical thinking and linking the knowledge with practice." (M-level nurse 3/ survey data)

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"A nurse practice in a critical area which needs a critical thinking, problem solving and up to date knowledge in the area of practice." (M-level nurse 7/ survey data)

The tasks and roles of M-level nurses in practice were described by some M-level nurses as 'more advanced' in comparison to other nurses, and the care they provide was described as being based upon evidence and a questioning of practice, rather than a routine uncritical approach to work:

"it (ANP) means that the task and roles of the nurse are more advanced than the task done by other nurses also the practice is based on research." (M-level nurse 6/ survey data)

"higher level of responsibility beyond the routine nursing practice, being consultant in the area of practice, education role." (M-level nurse 15/ survey data)

Nurse educationalists adopted similar views to those of M-level nurses when they were asked what ANP meant to them. M-level education was also seen by them to entail both advanced cognitive skills and advanced knowledge. They identified a range of activities they expected M-level nurses to engage in. These competencies were understood to differentiate M-level nurses from other nurses. They stated that nurses' competence is enhanced through acquiring more advanced knowledge and advanced learning skills. It is expected that this advanced knowledge and advanced cognitive skills would enable the M-level nurse to move on to doctorate level:

"They (M-level nurses) access advanced resources of knowledge; they are equipped with the most up to date methods of learning such as e-learning, computer skills, and advanced skills that are much more than those of undergraduate students. They can also move easily to higher level of education such as doctorate education smoothly." (Nurse Educationalist 3)

Thus advanced knowledge and cognitive skills acquisition was seen as an inherent consequence of M-level education. One nurse educationalist viewed M-level education as a means by which outstanding clinicians could be nurtured who could bring a different vision to practice as well as the ability to undertake research and teach others. This narrative also suggests a hierarchy or cumulative notion of knowledge and skills development:

"These programmes were developed to have significant contribution so that the student will be able to undertake research, to be nurse educator and outstanding clinician. When I go with my students to clinical areas, I ask them how they will be different from bachelor students. I say to them: your knowledge is advanced; your skill is advanced;

you have a different vision, and you can find solution to different problems." (Nurse Educationalist 5)

As the quotes above suggest, participants emphasised that M-level nurses were seen to have broadened and deepened their knowledge and acquired new knowledge. They were also expected to be able to justify actions using theoretical insights at levels beyond what could be achieved through undergraduate education. One nurse emphasised that ANP entailed stepping outside traditional nursing practice by undertaking the role of educator and consultant:

"It entails a higher level of responsibility beyond the routine nursing practice, e.g. consultant in the area of practice, education role." (M-level nurse 15/ survey data)

These findings are consistent with those of Ashworth et al. (2001) who reported that stepping outside traditional nursing practice is the defining feature of M-level nurses. The participants' narrations also find an echo in Ball's (1999) suggestion that good clinicians must draw upon the best scientific evidence to make sound clinical judgments. Their views are also reflected in the work of Ashworth et al. (2001), Gerrish et al. (2000), Davis and Burnard (1992) and Drennan (2007) who note that M-level students not only acquire new knowledge but also deepen and broaden their existing knowledge.

Being able to draw upon their new knowledge, M-level nurses in this study were also considered by some participants to have developed critical thinking and analytical skills that would enable them to find solutions to different problems they encountered in their practice. This view was similar to that highlighted by Mantzoukas and Watkinson (2007) who consider critical thinking, a process that requires both the best scientific understanding of a particular patient problem and clinical experience, to be an integral feature of ANP.

Critical thinking generally encompasses problem solving, decision making, and reasoning. This cognitive skill engenders in students a questioning approach to both theory and practice, allowing the students to interpret and analyse the situations they face in the real world of work, and develop rationales for evidence-based solutions which require them to develop and use their knowledge in a variety of settings. In the current study many participants reported such cognitive skills as central outcomes of M-level

education.

Drennan (2007) suggests that there is a tension in the outcomes of M-level courses between the development of generic capabilities such as the development of critical thinking skills, the utilisation of research in practice, problem-solving, changing practice, and the development of leadership and teaching roles (Cryer, 1998; Gilbert et al., 2004; Mantzoukas & Watkinson, 2007), and the place within these programmes for practice specific outcomes. These practice outcomes include the development of specialist practice competencies such as the helping role, the teaching role, diagnostic and patient monitoring function, effective management of rapidly changing situations, administration and monitoring of therapeutic interventions, monitoring and ensuring the quality of health care practices as well as organisational and work role competencies (Benner, 2001, p. 46).

Drennan (2007) emphasises that practice-specific outcomes have become important to the nursing profession as it strives to identify a unique body of nursing knowledge that separates it from other healthcare professions. However, he asserts that one of the problems identified in the literature is the ability to identify and define nursing knowledge and its subsequent outcomes. The development and outcomes of nursing knowledge do not happen directly after graduation but evolve as the practising nurse gains experience and undertakes further education. He adds that the development of specific outcomes cannot be separated from the development of generic outcomes. Drennan also argues that the intertwining of specific and generic outcomes is viewed as important in ensuring that postgraduate students receive a quality learning experience, and bridging the gap between theory and practice. However, the question remains in how these outcomes are achieved and can be measured. This could be explored in the future research.

In general, M-level nurses in this study were seen to acquire cognitive skills through their Master's programme. These cognitive skills were more frequently noted as outcomes of M-level education than were learning new clinical or practical skills or

procedures. For example, when asked about what new clinical or practical skills they had learnt, one M-level nurse stated:

"*Not much, we learnt how to do intubation, but we did not try it on real patients. .... We also learnt physical assessment, advanced cardiac life support. The other skills are mainly basics in the ICU like IV cannula, arterial line.*" (M-level nurse 1)

Although M-level nurses could specify advanced skills that were taught as part of their Master's programme, they did not specify advanced skills in relation to ANP. This might be because these advanced clinical skills are practice-area specific. However, in the questionnaire, when asked if a Master's qualification equipped them with specialised skills and knowledge, skills such as physical examination and advanced cardiac life support (ACLS) were noted specifically by three M-level nurses. A further two mentioned communication and presentation skills, and the use of new technology, computer, and information searching skills.

The lack of focus on specific clinical skills or procedures could be related to the need to deploy M-level nurses in different settings, including education. They were expected to provide high quality care, and to be educators, role models and change agents, hence the need to foster generic rather than specific skills:

"*For sure this clinical nurse specialist and the nurse specialists who have Master's are expected to be educators for their colleagues, to give high quality care, to be a role model. We ask them to change things, to teach their colleagues, to participate in different activities and committees, and to give feedback on different policies, and job descriptions.*" (MOH Representative)

Similarly, one nurse educationalist suggested that M-level nurses should be expert nurses who are able to integrate different sub-roles, though she does not highlight the need to learn new clinical skills:

"*basically we are talking about competent quality care, we are talking about different roles that will involve the expert, the consultant, the educator, the person who can use evidence, to put it mildly we need to see that these roles are integrated into the role of the expert nurse, the very competent nurse.*" (Nurse Educationalist 6)

This lack of focus on clinical skills could also be related to a concern that nurses in Jordan are functioning in the shadow of medicine. Hence, there was a desire to ensure a clear distinction between nursing and medicine to claim a discrete domain of expertise:

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"I don't think what we do in nursing now in the clinical area would fit into the criteria of nursing; this is my personal opinion again because most of what nurses do now is not nursing. Probably you could call them physician assistants." (Nurse Educationalist 1)

Thus, one nurse educationalist emphasised that new graduates' roles, after getting their Master's, should be providers of care. She described nurses as having the potential to be 'actual nurses'. ANP is, therefore, seen as a route to developing holistic direct patient care and not only performing certain tasks. As such, ANP is regarded as an ideal concept:

"It's actually preparing them to be actual nurses who are working according to human needs of the patient and mostly caring, care that is to be provided according to the need and the nursing diagnosis." (Nurse Educationalist 4)

Similarly, some M-level nurses were also concerned with delivering holistic care to the patient. They suggest that advanced practitioners are:

"highly qualified staff who is concerned with direct patient contact and care and to answer the patients' questions and see to their needs, give education, psychological support and communication." (M-level nurse 18/ survey data)

And that they:

"provide holistic care for critical patient in any area by highly qualified nurses." (M-level nurse 13/ survey data)

Hence, M-level education was seen to be preparing nurses to work in accordance with the nursing process (assess patients' needs, diagnose and implement care plan). Despite the lack of a consensus definition of nursing in Jordan, Petro-Nustas et al.'s (2001) survey of bachelor-level nurses' perceptions and expectations of the 'nurse', and of 'nursing' as a profession, indicates that nurse administrators, educators and direct care providers perceive nursing within Jordan as:

> an art and a science that is based on theories from nursing and other fields, it is a humanistic profession, which is concerned with the care of the person as a whole biological, psychological, social and spiritual being. It is also a profession that involves the provision of care for healthy and sick individuals and groups, and requires certain educational preparation to meet the desired standards of nursing care. (p. 352)

Petro-Nustas et al., (2001, p. 353) also explain that physicians and pharmacists defined nursing as 'taking care of the patient as a whole entity (physically, mentally and

psychologically), and implementing physicians' orders; nursing complements medicine and is an essential part of health care'. Consumers, on the other hand, emphasised the humane aspect of the profession and defined nursing as 'a profession that is mainly based on humanistic principles and is concerned with helping the sick persons in hospitals or at home'. It is clear from the above descriptions that there are inconsistencies and elements of confusion about the role of the nurse and what nurses in general do. It is, therefore, not surprising that there is also a lack of clarity about what advanced nurse practitioners do:

"So the definition of nursing for example now is about what nursing is and what nurses do. That's really an argument that's been on all over the world and that continues. What the hospitals want out of nurses is what makes a nurse." (Nurse Educationalist 1)

"We are still very traditional in the way we deliver care so what they (hospitals) need is a regular nurse, a magic nurse who can provide everything." (M-level nurse 1)

As Shuriquie et al. (2008) report, most nursing care delivery across all health care sectors in Jordan is task-oriented. As a response to that, nurse experts in Jordan have decided it needs be more orientated towards the provision of holistic care. A concern reported by some of the participants in the current study that M-level nurses might take over some of the physicians' clinical tasks and responsibilities is also reflected in the broader literature. Donnelly (2003) asserts that those advanced roles which include medical procedures and prescribing are not the focus of nursing knowledge. Similarly, Sutton and Smith (1995) argue that becoming physicians' assistants will not give nurses autonomy or professional recognition. However, strong medical influence within health care systems continues to have an impact on how advanced nursing roles are shaped worldwide**.** Woods (1998b) suggests that, in the UK, the potential for nurses to act as physicians' assistants is great in intensive care areas, which by their very nature, are often highly technical and medicalised. Building on this, and as most of the survey participants in the current study are working in ICUs, it can then be justified to claim that they may have the potential to act as physicians' assistants.

These arguments draw attention to the ongoing tension between nurses' efforts to extend their roles and their efforts to expand their roles. Woods (2000) makes an important distinction between these two endeavours: role extension and role expansion. Role extension is seen as task-oriented activity that extends outside nursing into another

professional domain such as medicine. Woods notes that extending nursing roles on such bases is undesirable, and hinders the quest of nursing to be recognised as a profession in its own right. On the other hand, role expansion focuses on developing nursing generally, emphasising nurturing and caring rather than the acquisition of specific task skills. It has to be determined by nurses and nursing rather than imposed by other health professionals within the healthcare system.

Drennan (2007) notes that the philosophy of nursing includes the concept of holistic patient care in which the individual is viewed as having biological, social, psychological, and spiritual needs. This care is provided through the application of evidence-based practice. In the current study, nurse educationalists felt that the role of the advanced practitioner should be not about reconfiguring nursing practice to undertake a medical role; indeed, nurses in Jordan already undertook many medical procedures (Shuriquie et al., 2008). M-level education was, rather, expected to prepare nurses beyond basic practice by enabling the development of higher levels of knowledge and cognitive skills enabling an expanded range of theoretical and research-based interventions. Some participants were wary about taking over medical domains of practice which risked reducing the emphasis on a nursing model of health and caring. It is clear that nurse experts in Jordan are aware of the challenges that nurses in other countries have faced. Thus, anticipating similar challenges and learning from other's experiences was highlighted:

"We learnt from other countries' experiences that nurses working in this way (taking over medical domains) started moving away from nursing model to medical model." (MOH Representative)

M-level nurses and nurse educationalists placed more emphasis on developing cognitive skills than clinical skills. This is also reflected in the broader literature about ANP where the debate about the value of different forms of knowledge and their application to practice is ongoing (Mantzoukas & Watkinson, 2007). It seems that M-level nurses and nurse educationalists in this study were aware of the tension between two kinds of knowledge: "knowing that" and "knowing how". The expectations that M-level nurses place upon themselves, and that educationalists place upon them are that they

should bring both types of knowledge, which the broader literature suggests is problematic everywhere.

This debate finds support in the work of Burnard (1992): Burnard notes that, although most educational programmes are concerned with both propositional knowledge (contained in theories and models - 'knowing that') and practical knowledge (developed through acquisition of skills - 'knowing how'), more emphasis is placed upon propositional knowledge. Gerrish et al. (2000) warn that such an emphasis is a disadvantage to professional education where knowledge of day-to-day practice in hospitals is largely know-how. Prioritising theoretical knowledge does not help these nurses when they go back to clinical settings as they need both kinds of knowledge. In other words, the authors draw attention to a theory-practice gap. Burnard (1992) asserts that the proficient nurse is one who is both clinically skilled and academically able and explains that knowledge development in an applied discipline, such as nursing, consists of extending practical knowledge through theory-based scientific investigations and through the charting of existing 'know-how' developed through clinical experience in practice. Burnard adds a third type of knowledge that is named experiential knowledge (gained through direct encounter with a subject person or thing -'personal knowledge'). He explains that it is the subjective and affective nature of that encounter that contributes to this sort of knowledge. In the current study, more emphasis was placed on practical and experiential knowledge than other forms of knowledge by nurse managers (see section 8.2.3).

6.2.2 Research-related competencies

Using research to guide clinical practice was emphasised as a feature of ANP. Some participants were very clear about what they meant by research skills, emphasising that M-level nurses should be skilled to undertake research and make it available to their colleagues. Others, however, emphasised the ability of the M-level nurse to utilise research findings and apply them to change practice. This tension between the expectation that M-level nurses should undertake research and the expectation that they should merely be able to utilise research findings could be related to the fact that participants themselves were unsure what the rhetoric of 'research' should mean in

practice for M-level nurses. This was also evident in the way M-level nurses talked about their own research skills. I must also acknowledge that, on reflection, this lack of clarity could also be an issue that could have been explored more fully during interviews.

Some M-level nurses defined ANP in terms of 'utilising' and 'using' research, rather than conducting research:

"Using nursing research and knowledge in practice area for improving patient care is something they (advanced nurse practitioners) can do." (M-level nurse 27/ survey data)

"Using evidence based nursing and new knowledge while providing care to our patients." (M-level nurse 18/ survey data)

In their definition of ANP, M-level nurses referred to evidence-based and research-based practice as a central component of their role. They felt responsible to introduce and encourage evidence-based practice, a phrase which they used interchangeably with research-based practice. As explained by one M-level nurse, this reflects a global emphasis that is put on evidence-based practice in nursing:

"*Utilising more science in your practice to flow with the current of evidence-based and in compliance with acquiring more advanced roles of being an educator, a specialist, a consultant, a resource person and preceptor."* (M-level nurse 30/ survey data)

These views were also reflected in nurse educationalists' narratives:

"they have the research base so they could use the clinical trial and research base to improve practice." (Nurse Educationalist 3)

This reference to research could be interpreted in a number of ways. However, it is important to articulate the difference between evidence-based practice and research-based practice in order to discuss what this conflation means, especially in relation to the further conflation with 'science'. The quotes articulate a value system that values 'research' above other forms of knowledge. As such, research is a systematic investigation undertaken in order to gain new knowledge or to verify existing knowledge (Gerrish & McMahon, 2006; Watson & Keady, 2008). It can provide new insights into nursing practice, develop and improve methods of caring, and test the effectiveness of care. Evidence-based practice is more complex; it requires a blending of the research-based and experiential knowledge of professionals and patients' and their carers' personal knowledge of. It involves identifying and appraising different sources of evidence

referred to as hierarchies of evidence, translating evidence into clear guidance for practice, implementing and finally evaluating the impact of change (Gerrish, 2006).

However, it was not only the ability to conduct research independently but also the ability to understand, critique, and utilise the findings of research conducted by others that was seen to distinguish M-level nurses from other nurses: it was the M-level graduate's ability to analyse and apply research findings that was thought to be important. In response to a question about the roles that M-level nurses are expected to undertake in clinical settings, a nurse educationalist emphasised:

"we decided they're not going to be 'a researcher' they are consumers of research findings and they should look for evidences and integrate them into practice, some of them they could contribute into studies of surveys. I myself as an associate professor probably when I got the associate I would say I am a researcher, it's very difficult to call someone a researcher if he doesn't conduct on his own a research and understand and publishes and disseminates but I think at the Master's level the nurse specialists participate in research; they collect data; they identify problems; they do surveys and surveillance, which is very important and lots of community course graduates can do epidemiological approaches but when we talk about research I don't expect them to be researchers." (Nurse Educationalist 5)

This view seems to be very contradictory: on the one hand, this nurse educationalist suggests that M-level nurses should be consumers of research; on the other hand, she expects them to do surveys and epidemiological studies. For some participants, it was the ability to conduct research that made the M-level nurse an asset to his or her institution, while others emphasised instead the ability to understand research and utilise its findings. Nevertheless, the majority of participants asserted that research-related activities are an important feature of ANP. A nurse educationalist emphasised that M-level nurses learn how to do research as part of their degree and should be able to apply this knowledge by conducting research for their institutions:

"I should say there is no doubt that they [M-level nurses] know how to do research; in many institutions, there is a good focus on research so they will be able to apply the role. Yes the role related to research I think can be implemented by these nurses." (Nurse Educationalist 6)

Similarly:

"They can do research, scientific days and so on." (Deputy Director of Nursing1)

"Nurses who hold Master's degree can implement the roles of advanced practitioners, the nurses can for example undertake research." (M-level nurse 1)

Research skills that were taught in their Masters' programmes were seen by some M-level nurses as insufficient to enable them to undertake research in their practice settings. Therefore, in the survey data, research-related activities and evidence-based practice were highlighted as areas requiring further education and training. Although the majority of M-level nurses did not undertake research, the need for further training to develop their research skills might be related to their perception that research skills are an integral part of their potential role as advanced nurse practitioners. Some M-level nurses emphasised the need to practise and undertake research in order to develop their research skills in practice. This research should be published so others can refer to it:

"at the university there is more emphasis on research. With experience we could learn more; we have to continue reading and undertaking research and we need to publish this research. This way we could develop ourselves." (M-level nurse 18)

Universities provide M-level nurses with theoretical input, and practitioners have to apply this in practice. On-going involvement in in-service activity may offer one way for M-level nurses to bridge the gap between theory and practice. This nurse went on to explain that they required support to do so, and thought that this might be achieved by collaboration between hospitals and universities:

"After graduation we have not done any research so we need more training in research. The in-service education department has sent nurses to do a course in research, in our in-service education department they are asking for this collaboration (between hospital and universities) at least at the beginning we need people who are expert in research to support us." (M-level nurse 18)

This dilemma of whether or not an M-level nurse should be responsible for conducting research is also reflected in the Irish and UK literature (Drennan, 2007; Ashworth et al., 2001; Woods, 2000; Scott, 1999; Raja-Jones, 2002). Although the researcher's role is widely considered to be a core aspect of advanced practice, Read et al. (2000), for example, report that it is the least frequent activity that advanced practitioners perform. There is, however, considerable international debate about whether M-level nurses should be prepared to undertake research or whether they should be trained to be skilled utilisers of research findings. In the UK, for example, understanding of research and research utilisation have been emphasised at M-level (Boore, 1996;

Woods, 1997). Gerrish and McMahon (2006) note that few nurses may undertake research, but all nurses should develop research awareness and utilise research findings. They add that evidence-based practice requires considerable skills in identifying and appraising evidence. However, Ashworth et al (2001) note inconsistencies in nurse lecturers' expectations of the research skills that are appropriate to an M-level nurse: some require students to undertake a research study, while others argue that the student needs only to be able to analyse and apply research findings.

Similar tensions between 'doing' and 'applying' research have been reported in other developed health care systems. In Australia, the Confederation of Australian Critical Care Nurses recommended that the curricula for postgraduate critical care nurses should include the use of current research findings to plan and give care (Dunn, 1996), a recommendation which is current today. Similarly, the American Association of Colleges of Nursing (AACN, 1996) has developed a framework for designing and assessing M-level nursing education programmes for APNs. The AACN state that the nurse at M-level is prepared to be an active member of the research team, not an independent researcher. The M-level nurse is expected to be able to understand the various stages of research and collaborate with an experienced researcher in all aspects of the research process. According to the AACN, the goal of the research component of the curriculum is to prepare a clinician who is proficient at utilising research, including the evaluation of research, capable of problem identification within clinical practice settings, aware of practice outcomes, and able to apply research findings. However, as Bower and Timmons (1999) note, there is no agreement between professional or educational organisations in the United States on how M-level students should be prepared in order to achieve this goal.

In Jordan, research modules taught at M-level consist of two components: the theoretical part and the applied part. The theoretical component emphasises the different research methodologies, the formulation of a research problem, and the development of research questions by which students develop their research proposal. In the applied component, the students learn the techniques for data collection, data analysis, and the dissemination of findings; the last of these is achieved through presentations to a wide audience at the university and presentations at scientific days and conferences. M-level

students usually undertake research as part of a team (groups of two to three students work together on one project) (Dr. S. Al-Majali, personal communication 4th Feb 2009). See Appendix 8 for nursing Master's degree course modules at Jordan University of Science and Technology.

6.3. Advanced Nursing Practice: generic and specific understandings

The analysis of survey free-text responses revealed that understandings of ANP are characterised by M-level nurses either in terms of generic role characteristics or in relation to a specific area of clinical practice. For some participants, ANP is a generic term that has relevance to, and resonance in, all areas of nursing where direct patient care takes place:

"ANP is to provide good nursing care in a proper way to those who are in need of this care regardless the area they are in." (M-level nurse 12/ survey data)

"it means to be more generalised in conducting nursing care at the level of knowledge – research based in area of practice." (M-level nurse 31/ survey data)

For other respondents, their effort to articulate their understanding of ANP is focused upon a specific area of clinical practice, such as critical care:

"A nurse who practises in a critical area which needs critical thinking, problem solving techniques and up to date knowledge in the area of practice." (M-level nurse 7/ survey data)

"to work in specific area with high skills based on advanced knowledge and updated knowledge." (M-level nurse 25/ survey data)

A similar overlap between 'ANP' and 'specialist' practice was reported in the broader literature. In the UK, Fulbrook (1998), and Woods (2000) note that advanced practitioners in their studies believed advanced practice to be located in a specialist field of clinical practice. However, practitioners also acknowledged that the core components of ANP, including research, education, and general knowledge, could be transferable, and that ANP curricula could reflect both generic and specific practice principles (Woods, 1997).

Hamric (2001) distinguishes between specialisation in nursing and ANP. She suggests that specialisation involves concentration on a selected clinical area within the

field of nursing, and therefore all nurses with extensive experience in a particular area of practice (e.g. paediatrics) are specialised in this sense. On the other hand, ANP includes specialisation but goes beyond it. It also includes expansion, and advancement. The American Nurses Association (1995) characterised ANP as having three components: specialisation, expansion, and advancement:

> Specialisation is concentrating or delimiting one's focus to part of the whole field of nursing. Expansion refers to the acquisition of new practice knowledge and skills, including the knowledge and skill that legitimate role autonomy within areas of practice that overlap traditional boundaries of medical practice. Advancement involves both specialisation and expansion and is characterised by the integration of a broad range of theoretical, research-based and practical knowledge that occurs as part of graduate education in nursing.

Review of the course content of the Master's in critical care nursing at Jordan University of Science and Technology shows clearly that both specific and generic features are included. The generic features within all Master's programmes in Jordan University of Science and Technology include advanced health assessment, advanced nursing research, nursing theories, and applied epidemiology and biostatistics. The specific features include specialist study such as adult acute care (see Appendix 8).

Study data also suggest that some participants were not familiar with the term ANP. These respondents were generally familiar with Master's degrees in specialities such as critical care, but they did not spontaneously associate this with the term ANP. Drawing upon their awareness of specialist nursing posts, nurse managers, in particular, identified ANP as a sort of specialisation in nursing:

"*you mean like the clinical nurse specialist and such specialities. We learnt about them when we were studying Master's----- In Jordan we have some degree of speciality; now these specialities are acquired by higher degrees such as critical care 'ICU nurse' and haemodialysis nurse; these are the most common.*" (Director of Nursing 1)

One nurse supervisor reported that she encountered the term 'ANP' through her colleagues who worked in the RMSs, and she noted that she had heard impressive things about it. However, her narrative refers to specialisation in one area of practice:

"*I heard about the specialist nurse-----in the military classification (Royal Medical Services) they have for example special ICU nurse, and CCU nurse. I heard about their experience; they talk about it in our meetings with them, and I heard about it from my*

friends… the specialist nurse got special knowledge and experience about what she is doing; for example CCU nurse knows everything about cardiology; she is licensed to be a CCU nurse; she has major responsibilities about the patient, how to care for the cardiac patient, how to analyse the situation and how to make decisions." (Nurse Supervisor 1)

Not only was this lack of familiarity with the term ANP common amongst nursing supervisors and directors, but it was also prevalent amongst non-M-level nurses. The sentence: *"I don't think I have heard of it"* was frequently reported by staff nurses. The situation with physicians was similar as physicians acknowledged that they had not encountered the notion of ANP.

"to be honest with you I have never heard about it and nobody told me about it, but I know that there are nurses here with Master's degree." (Physician 1)

Participants' lack of clarity about the term might be related to the fact that the term 'ANP' is not formally recognised in Jordan. There was, however, some recognition of the difference between the role of the specialist nurse and the role of the CNS, as this professional body representative explains:

"we have two levels a specialised nurses, a nurse in one area like paediatric nurse, psychiatric nurse… the preparation should be a diploma after bachelor degree; we will have another level which is the advanced, the clinical nurse specialist which is really a Master's degree level…- the education is one criteria for accreditation; there are also other criteria, experience. For example, did she do any research? There will be other requirements that we will decide later on." (Professional Body Representative 1)

The classification given by the professional body representative acknowledges that the level of academic preparation expected for CNS, which she described as 'advanced', is a Master's degree. However, the definition does not specify any personal or practice characteristics that must be demonstrated by the advanced practitioner. The lack of clarity about what is meant by ANP and specialist nursing in Jordan has resulted in many people, including nurses themselves, not clearly understanding the attributes and nature of ANP. Moreover, the title of 'advanced nurse practitioner' is not yet recognised in hospitals in Jordan.

During field observations, conversations with some nurses and physicians in the study hospitals highlighted this lack of clarity: in general, nurses and physicians expected

M-level nurses to be educators and managers or to have other posts that were not related to direct patient care.

Overall, non-M-level nurses and physicians articulated their understanding of elements of ANP in terms of what M-level nurses do in practice. Other participants, M-level nurses, nurse educationalists who were responsible for delivering Master's degrees, and representatives of professional bodies who were trying to enhance the development of the nursing profession in Jordan, were more familiar with the concept. They emphasised that the competencies required for ANP had to be formally taught through an advanced educational programme such as a Master's or a PhD.

6.4. Perceived benefits of advanced nursing practice

Some participants assumed that ANP should be associated with direct benefits to others (patients and nurses). Others suggested that some elements of ANP should extend beyond direct patient care. In this study, the majority of M-level nurses felt that they were required to utilise the knowledge and skills they gained through their education to improve nursing practice. They did not see themselves as only providers of direct patient care, but also as educators, consultants, and resource persons for patients, their families, and other staff:

"---acquiring more advanced roles of being an educator, a specialist, a consultant, a resource person and preceptor." (M-level nurse 30/ survey data)

"advanced practitioner is a registered professional nurse who uses special education (Master's degree), specialised knowledge and new skills in the care of patients and families and also training other staff" (M-level nurse 23/ survey data)

Similarly, research skills and knowledge were also seen as resources for improving patient care:

"Using nursing research and knowledge in practice area for improving patient care." (M-level nurse 27/survey data)

The narratives of these M-level nurses indicate that they were convinced of the potential benefits of introducing elements of ANP in practice. Mantzoukas and Watkinson (2007) refer to these roles as coaching, facilitating and mentoring other colleagues to develop personally and professionally, or coaching and facilitating patients

to progress though their disease. Furlong and Smith (2005) point out that patients are the ones who should be the ultimate beneficiaries of new nursing roles, and acknowledge that developing the role of the advanced nurse practitioner and demonstrating its value to patient care poses a major challenge.

However, enhancement of the caring role of nurses and benefits to patients were rarely mentioned by nurse educationalists in this study. M-level programmes are informed by a vision for nursing of increasing professionalisation. Nurse educationalists saw M-level education as a tool to equip nurses with an enhanced knowledge base that increased their status and legitimised their position in relation to medicine. Nurse experts' narratives highlighted aspirational statements in relation to nursing and nurses: their hopes for the future of the profession and the ability of nurses to exercise influence and leadership to strengthen the power and status of nursing in Jordan. When asked about the potential impact of M-level education, nurse educationalists and M-level nurses agreed that the professional identity of the nurse could be enhanced through such education:

"Knowledge is power--- it will help more to advance the profession and whenever you work with other health care professional, other sectors of health would appreciate more the nurse who has the knowledge, skills and attitudes which are appropriate to provide care which is different from others." (Nurse Educationalist 1)

"knowledge is power and if you show people that you are capable of taking decisions and providing knowledge and make a difference so people will try to start to appreciate you." (Nurse Educationalist 3)

The development of nursing in this way was assumed to be associated in a straightforward cause-and-effect manner with improved patient care:

"we hope by having this (ANP) to develop the nursing profession and to develop the practice of nursing in the areas of specialties that are going to be accredited. Yes I hope that it will have a positive impact on the patient." (Professional Body Representative 1)

However, there was an awareness that change in Jordan would not be easy, and that it would require an increase in the number of M- level graduates:

"you need many graduates to do this; we're graduating a very good number of nurses but they've not been spread in different places to change the image about the role of the nurse or the advanced roles of nurses and specialised practice." (Nurse Educationalist 4)

In acknowledging the impact that these nurses might have on practice, some participants saw the poor image of nursing as a barrier to understanding the potential benefits of enhanced nursing care in general and ANP in particular. However, the number of M-level nurses currently in practice in Jordan is small, and their potential influence is therefore limited (further discussion of the image of nursing in Jordan is presented in section 8.4.1.2).

6.5. Drivers for educational change

It was difficult to derive a coherent account across different groups of participants of the drivers for change and the development of ANP. The majority of nurse scholars in Jordan were influenced by nursing education and practice in countries such as the United States and the United Kingdom (Shurique, 2008). It is within this context that the drivers for educational change in nursing and for the introduction of ANP were articulated in participants' narratives as: globalisation and the increasing technologisation of healthcare; the perceived needs of the country; and expanding opportunities for continuing nurse education.

6.5.1. Globalisation and increasing technologisation of healthcare

Nursing is undergoing rapid change in Jordan, but it is difficult to clearly identify the drivers for change which are informing such development as many bodies are involved in the process of change. Nevertheless, clinical Master's programmes are usually led by nurse educationalists. A statement given by a nurse educationalist who had been involved in establishing Master's programmes suggests that their establishment was fuelled by a concern to improve the quality of patient care. However, other drivers can also be identified: one early intention was to produce as many M-level nurses as possible regardless of the nature of their studies (Dr. S. Al-Majali, personal communication, 4th Feb 2009). This was done in order to demonstrate and enhance the value of specific educational institutions within the Jordanian market place for higher education. Other participants, in particular nurse educationalists and professional body representatives, also saw that M-level nursing courses reflected the globalisation of nursing and the use of high technology in contemporary health care:

"---.in this time and place and with the advanced technology and globalisation that are impinging on our daily activities and daily life we think we need some change and it is happening." (Professional Body Representative 1)

"*I think we're obligated to have universal standards because of the openness of our world now and this is what we're aiming for. Eventually this is our ultimate goal; we are really after excellence."* (Nurse Educationalist 6)

Universities in Jordan have exchange programmes for faculty and students in different countries such as the USA, UK, Canada, and Australia. These programmes are intended to help to ensure quality education that meets international standards (Shuriquie et al., 2007). Globalisation, as highlighted by some participants, is well evidenced in the nursing literature. Thompson and Watson (2003) point out that, in an age of globalisation and diversification, nursing needs to ensure that it remains responsive to changing health care needs.

Gerrish (2004) suggests that the globalisation of nursing occurs by means of nurse migration*,* where nurses move from one country to another, creating a global workforce of international significance. She emphasises that international collaboration in curriculum design provides an important vehicle whereby the core elements of nursing can be enhanced through the development of shared educational programmes. International exchange programmes are seen to create valuable opportunities for nurses to gain insights into alternative health care systems and therefore enhance their understanding of nursing within different cultural contexts. Moreover, access to the internet provides opportunities for nurses and nurse educators to maximise learning and network. Jarvis (1997) suggests that globalisation provides an opportunity for advances in nurse education to be more widely offered to countries where this expertise is needed. Ketefian et al. (2001) note that nursing work is heavily dependent on knowledge that is constantly changing. They confirm that nursing education and practice must also change if they are to stay relevant, and that frequent conferences at national and international levels enable nurses to access the latest research and network with other nurse scholars.

6.5.2. Perceived needs of the country

In addition to globalisation, the needs of the country in terms of skill mix to be able to deliver contemporary healthcare within the current Jordanian context, as assessed by the educationalists, was another driver for the development of the role of advanced practitioner. However, most educational institutions work independently in Jordan, and there is no formal means of evaluating the existing programmes and modifying them in response to feedback given by students and healthcare providers. Nurse educationalists define educational priorities based on their observations and their contacts in the field, and revise educational programmes accordingly. Recently, they have noted a need for the inclusion of more clinical practice and the development of further clinically-focused Master's programmes. As a result, programmes are currently being reoriented to address this perceived deficit, as indicated by one of the pioneer nursing educationalists in Jordan (Dr. S. Al Majali, personal communication 4th Feb 2009).

One nurse educationalist who was involved in planning for these programmes explained that proposals for change are generally made by nurse educationalists themselves:

"I was able to be part of the area assessment and planning for the programme, we developed the programme based on community as well as health care providers' perception and needs, the characteristics of the new graduate of the Master programme and all people they agreed that it should be clinical nurse specialist and that's what the country needs." (Nurse Educationalist 5)

She went on to note that, although they consulted people and assessed the situation, it is the educators who are believed to know the needs of the country:

" we planned, we conducted two workshops; one with academic people to see whether we're in line and the second with the service people and we included physicians and all people from the service area they don't know what the clinical nurse specialist is, but they said we want people who are clinically well prepared and competent. Actually to be honest with you it's the critical care or the acute care area that they emphasised very much. By the time we developed the programme many critical care units are being opened and new technology has been transferred to Jordan through very advanced medical procedures, and as you know sometimes the service could be very much faster than the education so we wanted to really keep up with the medical technologies and medical interventions, the advanced ones, so we thought we will start with acute care but definitely it was the consumers, the graduates who decided on these and I think it's the service area that emphasised, in addition as an educator you know what are the needs of

the country because we are very up date with the country….just prior to conducting the workshop we were able to develop a report for WHO analysing the situation of nursing in Jordan and what are the lacking areas and specialisation was one of them." (Nurse Educationalist 5)

Another nurse educationalist, in a different university, who was also involved in establishing a clinical Master's programme, had similar views:

"we felt that there is a need in the country to start a clinical nurse specialist or a clinical nursing programme to have different kind of qualification, Many hospitals are opening and we have a need for the advanced nurse practitioner or a clinical nurse who has a Master's degree in nursing to have a role in the ICU and CCU and the different kind of services provided to patient in Jordan, in addition we need them to other countries like Saudi Arabia and Gulf area and many other country are recruiting our students even the States and the United Kingdom." (Nurse Educationalist 2)

These accounts suggest that the perceived demand of hospitals for specialised nurses in areas such as critical care was met by educationalists by opening clinical Master's programmes that place more emphasis upon critical and acute care. There was also awareness that Jordanian nurses are recruited by other countries, and that there was a constant need for graduates with various qualifications. This demand was also justified by the need to improve patient care in Jordan:

"our main target is the patient. We want to improve the care provided to patients. It is expected that the nurse with special courses, higher diploma or Master's have knowledge and skills much better than the general nurse whose knowledge and skills was gained by experience and this experience might be gained through learning from others, through routine work or even wrong information." (MOH Representative)

Other participants thought that there were no specific aims associated with the development of M-level programmes. However, the expectations of M-level education seemed to be ambitious and to place a heavy burden on the M-level nurse:

"but to be honest I don't think that the people who developed the programme (clinical Master's) have or had at that time a clear vision of what we want out of this programme. What they had in mind is really to shift from education to clinical because there is a lot of demand for clinical. Education as you know has been saturated according to what they think and students would like to have clinical programme as well aiming to graduate as postgraduate nurses who are prepared at postgraduate level and who are able to serve in a clinical settings ---- what they want is somebody who can assume the role of the advanced practice nurse, who can give probably high quality nursing care, who can conduct and be involved in research and who can teach as well as work in the clinical area and be a good educator and who could also serve as a resource person for his colleagues or her colleagues, these are really the main things that are behind the

programme, to what extent we achieved this is a different question." (Nurse Educationalist1)

There was also an increasing demand for specialisation from both nurses and their managers at government hospitals:

"There is an increasing demand on the specialised courses from the nurses and their area managers, we try our best to fulfil their needs and get them trained once the appropriate courses are available." (MOH Representative)

At the MOH hospitals, courses in different specialities are offered to qualified nurses:

*"We have as well high diploma specialities such as, renal, palliative care, diabetic nurses, oncology, psychiatry and intensive care and neonates. After these nurses complete the course, they go back to their units and they help in training other nurses in their units. Nurses are sent from all ministry hospitals so that we could have these specialised nurses all over the kingdom…for the time being they remain as registered nurses who have, for example, speciality in intensive care or palliative care." (*MOH Representative)

It is emphasised that the main goal of these courses is to improve nursing care. It is also worth noting that the availability of these speciality courses is dependent not only on the needs of organisations and staff but also on funding and sponsorship from external resources such as World Health Organisation (WHO) and foreign aid:

"We want to develop the nursing care so we sponsor these nurses and we take into consideration the needs of the hospitals in addition to the budget provided. We sent nurses to the Royal Medical Services for courses in cardiac cath and heart lung machine…., we send them abroad in some specialities which we don't have in Jordan. For example we sent nurses to Bahrain to train in psychiatry and addiction. It also depends on the fund and agreements between the MOH and the WHO. Otherwise why should we send them abroad if we have Master's in Jordan? We also have collaboration with the Spanish, Japanese, Singapore, and Korean governments to train our nurses. Experts from these countries come to Jordan and help in training our staff." (MOH Representative)

Therefore, sponsoring nurses for speciality courses is largely dependant on the collaboration between health sectors at both national and international levels, and, to reduce the costs of these courses, nurse experts from other countries are brought to Jordan to help in training qualified nurses. Specialised education requires specialist educators, and the lack of specialised faculty members in areas other than critical care has inhibited the development of other programmes at a university level:

"we have plans; let's say it's just plans now and we will implement these plans in the future... To implement them we need staff specialists in certain fields in order to start new tracks in the M-level, but in our minds let's say at this time to start oncology nursing and have oncology nurse specialist; we need this due to different reasons but may be we will start with this branch. Another branch that could be started is palliative care. With the passage of time may be we can spread over more and more." (Nurse Educationalist 6)

In Jordan, ways were found to solve skills gap in the past, mainly by sponsoring nurses for postgraduate studies overseas in order to fill the gap for nurse educationalists. It can be claimed that because of the provision of M-level courses in critical care, there are now a good many nurses with those skills, but there is not enough funding to start up Master's courses in other specialties such as oncology nursing.

Although some nurse educationalists claimed that the perceived needs of the country were driving the educational developments noted within the profession, it was not clear how they assessed those needs. However, their emphasis on the expansion of nursing education to meet manpower requirements and supply in the market could be seen as one way of defining the needs of the country. Similar drivers were reported in the broader literature (Ketefian et al., 2001; Thompson & Watson, 2003). Thompson and Watson note that advancing nursing practice will largely depend on contemporary societal health care needs, new knowledge and technology, and increased patient and professional expectations.

6.5.3. Expanding opportunities for continuing-nurse education

The expansion of opportunities for continuing nurse education was also seen as a driver in its own right. At the time that the Master's programmes were established, there were faculty members prepared to teach these programmes:

"after around may be 7 to 8 years of graduating nurse educators we felt that there is a need in the country to start a Master's programme in clinical nurse specialist or a clinical nursing to have different kind of qualification." (Nurse Educationalist 2)

Sheer and Wong (2008) and Duffield et al. (2009) reviewed the development of ANP internationally. They found that the readiness of the nursing profession to advance to a higher educational level was an important factor in this development. The authors point out that this 'readiness' depends on the presence of a substantial general nurse

population and a well developed system of nursing education at the bachelor level to allow further development of the discipline. They also emphasise that, where postgraduate education existed, APN roles were established. This process began with demands from healthcare services. Some countries began with the role and then developed the title, scope, and regulation. This process is currently evident in Jordan where the Master's programmes were first established to develop such roles, but much work is still needed to establish regulations, title, reimbursement, scope and standards of practice. However, Sheer and Wong (2008) note that, in some other countries, regulation preceded educational preparation and the development of the ANP role. Shuriquie et al. (2007) note that the clinical focus of postgraduate education reflects the need to develop advanced clinical nursing practice in Jordan.

As one nurse educationalist emphasised, the demand from highly specialised hospitals for nurses with critical care training has been interpreted by nurse educationalists as indicating the universities' success in meeting the needs of hospitals:

"..but I think the very specialised hospitals are very happy with the acute care graduates so far...." (Nurse Educationalist 5)

By contrast, the demand for nurses with specialist community training was believed to be very restricted, and community nursing was less valued by nurses. This lack of emphasis on community nursing was highlighted by one nurse educationalist, and was the focus of her narratives. As mentioned earlier (section 3.4.1.5), there is only one community postgraduate nursing programme. Nurses who graduate from this programme do not work in community settings and are not seen to have any impact upon practice. Nurse educationalists suggest that many people involved in health services consider community nursing to be less in demand and less privileged:

"..I think with the community the market had or still does not really recognise the role because none of them has worked in the community to make a difference in the primary health care." (Nurse Educationalist 4)

This participant went on to explain:

"..that's probably why community graduates are not being looked upon highly. It is because they have a very general line of practice, but I think they should focus more." (Nurse Educationalist 4)

This quote suggests that even community nursing, which usually emphasises generic nursing practice, should encourage more specialist expertise and practice. This suggests a particular value system in which specialist practice is subject to super-valuation while generic nursing practice is under-valued. This has significant implications in terms of evolving nurse education and practice over time. Moreover, some nurses who studied on a community Master's programme did not do so because they were committed to this speciality, but because it was the only choice available to them:

"..we have to understand one thing; they went to community because that's what they got; it's not because they like community; it's because that's what they have been accepted in." (Nurse Educationalist 4)

This is reflected in a comment made by an M-level nurse:

"I studied community nursing because it was the only specialty available for me because of my [low] marks." (M-level nurse 20)

He added:

"I prefer education more than practice." (M-level nurse 20)

For this M-level nurse, the community Master's degree was the only programme available to him. Admission to Master's programmes is highly competitive in Jordan. Nurses are accepted in these programmes depending on their Grade Point Average (GPA) in the bachelor degree. Because of the high demand for critical care, nurses who have a higher GPA are offered places in this programme; nurses with a lower GPA have no choice if they want to pursue M-level education but to apply to other programmes. Although there is one community nursing Master's programme, the role of the nurse in this programme is not clear. It is difficult to get a clear feel for what the anticipated practice of the graduate would be, and I could not find evidence of real employment opportunities in the community settings for its graduates:

"I think the acute care was a success more than the community because of its limited areas and its tangible areas you know you can see the outcomes immediately, we succeeded with the quality and I think we can see tracks for students into acute care, into cardio pulmonary as well as into cancer care or oncology nursing." (Nurse Educationalist 3)

However, it seems that nurses sometimes enrol in this programme in order to pursue an educational route because they see value in the postgraduate qualification in general, rather than in the specific qualification.

It was noticed that only one of the participants in this study had taken a Master's in community nursing. Haddad and Umlauf (1998) and Mrayyan (2004) relate the lower status of community nursing Master's course to the fact that many nurses do not value and therefore do not consider nursing practice in community settings. Primary health centres in Jordan generally employ nurses who are not qualified registered nurses (Francis et al., 2005). Francis et al. (2005) argue that the practical nurses and nursing aides who work in these settings have little understanding of contemporary health issues and developments in nursing. Hijazi and Al-Ma'aitah (1999) note that the Jordanian government is working towards supporting and improving primary healthcare services (PHC) through a particular 'health for all' programme. However, the authors note that nursing has not figured a great deal within that priority. Nurses in the PHC are mainly responsible for prenatal care, growth monitoring, and immunisation. There are no plans to utilise the expertise of highly qualified nurses in these settings as Hijazi and Al-Ma'aitah suggest.

6.6. Conclusion

ANP is a complex concept which non-M-level nurses, nurse managers and physicians were not familiar with. By contrast, M-level nurses, nurse educationalists and professional body representatives were familiar with the concept and articulated their understanding in terms of characteristics attributed to the M-level nurse. This situation is not peculiar to Jordan, and lack of clarity about ANP, and the conflation of ANP and specialisation, has been widely reported in the literature. ANP and M-level education were also seen as a professionalising strategy, a finding that was echoed in the broader literature.

The findings also suggest that advanced nursing practice to be located in a specialist or generic field of clinical practice. On the one hand, the specialist knowledge and specialist expertise are not transferable. On the other hand, advanced knowledge and

cognitive skills and research skills would enable the M-level nurse to work in and transfer these skills in non-speciality areas. The drivers for change in nursing education have also been key factors in shaping the nature of nursing education in Jordan. Understanding these drivers is significant in setting up advanced practice in Jordan.

Taking these findings into considerations, there is little evidence that nurse educationalists, professional bodies and employers currently collaborate effectively to identify a framework for ANP in Jordan. Furthermore, there is a lack of clarity about scope of practice, regulations, person specifications, and appropriate educational preparation.

In the next chapter, I shall discuss the motivation of nurses to undertake a Master's degree, and the challenges they face throughout their journey to achieve their goal.

Chapter 7

Becoming an M-level nurse

7.1. Introduction

This chapter begins by presenting the motivations of Jordanian nurses to undertake a Master's degree. This will be followed by a discussion on the perceived necessity for M-level education for nurses. Educational issues affecting the nurses through their journey to becoming M-level nurses will also be discussed. These issues are related to the educational challenges that such nurses face, the nursing educational system, faculty preparation, and teaching strategies.

7.2. Motivation

During the interviews, all M-level nurses were first asked about their reasons for doing a Master's degree. Most of the underlying reasons mentioned by the participants were congruent with Dornyei's (2001) notion of instrumental motivation. Instrumental motivation refers to the desire to do something in order to achieve practical goals. Some M-level nurses cited several motivations for undertaking M-level education. The analysis of the interview data illustrates three main themes underlying nurses' motivation to get a Master's degree: self development, broadening career opportunities, and developing practice.

7.2.1 Self development

The strength of the drive for self development as an instrumental motivation shows clearly in the responses of this M-level nurse who reported that he chose to undertake M-level education to:

"improve myself and to improve my skills, my ambition is more than a bachelor degree because I see that nursing is a more subordinate job than the doctors, my ambition is very high, and I found that nursing is not enough for my ambition." (M-level nurse 18)

He expressed his dissatisfaction with his status as a nurse within practice settings, and with nursing as profession. Convinced that nursing was still subordinate to medicine, he sought a way to further his own ambitions without jeopardising his security of employment:

"For a while I thought of changing my profession then when I gave it more thinking I found that a Master's degree is more suitable for me in this country, if I wanted to change my career, I would not be able to find a job. Most of the graduates of other specialties are not working so the best thing to do was studying Master's." (M-level nurse 18)

A Master's degree could bring personal benefits; it was an investment for the future as this nurse suggests:

"I thought I would like to invest my time in something useful; a friend of mine encouraged me to study Master's, so I did some brainstorming, then I thought why not, instead of wasting time and money let me invest them in something useful." (M-level nurse 5)

Nevertheless, she found it difficult to articulate the benefits of this degree in her practice:

"it added something…but it is not happening in the work that I am doing."

On reflection, she explained that pursuing a Master's degree had affected her personality and her ability to deal with different situations at work: she had benefited in terms of increasing self-esteem:

"Now I am not the same person who I was two years ago. This was reflected in my work, how I deal with things, and how I solve problems; its effect was positive on my life." (M-level 5)

The following M-level nurse perceived his degree as a way of gaining knowledge and professional development:

"there is more than one reason. Firstly to gain knowledge so its knowledge wise, secondly to improve myself at the professional level." (M-level nurse 12)

Pursuing a Master's degree was seen to distinguish M-level nurses from many other nurses: a postgraduate degree meant a hope for developing and empowering nurses and raising the status of nursing itself:

"if *you noticed studying nursing is very popular in Jordan, I think we should be distinguished practice and knowledge wise. Moreover, we have to develop ourselves and this could be done through gaining a certificate which will give us power."* (M-level nurse 19)

Another M-level nurse was hoping to strengthen her position in her employing organisation and enable her career development:

"Master's is a degree that strengthens my position." (M-level nurse 24)

One M-level nurse described herself as a high academic achiever, and this encouraged her to undertake higher qualifications. Being a wife and a mother, she could not pursue her goal abroad. However, being pragmatic, the availability of the course in Jordan and the close proximity of the university to her house motivated her to enrol in the Master's programme:

"I got high marks in the diploma and afterwards in the bachelor degree; this encouraged me to study at Master's level. The university was close to my house and being married it was easy for me to go to this university. These things encouraged me to register in the programme because it was accessible and I did not have to travel abroad." (M-level nurse 11)

Instrumental motivation can be very effective in stimulating learners of all kinds, including nurses. Hayajneh (2009), in a survey of 472 Jordanian nurses, reports that nurses in Jordan have positive attitudes toward continuing education in general, and that they value such activities for professional promotion and development reasons. According to Hayajneh, Jordanian nurses are also interested in maintaining professional competence and keeping up-to-date. Schwirian (1998) notes that many nurses see higher education largely as a means of advancing their own careers and of furthering the professionalisation of nursing. Schwirian adds that changes in the work place prompted practising nurses to pursue advanced education in the USA.

In Jordan, an enormous value is attached to higher education. Part of the value of higher education is that it is seen as a way of improving the status of nursing in relation to physicians. The existing hierarchy between nurses and physicians has fuelled the development of and helped to maintain task orientated nursing practice.

The findings of this study are consistent with those of Murphy et al. (2006) who reviewed the literature on professional development amongst nurses in Ireland, UK, USA and Australia, and found that nurses' main motivators for participating in professional development were improving self esteem and confidence, and increasing opportunities

for promotion. Similarly, Chiu (2005) found that the main motivational factor that prompted Malaysian nurses to pursue higher degrees was their desire for personal and professional growth. A consistent finding in the literature reported by Dowswell et al. (1998), Davey and Murrells (2002) and Joyce and Cowman (2007) is that gaining professional knowledge and achieving professional advancement have the highest priority for nurses to undertake a Master's degree.

7.2.2 Broadening career opportunities

A broadening of career opportunities was an important motivation for pursuing M-level education. The security of a stable and well-rewarded job meant that this nurse intended to stay in the profession but, if the opportunity arose, he would leave Jordan altogether to work in a country like Saudi Arabia where working conditions, salaries and benefits are much better for nurses:

"I wanted to be in in-service education in the clinical field. Yes, I wanted to be a clinical instructor or a teacher in the hospital. Sadly, after one year I changed my mind. Honestly, I am telling you how I felt. Things have changed because I did not feel that anything could change in this country, may be abroad in the gulf area (Saudi Arabia) things are different because they have a system and the situation is much better for M-level nurses." (M-level 18)

Difficult working conditions and unsociable shift patterns encouraged this M-level nurse to undertake Master's education in order to broaden his career opportunities. He did not intend to leave nursing, but he wanted to escape shift work and improve his working conditions:

"because our work is hard and we work shifts so having Master's might help us work on day shifts. I do not want to go for academic position; on the contrary I want to stay in the clinical area so things get better for me. Also salary and money wise." (M-level nurse 12)

One M-level nurse expressed frustration at his lack of career advancement and viewed Master's education as a means to self development, improved working conditions, and subsequently, access to a post in education:

"I think it's the nature of the role of the nurse. For me after three and a half years of working I found out that I am still the same I wanted to improve and develop myself in both theory and practice; that was the main purpose. The idea of working three shifts is

too exhausting and this could be an opportunity to work on day shift. Moreover, I prefer education more than practice." (M-level nurse 20)

Reflecting on her experience, another M-level respondent clearly stated that, because of work-related factors, most of the nurses who pursued Master's education did so in order to leave clinical nursing:

"in general no one in my batch had high expectations. All of them knew the situation; they were working in hospitals, and they knew how the situation is in hospitals. They knew why they studied nursing; they were honest with themselves; they said they studied nursing to leave nursing- Most of them left the country or were appointed as clinical instructors or are waiting for scholarships to continue their PhDs….all of them were talking about travelling and salaries and all these things." (M-level nurse 5)

For these nurses, expanding their job opportunities within nursing in Jordan, or moving abroad to obtain promotion and better working conditions, was a reason to undertake a Master's degree. Others thought of moving away from direct patient care to education, and thus escaping what is considered as a subservient role and traditional nursing identity to gain recognition and status within or outside the organisation. Rafferty (1996) stated that higher education is perceived as a strong social force in influencing the direction an occupational group may take towards professionalisation (as discussed in section 2.2). This may be explained in terms of the roles envisaged for and by many Master's graduates. M-level nurses are expected to contribute to, and mainly be utilised in, hospitals as part of the in-service education department rather than working directly with patients, as I will discuss in chapter 8.

Mrayyan and Acron (2004) identify several reasons for the high turnover amongst nurses in private and public hospitals in Jordan, and suggest that attrition is associated with low autonomy, poor working conditions, and the availability of career opportunities outside Jordan. In a country like Jordan, a culture that places a high value on higher education encourages the desire to move from being a nurse in a hospital into a university teaching post which enables these nurses to claim professional status and social prestige. Al-Mahadin (2004) points out that the lack of natural resources in Jordan has nurtured a culture that could be described as no less than obsessive with regards to education.

7.2.3   Developing practice

Some nurses who saw a Master's degree as a means to self development also saw it as facilitating practice development. Integrative motivation is characterised by the learner's interest in the topic and his or her desire to bring about practice change, as described by Dornyie (2001). Such integrative motivations for undertaking a Master's degree in nursing were less frequently described by M-level nurses than were instrumental motivations. However, for a small number of nurses, undertaking a Master's degree was prompted by a desire to improve direct patient care rather than a desire for self development:

"for me I really love clinical practice, and I don't like to be an academic so I was really happy to hear about the programme." (M-level nurse 1)

For others, a Master' degree was important because it equipped them with research skills that they could utilise to improve practice:

"Another important thing is that Master's education opens up research opportunities for nurses so that we could improve practice on different levels whether it is our own practice or other people's practice, which at the end will be reflected on practice settings as a whole. I also wanted to link theory with practice; for me Master's is not an academic gain; I could as well remain in the clinical area and improve practice." (M-level nurse 19)

"The programme was in the field of nursing and I love nursing. The main goal was that we love Master's because we want to be innovative in nursing practice, to get borderline for our practice, to undertake research; all these things encouraged me especially it was in intensive care." (M-level nurse 11)

Another M-level nurse was passionate about knowledge and linking this knowledge to practice:

"I have a passion for knowledge; I love to continue my education… I find myself in it. I like to combine theory and practice because both of them can't be separated." (M-level nurse 27)

The motivation to develop practice has also been reported in the broader literature (Gould et al., 1999; Smith & Topping, 2001; Davey & Murrell, 2002; Joyce & Cowman, 2007). It is also noticed that some participants expressed concerns about the value of Master's degrees to professional practice and questioned the outcomes of such programmes for clinical practice. This is discussed more fully in the next section.

7.3 Continuing professional education: the necessity for a Master's degree

Some participants, especially nurse managers, considered that certified short courses with specific content were more appropriate for practice development than a Master's degree. They suggested that registered nurses might take specialist courses in order to develop the knowledge and skills to equip them to practice in areas such as those relating to critical care and diabetes:

"I don't think you have to have a Master's to work with patients in critical care. Bachelor degree nurses can have courses or programmes, nine months, eight months, one year programme in certain specialities, for example, *diabetic centre, sent one nurse for one year to take special course as diabetic nurses, then they sent two nurses; that's very good."* (Nurse Supervisor 1)

The reason this nurse supervisor gave for holding such a view stemmed from a concern that Master's degree graduates often left the clinical field to seek other alternatives:

"all Master's degree nurses want to do PhD or be teachers in universities. I think courses in critical care are better than Master's degree in critical care if they want to work in the field." (Nurse Supervisor 1)

One physician noted that gaining a Master's degree does not necessarily generate good teaching skills in clinical areas. He stated that physicians could judge the ability of the M-level nurse to teach. Nurses who are active in their work, competent, knowledgeable, and broad minded, are the nurses who can teach others:

"Having a Master's by itself does not mean the nurse is good for teaching---from our rounds, from our daily work we can tell this nurse is active; can really teach; is good enough; is knowledgeable, and is broad minded; we can tell." (Physician 3)

Some staff nurse participants were in favour of Master's courses, highlighting the benefits of continuing educational programmes for updating M-level nurses' knowledge:

*"with Master's you update knowledge; updating the knowledge is always required; no one is perfect." (*Staff Nurse 1)

The findings of several studies have reported a divergence of opinions about what adequate preparation might mean, and who should provide it for nurses. In the UK, Cameron and Masterson (2000) sought out the views of Nurse Executive Directors on new role developments in nursing. They reported that some nurse directors felt that

nurses in innovative roles should be encouraged to go on Master's degree courses. Other directors had developed in-house programmes that were sometimes linked to a local educational provider. Similarly, in Canada, the Advisory Committee on Health Human Resources (ACHHR) (2001) investigated the nature of the extended/expanded nursing role. Inconsistencies were noted in expectations regarding the educational preparation of registered nurses for the extended/expanded role, which ranged from 2-6 week intensive courses, through one-year diploma programmes to undergraduate and postgraduate programmes. ACHHR notes that, regardless of the method of gaining knowledge, it is what is gained that really matters.

The significance accorded to M-level education derives from the assumption that it builds upon what was obtained at the undergraduate level (Conneeley, 2005). Advocates of Master's education in nursing propose that it prepares nurses so that they can shape the health care environment and context of care in ways that create an appropriate climate for the development of standards of practice and assessment and evaluation tools which enable accountability (Ketefian & Porter, 2000). Watson (2006), however, questions whether higher education has a necessary role in preparing nurses. The answer to this question, he suggests, depends on whether or not nursing is viewed as a profession. He goes further to explain that it also depends on what the purpose of a university is. In his view, a university is not just about training people but also about the preparation of accountable people. Watson suggests that accountability is the hallmark of a profession. Nursing's aspiration to professional status emphasises the need for higher education that prepares nurses who are capable of adapting to unfamiliar circumstances in unfamiliar contexts. The next section will discuss the challenges that nurses face while undertaking a Master's degree.

7.4   Challenges of undertaking an M-level degree

Nurses who wished to continue their education through M-level study had to have the approval of the hospital management to facilitate their study time. For those who were not granted hospital management approval, the hospital was not obliged to accommodate the demands associated with studying for a Master's degree. These nurses

were required to adapt their study to their work time without being given time-out or study days. It was hard for the majority of M-level participants to do so, especially that the part time option of study is not offered in the Jordanian universities.

Nurse managers were asked why some hospitals sponsor nurses for M-level education. A variety of reasons for doing so were noted. These include improving the status of the hospital, encouraging nurses to remain in practice, improving nursing care, and undertaking research:

"the hospital got only this number of Master's degree nurses. When we attend conferences you find papers and research from all hospitals except ours. We want as well to cancel the concept that if you have a Master's degree you have to be in a position. Secondly, we want to improve the level of nursing care in the hospital. I worked in a committee with the Royal Medical Services; they have what they call professional ladder. In America there are nurses who don't like to be managers or to be nurse-in-charge so they developed certain positions that enabled these nurses to work with the patients. We thought why don't we have Master's level nurses in all the wards? They can do research, scientific days and so on." (Deputy Director of Nursing 1)

Where sponsorship was available, this entailed paying the fees and shuffling shifts around and facilitating working hours to cope with study demands. This way of accommodating nurses who were undertaking Master's degrees created problems for all nurses and for management. Coordinating nurses' working time with their study time caused difficulties for managers:

"We sponsored six nurses, but we suffered a lot because they wanted everything from the hospital. They wanted time; they wanted the practice credit hours to be counted from their working hours. Here we don't have the luxury to allocate them study days. With the shortage we have it is not possible to give six nurses study days, and the policy here does not allow us to do so." (Director of Nursing 1)

A nurse supervisor in the ICU expressed her frustration by saying:

"I have problems putting schedules together, so I need to make considerations to their duty and their university; for example, one of them asked for three days off in the week; this is a very big problem for me; we have 14 staff for seven patients (ICU); we have holidays; it is a headache." (Nurse Supervisor 2)

Allowing nurses to undertake a Master's degree was sometimes described as 'a burden'. M-level nurses put additional pressure on the hospital by requesting support and time to undertake academic work. One Director of Nursing expressed frustration that these nurses did not, he felt, take into consideration the needs of their hospital. There was

also a fear that Master's degrees might lead nurses out of practice. This attrition, it was felt, might influence managers' support for Master's education. It is, therefore, common practice in Jordan for sponsored nurses to be tied with a binding contract that obliges them to work at least double the period they spend studying, in their sponsoring hospitals or to pay back the financial costs of their studies. Nevertheless, when M-level nurses graduate, they tend to pay and leave:

"That's why allowing the nurse to study for a Master's has become a burden on the hospital because you have to arrange his rota, his holidays. Everything has to be arranged the way he wants it and not the way that suits the hospital then when he graduates he will leave; that's the tragedy." (Director of Nursing 2)

"The concept in Jordan if you have Master's you have to go and teach in the university, as soon as the nurse graduates he will resign, no one stays in the hospital." (Deputy Director 1)

An M-level nurse explained the situation in her hospital:

"The nurses who were sponsored by the hospital might get a managerial post. In return, they have to work for the hospital (compulsory) for three or four years. For example, a colleague of mine is waiting to complete this mandatory service and leave the hospital." (M-level nurse 1)

In addition, for nurses enrolled in a Master's programme to be able to attend their classes in the morning, some of them had to work night shifts, which in turn affected their performance in practice, reinforcing an undesirable image of M-level nurses and fuelling dissatisfaction with their role in hospitals. The academic challenges and demands on M-level nurse students caused some nurse managers to criticise their commitment to practice:

"they want to take night shift so they can be at the university in the morning; they need the money to continue their education; few of them tried to educate us or tell us something new about what they learnt----they are very exhausted; the university asks them many things, research, papers, exams, so many things. They don't have time to waste in the unit." (Nurse Supervisor 2)

Nurses are usually recruited into a Master's programme on the hope that their newly acquired knowledge and skills that would enable them to improve practice. However, their inability to commit themselves to their nursing work while studying is of a particular concern because these are experienced nurses who have been demonstrated to perform well in practice:

"We select them [for Master's degree] based on years of experience, and performance evaluation." (Director of Nursing 2)

Some nurse managers expressed concern about those nurses who were studying in fields in which they had no clinical experience. One charge nurse, for example, questioned how a nurse would benefit from studying critical care when he had only worked in the delivery room. As a result, nurse managers were unsure of the usefulness of such nurses to practice after completion of their Master's. M-level nurses' credibility was therefore considered to be dependent on their experience in the speciality area, not their degrees. Prior knowledge of, and practice experience in, the speciality was considered necessary for service improvement. A Master's degree was seen as an asset, but not as the most important element:

"there are those who are sponsored by the hospital; we have someone in delivery room. How can she use her knowledge in critical care in delivery room; the other is in operation room; another is in surgical floor; one of them is in postpartum department. What can they do there?" (Charge Nurse 1)

Nurse managers, therefore, argued that nurses who wished to pursue higher education should do so in their own area of speciality. They further argued that such individuals should be selected for their experience and clinical performance. In short, nurse mangers want experienced practitioners to go out from a particular practice area and come back to it; they are not interested in the generic outcomes. It seems that they do not consider that M-level education equipped nurses with sufficient transferable skills to make them a valuable asset in other practice areas. This also suggests that, because of the predominance of critical care courses, nurses not working in that specialty area do not have many prospects for study and their potential educational development is limited. This view shows that there is a tension between what educationalists expect, which is the generic value of M-level education and what nurse managers want.

An M-level nurse noted that one of her M-level colleagues had been sponsored by the hospital after working for twenty years in the operating theatre. This colleague had been promoted (after gaining a Master's degree) to a nurse supervisor in the ICU. Her narrative suggests that experience in the operating theatre was not relevant to the ICU. However, the sponsoring hospital may have considered that significant experience in any

field of practice, when allied with a Master's qualification, entitled this nurse to a managerial post:

"those nurses who were sponsored by the hospital they might get a managerial post. In return they have to work for the hospital (compulsory) for three or four years. A colleague of mine is waiting to complete this mandatory service and leave the hospital. He has been transferred from the operation room after working there for twenty years and was appointed as a supervisor for the ICU. He is not familiar with the ICU work and procedures, not even the basics. The only good thing that came out of having the degree is the promotion and the increment in his salary." (M-level nurse 1)

This narrative may give an indication that hospitals are not deploying M-level nurses appropriately, and that hospital settings are not prepared to cope with the M-level graduates' qualifications. It also indicates that hospitals are not willing to tailor specific posts for them in terms of assigning them new roles that recognise specialist skills. This may also suggest a lack of communication between the educational institutions and employers of nurses, further reflecting the tension between generic and specific outcomes as discussed earlier in this section:

"The practice settings are not equipped to use their (M-level nurses) advanced skills and knowledge." (Staff Nurse 2)

Challenges such as lack of funding, restricted availability of study leave, and difficulties in replacing staff on study leave, have been reported in the broader literature (Beeston et al., 1998; Gosling, 1999; Nolan et al., 1995; Read et al., 2000). Nurse managers' concerns are also echoed in Joyce and Cowman's (2007) comment that education is expensive and time consuming in terms of financial, personal, and work commitments, and requires careful consideration from nurses and employers. The authors point out that one of the challenges is to convince nurse managers that professional development is vital for developing practice. They also draw attention to the need for policy makers and funders to consider the importance of planning strategically for continuing professional development to keep nurses in the profession.

7.5 The nature of the nurse education system in Jordan

The majority of nurse educationalists also expressed concern about the educational system in Jordan, in which Master's degrees in nursing are embedded. This was described by some participants as too rigid and lacking proper planning as many nursing schools are being opened without consideration of faculty members' (academic staff) availability or experience or nurses' educational needs:

"we need a very open and more liberal, I would say, educational system because the way we do things is very structured. Structuring things is good but you have to have flexibility in the way you teach these programmes especially clinical programmes. You know to be able to serve the purpose of your programme like now; we should have like a minimal number of students. We should have affiliation in each clinical area that we have a graduate of that programme who serve as a preceptor train these students in the role but the problem is as I said earlier is that you are preparing them for a role that they are not playing and they can't see anybody who's playing; it in the clinical areas; that's a problem. I am telling you to do something and nobody is doing it in front of you in the clinical area." (Nurse Educationalist 1)

Faculty preparation is an important issue which was raised by participants. It could be argued that, since the focus of the Master's programme is on preparing nurses to be able to work as CNSs, then the teaching faculty should have significant clinical experience in relevant specialist areas. However, this is no longer the case in Jordan. It was highlighted that, when the first Master's programme was established at one of the universities, most of the faculty members were CNSs who had graduated from Western universities:

"… faculty members who went with them are clinical nurse specialists prepared at this level; that's why we had the acute care clinical nurse specialist and actually the success goes back to them because they trained these students." (Nurse Educationalist 4)

However, when the university subsequently developed a new programme on maternal and new born nursing, this was developed by junior staff with more limited academic and clinical experience. One nurse educationalist emphasised that this factor might have affected programme implementation:

"they started a new programme on maternal and new born, and to be honest with you I did not teach maternal new born yet, and I don't know what the expected outcomes and competencies of the programme are, but I see an element that this programme was prepared by juniors so it had some kind of effect. If the seniors were there, I think they would have another track, a different track." (Nurse Educationalist 5)

Another nurse educationalist voiced concern about the background and preparation of faculty members. She emphasised that a clinical practice background is a vital requirement to enable them to teach clinical programmes:

"I know for a fact that the students are not taught by clinicians I mean nurses, nurse clinicians…. if you're going to have a programme for graduates clinicians, you'd better prepare your faculty as clinicians before you open the programme." (Nurse Educationalist 6)

Thus, nurse educationalists who teach on Master's programmes are perceived by some M-level nurses to have the theoretical knowledge but not necessarily the clinical expertise:

"They (academics) have a very important part to play. They just teach theory wise but when it comes to practice, I wonder. They teach physical examination but do they know how to do it on patients." (M-level nurse 11)

In the UK, Davies et al. (1996) also reported that both practitioners and nurse teachers felt that clinical experience was an important aspect of the nurse teacher's role. Schober and Affara (2006) from the ICN point out that neither Master's nor doctoral level preparation of faculty guarantees that they possess the necessary set of skills, knowledge, and expertise to teach theory and support the clinical experience appropriate for ANP. They point out that faculty members who teach advanced practice on M-level programmes should be prepared with a strong theoretical and practice base. Elliot and Wall (2008) argue that nurse academics are faced with the challenge to ensure that their teaching reflects the contemporary nursing environment. However, they further argue that nurse academics must take into consideration the benefits to their career and the students they teach when they decide to engage in clinical practice.

In addition to the concern about faculty preparation, there was a shortage of faculty both at university level and in clinical practice (clinical preceptors). This shortage is a result of opening new schools of nursing. University faculty members are also attracted to better job opportunities in the Gulf area, as some of the nurse educationalists reported:

"I think one of the challenges that faced us is the faculty migration." (Nurse Educationalist 2)

"We have severe shortage in nursing staff in terms of nurse educators." (Nurse Educationalist 1)

The majority of M-level nurses were also concerned that there were no qualified teachers who could act as clinical mentors or preceptors in the clinical areas:

"most of the academics in the university have an educational background which could affect our study, in clinical practice there are no qualified teachers who could guide us in the clinical areas." (M-level nurse 1)

In the early days of the Master's programmes, student numbers were small and manageable, so it was easy to provide mentors from the members of faculty. The increase in the number of students has made this difficult in recent years:

"at the beginning they were lucky because the size was manageable so the faculty members were able to go with them (to clinical areas)." (Nurse Educationalist 4)

"we found ourselves very limited in the clinical practice areas, we wanted to find more clinical time for students but I think if they spend more time in clinical areas they will be much more organised." (Nurse Educationalist 6)

Schober and Affara (2006) note that faculty shortage is a problem even in countries with a long history of advanced nursing education. Nurse educationalists' responses also highlight issues that parallel the findings of De Young and Bliss (1995) who identify increased job options for nurses with postgraduate degrees, inadequate salaries, and lack of job security as factors which contributed to faculty shortages in the USA. In the current study, the participants reported a shortage of clinical preceptors for M-level students. This is related to a shortage of Master's educated nurses in clinical settings who are adequately prepared to mentor and supervise these students. By the end of the current study, two nurse educationalists had moved to private universities in Jordan, and another two had left to work in Saudi Arabia.

7.6. Teaching strategies

Teaching strategies employed on Master's programmes was also of concern. Relying mostly on lectures as a way of teaching and on formal written examinations as a way of assessing students was criticised as affecting students' educational outcomes. A nurse educationalist noted that such exams did not encourage students' creativity and

critical thinking. This way of assessing students, and the increasing number of students, limited the extent to which they could be helped to be independent learners:

"I think one of the most important things is which I see is that they were much more independent like they didn't have many exams; they would go into innovative assignments and now because the number has changed, everybody is more into on-line exams and multiple choice questions, in the Master's programme they're not leaving space for creativity." (Nurse Educationalist 5)

Further concern was related to feedback from tutors; two M-level nurses felt that they could not benefit from their work because there was no feedback on their assignments. Their papers were returned to them without any comments:

"when we were studying there was a weakness in the programme; they don't give us feedback on the papers we write. We only got marks without knowing where we did wrong or right, so I feel we still need more training on how to critically analyse articles." (M-level nurse 24)

Another added:

"the lecturers used to ask us to do the presentations and explain to each other, then they would give you the mark but with no feedback;, if I hadn't had previous knowledge of critical care, I would not have got anything from the Master's programme." (M-level nurse 27)

These findings are reflected in the international literature. Drennan (2007) refers to a number of educational processes that impact on student outcomes. Educational processes are the means by which educational outcomes are achieved, and they include course delivery, teaching strategies, student assessment, and mode of attendance (full time or part time). Drennan highlights a number of effective teaching methods which affect student outcomes: group work, student participation, support from lecturers, and self-directed learning. He also notes that the most commonly used method of teaching is the lecture, while the most effective one is group work.

To gain more insight about teaching strategies and methods at the Jordanian universities, as these were not highlighted at the time of data collection, I contacted one of the nurse educationalists at the University of Jordan. The most common method of teaching is indeed lecturing, although group work is also used in undertaking research projects and critiquing articles. Multiple-choice exams are also used as a way of assessing students (Dr. R. Zeilani, personal communication, 23rd February 2009). Drennan (2007)

points out that feedback is a teaching skill that would produce effective outcomes for students such as satisfaction and good achievement. He adds that multiple-choice exams are used to assess higher order thinking skills, but they are generally limited in their ability to comprehensively assess the outcomes from M-level education.

7.7. Conclusion

This chapter reports the findings regarding the motivation of nurses in this study to undertake a Master's degree. Nurses chose to undertake a Master's degree because of a desire for self and practice development, or as a way of seeking alternative employment. These nurses were found to be self motivated, and there were no organisational pressures on them to undertake Master's education. Understanding these nurses' motivation can inform curriculum development and improve planning for continuing education. When nurse managers realise these motivations, this could help them in retaining these nurses, especially as it is emphasised in the literature that highly motivated nurses and supportive management can make change easier in clinical practice. The necessity for a Master's degree for nurses in practice was also argued from different perspectives as many M-level nurses move away from direct patient care and seek other employment opportunities.

The majority of participants emphasised that academic entry requirements, clinical background of the faculty and teaching strategies are challenges that nurses face while undertaking a Master's degree. Overcoming such challenges is important in the successful preparation of a Master's level nurse. In the next chapter a discussion of the reality of being an M-level nurse will be presented.

Chapter 8

Being an M-level nurse

8.1. Introduction

This chapter provides an overview of role expectations for M-level nurses from the perspective of different groups of participants. It also examines the perceived impact of M-level nurses on clinical practice, and provides an overview of the various factors that facilitate or hinder their practice.

8.2. Role expectations

Participants articulated different understandings of the M-level nurses' contribution to practice. The majority of participants referred to M-level nurses in terms of knowledge transfer, highlighting their clinical teaching and in-service education activities. M-level nurses were also associated with managerial and supervisory roles in clinical practice. In the following section, the themes that emerged from the data are described in relation to the perspectives of different groups of participants: M-level nurses, non M-level nurses, nurse managers, and physicians (nurse educationalists' perspectives were presented in section 6.2).

8.2.1. The perspectives of M-level nurses

Although a distinction between different levels of nursing qualification was not very prominent in other participants' narratives, it was strongly emphasised by M-level nurses. M-level nurses were highly appreciative when their role was perceived to be different from that of other nurses, and when this perception was reflected in different relationships with colleagues:

"I really feel they treat me in a different way. Our consultant always shares with me new articles and calls me to his office to look for articles on the internet." (M-level nurse 1)

Through their narratives, the M-level nurses sought to articulate a distinction between 'them' (other nurses), and 'us' (M-level nurses). They felt that they possessed

new knowledge that differentiated them from other nurses, and they wanted this distinction to be recognised in practice:

"The nurse with Master's degree pays attention to many issues which are not observed by other nurses. He knows that this patient needs nutritional assessment and he has nutritional requirements. He knows that nutrition can alter patient's immunity and helps in the healing process…Management of pain is also different; we learnt that pain can be managed by other methods other than pain killers. We are able to communicate with patients of different educational levels and how to make them understand the pain scale so they can give proper description of their pain." (M-level nurse 11)

This quest for distinction and recognition of the 'difference' of M-level nurses is reflected in other studies. Woods (1998b) reported that M-level nurses in the UK expected to be viewed differently and to be recognised and have their knowledge validated and valued by other nurses, other health professionals, health administrators and the general public. Knowledge acquisition meant the 'addition' of new facts and information, as Woods explains. M-level education entails a depth and critical utilisation of knowledge which is not evident at bachelor level. Drennan (2007) notes that, in nursing, undergraduate education is intended to develop nurses who provide direct care in a variety of healthcare settings. Master's programmes are, by contrast, intended to develop advanced levels of decision making in nurses working in advanced clinical management and educational roles in both the healthcare and education sectors.

Although the majority of M-level nurses felt that their qualifications were not recognised or valued by hospital managers, they perceived that there were, nevertheless, various benefits of undertaking a Master's degree. In responding to an open question in the questionnaire, all M-level nurses stated that a Master's qualification equipped them with specialised skills and knowledge. The findings suggest that they perceived that they had a positive impact on clinical practice through the application of skills such as critical thinking and the application of research. One of the possible explanations for why respondents noted these skills as significant is that these skills distinguish between different levels of education and core elements of ANP. They can also promote a commitment to lifelong learning and a questioning of practice (Hogston, 1995; Conneeley, 2005; Whyte et al., 2000; Pelletier et al., 2003; Drennan, 2007). M-level nurses perceived that quality of care would be influenced by these skills, which would

improve their knowledge base (Hogston, 1995). This knowledge base could be helpful to other people in the work place:

"This (Master's degree) was reflected on patients as well as on other nurses. Nurses consider us as a consultant who has base knowledge they can rely on, the knowledge also includes psychological status and mental status for the patient and his family…and not only that even in mentorship and preceptorship. It was also reflected in the management. For example, administration course taught us that our role is not only in writing the schedule, it also include other things such as building team spirit, how to design educational programme, how to council nurses in your unit. It was also reflected on the nurses who work with me, they felt empowered because their charge nurse has Master's degree which means she has more knowledge and she is a resource for them (sister said so this means she knows what she is talking about). So I was really satisfied with my Master's degree." (M-level nurse 11)

For this M-level nurse who worked as a charge nurse, a Master's degree helped her in her position by enabling her to provide consultation, counselling, mentorship, and management of colleagues, and empowering nurses.

8.2.2. The perspectives of Non-M-level nurses

Some non-M-level nurses expected their qualified M-level colleagues to be able to improve practice and transfer their knowledge to other nurses through teaching and in-service training:

"*as someone who studied so hard they are supposed to teach others, develop and improve practice, things he/she learnt at the university should be taught to others and applied in practice."* (Practical Nurse 1)

"they should co-ordinate with the in-service education, give lectures and teach their colleagues." (Staff Nurse 3)

Other participants had higher expectations of M-level nurses. They were viewed as an innovative, immediate, and reliable source of knowledge. Unlike other nurses, M-level nurses were assumed to read, understand, and do research, and sometimes have more experience, making them resources and potential role-models for other nurses:

 "The Master's degree nurse is always reading research and articles. I refer to him from a scientific point of view; his knowledge is more and his experience is more, so I refer to him whenever I need help. I also depend on him as a leader who is in-charge of the unit" (Staff Nurse 5)

Other non-M-level nurses emphasised that, in nursing practice generally, clinical experience should be supported by knowledge. Although experiential knowledge was generally valued, it tended not to be valued unconditionally as there was some doubt about the rationale in which practices were embedded; therefore, they placed value on propositional knowledge:

"we learn from other nurses with experience and they have learned through what they saw and what they learnt but the rationale is not always clear." (Staff Nurse 3)

Others argued that having a Master's degree without prior appropriate clinical experience was of no value. They indicated that clinical experience and theoretical knowledge should complement each other:

"experience makes a difference; I notice on many occasions that physicians appreciate the experience of the nurse and that the nurse is competent; there are many nurses who do not have a Master's degree, but they have knowledge." (Staff Nurse 4)

Observational data of M-level nurses in this study supports these findings. M-level nurses were noted to be preceptors or mentors for nursing students and junior staff; they also engaged in some teaching sessions for their colleagues. For example, one M-level nurse gave a demonstration on Central Venous Pressure Line (CVP) reading and management. Another M-level nurse discussed the use of ventilators in the ICU. Another was a mentor for nursing students, and her role involved teaching and assessing them. Others were involved in planning and participating in the scientific day in their hospital. These activities appeared to be appreciated by non M-level colleagues who seemed eager to attend these sessions. This is not to say that other nurses were not involved in such activities. Senior nurses, in particular, were noted to have performed similar activities. However, the M-level nurses were noted to communicate new and updated knowledge. Non-M-level nurses' appreciation of an educational environment within their working space highlights the contemporary globalisation of nursing and the movement towards evidence-based practice. Nurses were keen to access and learn from the knowledge and skills of their M-level colleagues. Gerrish et al. (2007) explain that some forms of evidence can be difficult for front-line nurses to understand. This can be related both to the complexity of research methodology and to difficulties with understanding the implications of research findings. Therefore, nurses who are trained to understand the

complexity of research, such as those with M-level education, may be more able to take such responsibility and pass this knowledge to others.

However, despite the perceived benefits of M-level nurses that some colleagues suggested, some participants thought that a Master's degree was not relevant in practice settings, reflecting a concern, already described in the narratives of managers, that it functioned mainly as a pathway to personal advancement, for example, as a precursor to a PhD. This view is perhaps not surprising as respondents indicated that they had seen many of their M-level colleagues leave practice for settings such as education. Others thought that a Master's degree had no practice value as they perceived that all nurses performed the same tasks regardless of their qualifications:

"I feel that a Master's degree is a transitional period from bachelor degree to PhD degree. Master's degree on its own does not add much to the person unless he or she does a PhD. I don't feel that a Master's degree adds anything work wise, salary wise or social status." (Staff Nurse 2)

Senior staff nurses acknowledged that M-level nurses might have more advanced knowledge, but when it came to practice and clinical skills they made no such distinction:

"they know more because they studied; they had taken advanced courses, and they are supposed to teach others--- practice wise there is no difference." (Staff Nurse 4)

In short, nurses who do not have a Master's qualification suggest that Master's education does not necessarily confer clinical competence; it reflects academic rather than clinical skills. Non-M-level nurses' insistence on the lack of difference between themselves and Masters' graduates may reflect real life experience. However, their views should be interpreted with caution. There is a potential that those who have fewer resources available to them may feel threatened by those who have more resources and may therefore work to negate any differences (see section 5.2.15).

Notwithstanding this note of caution, in observational data generated in the ICU, a clear distinction between the work of M-level and non M-level nurses was difficult to identify. M-level nurses undertook similar activities to those undertaken by other nurses. These activities included: starting their early shift with bed making; checking and re-stocking equipment; providing direct care for patients; giving drugs; checking vital signs;

setting up and monitoring drips; attending physicians' rounds; collecting blood; and performing ECGs. They also include following up results; interpreting results and following up with physicians; escorting patients to x-ray; answering phones; talking with relatives; arranging different activities with other members of the health care team (physiotherapists, pharmacists, x-ray technicians); monitoring ventilators and inserting intravenous cannulae. If the M-level nurse was in charge, like any other nurse, then her/his work would involve dealing with administrative matters, attending meetings, covering staff shortages, solving problems and allocating patients to other nurses. Moreover, she/he might be responsible for teaching and supervising junior staff and undergraduate students.

8.2.3. The perspectives of Nurse Managers

Nurse managers tended to place a high emphasis on visible and tangible outcomes for direct patient care rather than theoretical knowledge. All nurse managers and supervisors suggested that nurses could benefit from their Master's by working and sharing their knowledge with their colleagues, participating in in-service education programmes, undertaking research, and taking part in conferences. Such activities are usually linked to higher educational qualifications such as Master's degrees. Participants' narratives suggest that, as a result, the hospitals that sponsor nurses to undertake higher degrees have instituted a policy that gives priority to senior nurses. Experience is expected to facilitate M-level nurses' learning processes and their understanding of the new concepts and roles they encounter while doing their Master's degree:

"The nurses we sponsor are seniors because one of the criteria to sponsor nurses for Master's is experience. As a senior you should have an impact on your colleagues, show them your knowledge. As Master's holders, they should improve services, do research and present papers." (Deputy Director of Nursing 1)

Experience is supposed to enable them to apply the new knowledge they are expected to gain through their Master's education: to know how to accomplish different activities and improve practice.

Such narratives demonstrate high aspirations for what M-level nurses could achieve in practice by training less experienced colleagues, doing research, and presenting at conferences. They were perceived as a resource for nursing staff; their new

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knowledge was expected to be shared with other nurses either through direct supervision and guidance in the clinical area or by delivering specially tailored in-service training programmes for them:

"I believe nurses with Master's can do everything and have a very big influence. If we have Master's degree holders, then we can educate all junior nurses ...Master's holders have knowledge of how to do research, how to put plans for the future, and how to develop our staff nurses." (Nurse Supervisor)

It is this perceived ability to question practice, their research skills, and their ability to use and update knowledge that led some nurse managers to view M-level nurses as being more distinguished than other nurses:

"In our hospital we have around 15 nurses who are holding or studying Master's. The differences between M-level and other nurses are clear; most of the Master's degree holders are distinguished in their knowledge and performance. They always update themselves and they are convincing. They proved themselves in their areas. As for nurses with bachelor degree, some of them are distinguished, but others are only doing routine work." (Director of Nursing 2)

It is important for any organisation to be convinced that appointing people with high qualifications will bring about positive change in the working environment. However, due to the practical nature of nursing and the ambiguity of the M-level nurse role, some nurse managers remained unsure about what differentiated M-level nurses from their less qualified colleagues:

"They are supposed to be different, but I don't see any difference." (Nurse supervisor 2)

"let us say a nurse got a Master's and he can't apply his knowledge and he does not apply his knowledge in practice, there is no use of this knowledge; you can't distinguish him even if he has Master's." (Charge Nurse 1)

These participants reflected the concern, articulated previously in the narratives of non-M-level nurses, about the lack of clinical experience of some M-level nurses. Although nurse managers stated that only experienced nurses should be recruited to Master's degrees, there are, nevertheless, opportunities for nurses to go directly from undergraduate to postgraduate education. As a result, the lack of clinical experience of some M-level Master's graduates may contribute to the lack of distinction between M-level nurses and other nurses:

"Well recently there is no difference because the criteria for studying Master's degree have changed. Now they (universities) are accepting nurses with minimal experience like one year only, to increase numbers of students and for financial reasons. It is true they get more knowledge, but they have no experience so you don't feel much difference in practice." (Deputy Director of Nursing 2)

The relationship between experience and high qualification cannot be ignored. Experience can play two roles. On the one hand, it facilitates M-level students' learning as they come to the learning settings already equipped with an adequate background knowledge in the clinical nursing settings. It could also be argued that nurses with significant direct patient care experience would interact with Master's programmes differently to those who did not. However, this study was not designed to explore such relationships. In contrast, an M-level nurse with limited clinical experience will return to clinical practice with a Master's qualification but with little additional direct patient care experience. Thus, the Master's qualification will probably not fill the gap between propositional knowledge and practical knowledge. This, of course, may have no effect on the nurse M-level students' educational achievements because, as has been illustrated in section (7.6). This deficiency will not be apparent from the students' performance because M-level knowledge is assessed through formal examination and multiple choice exams.

8.2.4. The perspectives of Physicians

Physicians also expected M-level nurses to share their knowledge with their colleagues, and emphasised the importance of providing them with opportunities to do so in a systematic manner:

"let them teach the others at least theoretical information; these nurses are enthusiastic to teach others. If we give them the opportunity, they are ready to teach." (physician 2)

However, some physicians pointed out that M-level nurses are also trusted to perform some medical procedures, which are delegated to them by physicians:

"...for example, with haemodynamics or monitoring blood pressure of the patient, we give them some free hand to take action. Also if the patient is on insulin, I leave the things for the nurse to manage it. What I tell the nurse is that I want the blood sugar around 140 then I leave the things to that nurse to manage." (physician 1)

"they (M-level nurses) rely on physicians, but they feel more confident and we depend on them more; we give them more responsibility; they have experience and they have knowledge." (Physician 3)

Although undertaking such clinical skills, which are customarily done by physicians, does not require M-level education, the views of these physicians suggest that M-level nurses may be perceived differently from other nurses and trusted more highly, at least by some physicians. They also suggest a confidence in the M-level nurse and a willingness to enable a degree of autonomy in their practice, albeit an autonomy that is carefully circumscribed by physicians.

The performance, by nurses, of procedures that are regarded as the function of physicians has been debated widely in the literature (Sheperd, 1993; MacAlister & Chiam, 1995) and is not something that is particular to Jordan. The delegation of medical tasks to nurses has been reported in other countries. Jones and Davies (1999) point out that, in 1995, the General Medical Council in the UK instructed physicians to delegate what could be regarded as medical care to nurses only if the physician was confident of the level of skill of the nurse. In Canada, physicians supported autonomous practice as long as nurses working in extended/expanded roles adhered to their scope of practice guidelines and worked under collaborative practice arrangements with physicians (Advisory Committee on Health Human Resources (ACHHR), 2001). Many nurses in the UK, not only advanced nurse practitioners, currently undertake functions that were formerly in the domain of medicine such as inserting venous and arterial cannulae, interpreting chest radiographs, undertaking physical examinations, weaning patients from ventilators, and managing pain (Ball & Cox, 2003). Similar procedures are being practised by many nurses in Jordan.

When asked if M-level nurses could become CNSs or advanced practitioners, one physician suggested that holding a Master's degree is not enough for a nurse to be granted the title of CNS. Additional preparation, a certain type of personality, and a certain level of performance are required to enable the M-level nurse to become a CNS. One physician said:

"we should prepare him for this title (CNS), it's not only just to give him the title and it does not mean if the nurse got Master's he can hold the title. For this title he should have

the Master's but it depends on his personality depends on his performance in the unit, it should not be as a routine that if you have Master's you should hold this title. No, you might have the Master's for 10 years but you will not hold this title, on the other hand, you might have a Master's for 6 months or for a year and you get the title, it depends. A Master's degree is a must but to have the title after the Master's is not a must." (Physician 2)

This physician stipulated several criteria for the nurse to become a CNS: M-level nurses need to demonstrate both their ability to teach and supervise other nurses (educator role) and their ability to manage their area of practice (administrator role). M-level nurses need to show enthusiasm and the desire to demonstrate these abilities:

"they have to prove that they can hold the title, how to prove it? By the practice and their enthusiasm to teach others, it depends on their evaluation and their ability to supervise the shift and then see how they will act, will this nurse be good? From administration point of view, practice point of view and teaching point of view if the nurse fulfilled these criteria we can give him the title, otherwise he can't hold the title." (Physician 2)

This narrative also illustrates the power of physicians over nurses, and their influence over nurses in clinical settings. This is clearly stated in the following quote:

"we report to the nursing and we tell them this person is good and we recommend him for teaching." (Physician 1)

The views of these physicians confirm nurse educationalists' concerns for the future development of ANP in Jordan and the potential for M-level nurses to move away from a nursing model to a medical model dominated by task-oriented activities, which are undertaken for the 'convenience' of the medical profession. In the Jordanian context, physicians have tremendous influence on the extent to which nurses are able to exercise autonomy. Although physician participants perceived M-level nurses to provide a useful service, especially in terms of teaching, there was a belief that they needed both clinical skills and theoretical knowledge to be able to function as M-level nurses:

*"in any field experience is not enough, in any field not only in nursing. Unless you read, you have more advanced literature you can't take care of your patient. I don't say experience is not good, it's good, it's excellent but it should also be complemented with knowledge, if the nurse is experienced and is doing Master's he or she will be better, but if he has no experience and he is doing Master's, he needs experience so he becomes better in general." (*Physician 3)

This physician argued that at least 2 years are needed to gain clinical experience:

"in the ICU, the nurse needs at least 2 years to become a mature nurse." (Physician 3)

The participants' views on experience in relation to M-level education are congruent with those reported in the literature. Woods (2000) notes that any discussion of ANP will inevitably lead to a reference to clinical expertise and expert practice. However, Hernandez (2006) notes that, in the United States, experience is not a prerequisite for pursuing a higher degree in nursing. Nurses can progress directly from undergraduate to M-level education without having any practical experience in clinical settings.

Benner (2001) and Jasper (1994) argue that knowledge is built up over years, and that the possession of academic qualifications is insufficient to become an expert. Benner (2001), however, asserts that it is not only the longevity of service that promotes expertise, but also the nature of experience. Consequently, there is no consensus on the period of experience required for a nurse to be called 'experienced' (Woods, 2000). Woods reports that a minimum period of 5 years is usually considered necessary; however, he rightly states that it is the individuals' personal characteristics and the nature of their experience, rather than the duration of experience, that are important. For example, in the ICU nurses encounter more diverse clinical situations than might be available for nurses working in general wards, and they, therefore, have more opportunities for developing experience than do general ward based nurses. Interestingly, there is no discussion in the literature of what the 'nature' or quality of experience should be, or whether this is culturally specific.

8.3. Perceptions of M-level nurses' impact on clinical practice

There were differences between the perceptions of the different groups of participants of the impact of M-level education on clinical practice. In the survey data, the majority of M-level nurses suggested that their education had a positive impact on patient care. Nurse educationalists held similar views, and believed that M-level nurses could have a positive impact on clinical practice (see section 6.4). Some other participants considered M-level nurses to be important members of the health care team or perceived that they could directly enhance the quality of care. One physician considered that the clinical knowledge of M-level nurses, their knowledge of diseases

(pathophysiology), and their knowledge of patient care enabled them to assess different clinical situations and arrive at an appropriate therapeutic decision:

"these nurses (M-level) take better care of the patients because they know more about the care of the patient and they know more about the disease of the patients. This nurse knows when the situation is serious and when it is not and acts accordingly." (Physician 1).

It is important to state here that such expressions were highly individualised and there was limited evidence, in this study, of any generalised confidence in nurses' abilities. Some non-M-level nurses talked about M-level nurses' sharing what they could bring to practice and supporting each other to ensure quality of care and to update practice:

"we sit with M-level nurses and discuss different things; we observe what went wrong and what the right thing to be done. They help us a lot in taking care of our patients." (Staff Nurse 3)

Although only a minority, it is clear that some nurses do seek the advice of M-level nurses and discuss different activities and decisions made by them. They also seek the help of the M-level nurse on how best patient care can be applied.

However, some constraints were identified in relation to M-level nurses' impact. When participants were asked about the impact of M-level nurses on practice, some stated that it was too early to identify such an effect. This can be attributed to three reasons: the first is that Master's nursing programmes in Jordan are relatively new. The second is the small number of nurses with such qualifications currently employed in hospitals. The third is the continuous turnover of these nurses. Some participants suggested a need for a consistent and sufficient critical mass to determine whether there is a direct impact on the quality of direct patient care:

"in our hospital, the number of M-level nurses is small…we can't yet judge their impact but we hope that they will have an impact in their clinical areas." (Director of Nursing 2)

"Something should be done, but the thing is they leave and their number is too small." (Staff Nurse 5)

One M-level nurse explained that shift patterns in which nurses take turns in caring for patients makes it hard to determine the effects of a particular individual nurse

within a team of nurses. Therefore, organisational policy, and in particular the use of shift systems and the lack of continuity of care, may be seen as a hindrance to determining such an impact:

"Well our work in the ICU is accumulative. This means it depends on the work of the previous nurse and the nurse who comes after, so you can't see the direct effect of what you do on your patient." (M-level nurse 5)

One director of nursing stated that there was some recognition, albeit limited, of the impact of M-level nurses working in specialised units such as renal dialysis had a limited impact, but their small number made it hard to identify their contribution*:*

"For example, now we have the kidney dialysis nurse. The patients usually rely on these nurses more than physicians. They know it is the nurse who cares for them and works hard to help them, but this (M-level nurses) is a small sample of nurses and their number is too small to make that difference." (Director of Nursing 1)

Some participants did not perceive, or could not articulate, the impact of M-level nurses on practice or on patient care:

"in practice I noticed no change, usually because the M-level nurse is more knowledgeable, we let him become the in-charge on his shift."   (Nurse Supervisor 1)

"I think the Master's added to them personally but not work wise." (Practical Nurse 2)

A charge nurse also expressed similar views:

"they just want to get a Master's degree and leave the hospital to look for a position or continue on to do a PhD. The hospital does not hold any future for them; they want to improve their salaries and their social status." (Charge Nurse 1)

Controversy over the effectiveness of M-level nurses in enhancing patient care is not limited to the Jordanian setting. The exponential growth in the numbers of nurses undertaking Master's degrees has raised questions about the impact of their education on professional practice and the outcomes achieved in many other settings (Drennan & Hyde, 2008). However, Draper and Clark (2007), Whyte et al. (2000) and Drennan (2008) point out that studies evaluating continuing professional education have all tended to be small scale and have focused on process, teaching strategies, and nurses' satisfaction rather than their direct impact on practice. While the majority of studies suggest that higher order skills such as critical thinking and research application, which are developed through postgraduate education, can have a positive impact on clinical

practice, few studies have investigated the impact of such higher education on the quality of care (see section 2.3).

The views of the participants in this study, especially their emphasis on the fostering, through M-level education, of critical thinking and research skills rather than clinical skills, find support in the broader literature. Whyte et al. (2000), in their 10-year follow up study of 109 nursing students on a Master's programme in a Scottish university, found that the majority of nurses described the relevance of studying at M-level in terms of their personal, professional, and career development rather than in terms of direct patient care. Fifty percent had positions in education, reducing their potential to influence care quality directly. Davis and Burnard (1992) also reported that M-level education has an indirect impact on patient outcomes. They distinguished between different nursing courses and their relationship to levels of nursing practice.

8.4. Factors that hinder or facilitate the extent to which M-level nurses can apply their knowledge and skills in practice

There are multiple factors that can hinder or facilitate the extent to which M-level nurses can apply their knowledge and skills in practice. The factors identified can be classified as professional factors, organisational or managerial factors, and personal attributes. It was also noted that the absence of a facilitator might be a barrier, and vice versa.

8.4.1. Professional factors

Participants identified different professional factors which they perceived either to hinder or facilitate M-level nurses' performance in Jordan. These are related to: the professional bodies, nursing's professional identity, the theory-practice gap, and turnover and nurses' migration.

8.4.1.1. *Professional bodies*

One of the difficulties that nurses in Jordan are faced with is the absence of a coherent, authoritative professional body. The existing ones do not have a power base to negotiate working conditions and wage benefits for nurses, as Hijazi and Al-Ma'aitah

(1999) and Shruriquie et al. (2008) have noted. The findings of this study indicate that M-level nurses were dissatisfied with the ability of the professional bodies to meet their needs for recognition and role development.

In their narratives, M-level nurses were seeking role recognition as advanced practitioners. They asserted that they needed support from the professional bodies to set binding regulations in favour of M-level nurses:

"we need the support of the council. The council does not support us." (M-level nurse 11)

This lack of power was noticed by M-level nurses who emphasised that it meant that their ability to enforce regulations for nurses and nursing was insufficient, and there was limited effect, therefore, in practice. Moreover, the majority of participants, in particular M-level nurses, criticised the professional bodies for competing with one another rather than aligning in order to influence policy makers:

 "I don't think the JNMC could help in this matter, or the JNC for that matter. I hear they have problems, but if they meet with the management and act seriously, they might cause a change." (M-level nurse 18)

"they have a central role but unfortunately it is not prominent; there is no agreement and cooperation between (JNMC) and (JNC)." (M-level nurse 24)

Concern was also expressed by some M-level nurses that those in charge of the professional bodies work without involving nurses. They were thought to rarely interact with them directly:

"The council did not contact us. I work with them on different topics, but they never discussed the role with us." (M-level nurse 11)

 "They should work as a team; they should go to practice settings and see the situation; they should regulate many things related to nurses and nursing such as the role of the nurses in hospitals." (M-level nurse 24)

The criticisms levelled by M-level nurses are discussed in Sultan's (1998) book. He reported the conflicts between the two professional bodies on issues related to the responsibilities of each and the representation of nurses in Jordan. The JNMC has been

accusing the JNC of trying to usurp their role and downsize their responsibilities as the representative body for nurses in Jordan.

The M-level participants' dissatisfaction with the lack of recognition of their qualifications finds support in the findings of Woods (1998a) who stated that lack of recognition creates dissatisfaction and causes nurses to seek alternative employment. Kersley (1992) and Glen and Waddington (1998) also agree that lack of recognition runs the risk of losing qualified staff to education and management.

To sum up, Jordanian nurses felt distanced from their professional bodies. They perceived that nursing's professional bodies in Jordan lacked power and influence on decision making; these bodies were unable to create a situation in which they could put pressure on hospitals and government to acknowledge M-level nurses in practice. They were concerned that many decisions were made by what they described as the 'controlling elite' of the professional bodies. The council was criticised by participants for failing to consult M-level nurses about their potential contribution as specialist nurses or advanced nurse practitioners, or about legislation that concerned their role.

Whilst the majority of nurses in this study have little confidence in professional bodies; nonetheless, the vast majority of participants expressed a hope that the professional organisations would be able to enforce legislation for supporting the advanced nurse practitioner role. Some participants suggested that professional bodies should have a more active and prominent role in regulating nurses' roles in the hospitals:

"I need them to acknowledge me as a clinical nurse specialist. Without having this title, I remain as a registered nurse." (M-level nurse 27)

"no one accredits or acknowledges our certificate, this role is not being accredited by the hospital. They (professional bodies) have to come to help us." (M-level nurse 1)

Lack of regulations has led each hospital to set its own policies regarding the role of the nurse and the practice of nursing. Some participants argued that mandatory binding legislation could be the answer, as employers were not willing to recognise what professional bodies failed to regulate:

"the hospitals did not recognise them as nurses with advanced roles in relation to payment, titles and all these things--- some of the hospitals say as long as they (M-level

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nurses) are not certified as specialists, we're not going to acknowledge them that's why the council now is working on some of the hospitals to negotiate the new roles and connect this to the promotion in salary and all these things to acknowledge their expertise." (Nurse Educationalist 4)

Although Jordan is in the process of regulating advanced and specialist practice, most nurses and nurse managers appeared to be unaware this matter. Moreover, hospitals are not yet required by law to enforce the new regulations. It is left to the individual hospitals to implement them:

"At this stage it (specialist practice career ladder) is not mandatory because we want them to be self motivated to accept this classification. The hospitals are waiting to see outcomes from the nurses so that they can be called specialist or consultant." (Professional Body Representative 3)

It is suggested that, once legislation is enforced, hospitals will be obliged to implement it in practice:

*"But now we have a bylaw they (hospitals) cannot resist because a bylaw is binding. A bylaw goes to the prime minister office and the council of minister. The Legislation Bureau has to approve it and then it goes to council of ministers to be approved and finally it will be put in the gazette." (*Professional Body Representative 1)

In contrast, other participants argued that such laws cannot be enforced in hospitals if hospitals do not want to employ nurses with M-level qualifications or do not recognise the benefit of such nurses to clinical practice:

"There should be decisions made by people in power to change things. Who will force hospital to accept changes? The people who work in service should be convinced that this nurse will have a positive impact." (Nurse Educationalist 3)

Currently, there are two different proposed recognition systems in Jordan: one is from the JNC while the other is from the JNMC (see section 3.4.2.2). Despite what looks like clarity in relation to the regulation of ANP roles, the two proposed systems inevitably place nurses with a Master's qualification in a difficult position and add to their confusion about their roles in the future, especially as there is tension between the two professional bodies:

"we have a bylaw that will give certification for the clinical nurse specialist and the nurse specialist 'two levels' and later on we will see what types of specialties we'd like to recognise most. We have specialisation committee that is putting all the standards for the specialty." (professional Body Representative 1)

"the Council (JNMC) as a regulatory body for the nursing profession has developed a classification for different nursing levels and specialties, there is only one classification, that is the one in JNMC. The JNMC published this classification two years ago and there is no other classification in Jordan." (Professional Body Representative 3) (see 3.1.1 for more details)

However, in their quest for recognition, and with the current lack of real alternatives, M-level nurses appear to be willing to accept any kind of effective recognition, no matter who grants it to them. They are even willing to take advantage of the current dispute taking place between the two councils:

"we will follow what is in our best interests whether it comes from the JNMC or the JNC." (M-level nurse 19)

Some M-level nurses felt that it could take professional bodies many years to enforce legislation for ANP in Jordan. This again indicates that some participants felt that the nurses' councils, on their own, do not have an effective role or a power base from which to negotiate appropriate recognition and regulation for nurses:

"I don't think this will happen soon, not even in ten years. I think the progression in these matters is very slow. It is difficult to change the way people think." (M-level nurse 1)

As a result, they perceived a need for government policy, which is noted by Ketefian et al. (2001) as a critical element in the development of advanced practice roles, to enforce legislation that supports advanced roles:

"they (professional bodies) have a role, but our case should be dealt with at a higher level, that is the Ministry of Health." (M-level nurse 19)

"It's not enough for the nurses to say they have such roles; the government and the council have to make legislations." (M-level nurse 12)

As a counter view, one of the representatives of the JNC stated that the professional body took many steps to set regulations and standards for nursing practice. She acknowledged, though, that the members of the JNC still needed to work harder for nurses to believe in them:

".....so far and for the last 4 years I don't think they (JNC) were able to sell themselves strongly. I think the council succeeded to integrate everybody: the private, the government and the royal medical services...we've been criticised as being the council of the elites rather than the council of the public, but we actually work for the public; we're not the elite." (Professional Body Representative 2)

As some of the participants' narratives show, there was a perceived lack of communication between M-level nurses and their professional bodies. Bousfield (1997) and Ketefian et al. (2001) note that the support of professional bodies fosters the professional growth and development of nurses with advanced practice, whereas lack of support affects nurses negatively. In the Jordanian literature, AbuGharbieh and Suliman (1992) point out that role negotiation is influenced by the presence of a reference group (in this case the professional bodies), free and open communication between bargainers, and a common level of power amongst bargainers. They assert that reference groups provide the individual with a source of values, especially when difficult choices have to be made.

8.4.1.2. *Professional identity and the image of nursing*

M-level nurse education was widely perceived by the majority of participants as a means by which claims for professional status could be made and nurses could seek empowerment within Jordanian society, both individually and collectively. Study participants highlighted a range of issues that they felt impacted upon the current status of nurses in Jordan. These include the public perceptions of nursing, together with participants' suggestions about how the image of nursing might be improved, and the perceived impact of male nurses on Jordanian nursing.

8.4.1.2.1. *Public perceptions of nursing*

The relatively undesirable image of nursing in Jordanian society was seen as an important factor in shaping the role of nurses. Nurses are themselves influenced by such social norms and sometimes made disparaging comments about nursing, doubting nursing's claim to professional status and demonstrating limited confidence in their contribution to Jordanian health care:

"*The thing is we as nurses still think low of ourselves. Sometimes you hear from nurses that they feel embarrassed to say that they are nurses. The image of nursing is still low even if you have a doctorate in nursing.*" (M-level nurse 5)

Such views may both reflect and reaffirm the perceived negative image of nursing amongst members of the broader Jordanian society. Some participants claimed that many

members in their society still think of nursing as lacking in prestige even though an increasing number of those who practise are highly qualified:

"I think they still think the nurse remains a nurse whether he or she is practical, Master's holder or a PhD holder...at the end of the day a nurse is a nurse." (Practical Nurse 1)

"They say things are getting better and nursing image is improving. I don't think so; nothing has really changed." (Staff Nurse 3)

Some participants attempted to measure their work in relation to medicine, which is a highly regarded profession in Jordan:

"Here in our hospital, I don't think it (Master's degree) will make much difference because people and patients still look to doctor as the first and the last line because the doctor treats them." (Staff Nurse 4)

Furthermore, negative stereotypes of nurses and nursing, which reflect social norms about the image of the nurse, are projected through contemporary Jordanian and Arabic media. Unflattering images that are widely available promote nurses as ignorant servants:

"People think that nursing is a secondary service; the media also plays a role; they show the nurse as someone with poor education and as a doctor's maid." (M-level nurse)

The frustration some of the participants felt regarding their image is echoed in Schwirian's (1998) study. Schwirian states that, despite developments in nursing knowledge, the public does not recognise the unique contribution of nursing knowledge to health care, and this is seen as an obstacle in achieving professional status for nursing.

Hallam (2000) analysed nursing's professional image and identity in the media of Western cultures. She notes that nurses were often represented as ministering angels, physicians' handmaidens, battleaxes, or sex objects. Since the mid 1970s, nurses began to challenge media stereotypes, claiming that misrepresentation was a barrier to improving public understanding of their role.

Such representations have resonance in the Jordanian context. There are, however, signs of change: a former Prime Minister's daughter undertook a degree in nursing; a nurse has been appointed as a Minister in the Jordanian cabinet; and Princess Muna continues to give support and encouragement for young people to take nursing as a profession. The 1990s witnessed changes in the recruitment of nursing students as high

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academic achievers began enrolling in nursing programmes, both in government and private universities. Furthermore, nursing students used to pay the lowest fees for undergraduate programmes. Recently, the fees are equal to or even more than other academic programmes. These factors suggest ongoing cultural change and a burgeoning respect for the profession of nursing on its own merits. Thomas et al. (2000) and Shukri (2005) note that the image of nursing in Jordan is that of a profession which is growing and evolving, even though the role of the nurse is still viewed as not offering a great deal of prestige, especially when compared to the role of the physician.

8.4.1.2.2.   *Overcoming the poor image*

To overcome nursing's poor image, some participants suggested raising public awareness and educating people about the role of the nurse by making use of national school curricula, school textbooks, and the media. Participants emphasised the need for publicity campaigns that shed light on the nature of a nurse's job as a way gradually to replace the negative image of nurses with a positive one:

"The society should be educated... It should be in schools' curriculum and in the media; it should be explained to people what nursing is and what the role of the nurse is." (Staff Nurse 2)

However, the intransigence of public perceptions of nursing and the framing, within public understandings, of nursing as subservient to medicine were also recognised:

"I think before we develop the role of the nurse we should develop our society. Our society respects you, but when they know you are a nurse, their perception of you changes totally. So how are you going to develop nursing when the society is not even accepting it? (Deputy Director of Nursing 1)

"people still look to doctor as the first and the last line because the doctor treats them." (M-level nurse 5)

Some participants suggested empowering JNMC to enable it to establish and safeguard the identity of nursing as a profession and promote nursing's significance to healthcare, rather than emphasising nursing as a profession that offers secure employment and therefore stable income as it does currently:

"Unfortunately, the view of nursing has not changed and here comes the role of the JNMC. The JNMC must educate people about the role of the nurse and work with the

media…everybody wants to study nursing because of the money. This also reflects bad image about nursing." (Director of Nursing 2)

The recent increase in the number of students who want to pursue a career in nursing has not, to date, always been reflected in more positive public perceptions of the profession. On the contrary, it is sometimes seen as a negative influence as the main motive for studying nursing is widely perceived to be the availability of jobs, not the desire to be a nurse. Mrayyan and Al-Faouri (2008) report that, when compared to medicine and engineering, nursing in Jordan is still not fully accepted, and that students enrol in nursing because of guaranteed employment and not the desire to nurse per se.

Other participants emphasised that the demonstration, by nurses, of nursing knowledge, leadership, and the quality of their patient care in the work situation will be required to improve the image of nurses and to empower them:

"Knowledge will increase our power. If nurses are not knowledgeable and don't have leadership ability, they will be bad nurses. I think nurses must have a very good knowledge and leadership to show others what they can do" (Nurse Supervisor 2)

"We can only improve this bad image through the quality of care we provide." (M-level nurse 27)

Petro-Nustas et al. (2001) note that, in Jordan, nursing professionals perceived nursing as an art and science that is concerned with the holistic care of individuals and groups in health and sickness. These aspirational views seem to stem from the American influence on nursing education and do not reflect the real position of nursing in Jordan. Petro-Nustas et al., point out that, by contrast, physicians, pharmacists, and consumers perceived nursing as caring for the sick person, assisting physicians, and carrying out their orders. The findings of my study also coincide with those of Woods (2000). Woods indicates that, in their attempt to implement new roles in practice, M-level nurses in the UK found that establishing a new professional identity was fundamental in escaping what was still a subservient role. In attempting to establish a new identity, nurses in Woods' study hoped to gain recognition and authority and to enhance their clinical status.

In an attempt to improve the image of nursing, the JNC launched a campaign 'Nursing is a Model of Honour' under the patronage of HRH Princess Muna Al Hussein

in April, 2008. The campaign, which aimed to encourage females toward nursing, was conducted with the support of The United States Agency for International Development (USAID) funded programme. The campaign which, targeted female students aged 13-16 years, aimed to enhance the image of nurses in Jordan by focusing on specialised roles of nurses, and to increase the knowledge and understanding of opportunities available to them. To achieve its goals, the campaign set a strategy by choosing seven nurses called 'ambassadors' to be the speakers in all the campaign activities and to reflect the real image of nurses to the main target group of the campaign and to the community. Those ambassadors were chosen from different work settings, and they represented role models in their work areas (JNC, 2008a).

8.4.1.2.3. *Male nurses*

Although not related directly to Master's education and advanced practice, the narratives of some participants highlighted an increased concern amongst nurse academics and employers about the increasing number of male nurses in the workforce. In Jordan, more and more men are joining the profession, which is considered to pose a challenge for the nursing profession in Jordan:

"Now in Jordan we have a great number of males going into nursing, and this could be seen as healthy or unhealthy depending on the perspective that you take. Most of the people who go into nursing from the male population only want to seek a job because unemployment is high in Jordan…. Nursing is a job opportunity for males, and this is really a problem." (Nurse Educationalist 1)

The popularity of nursing as a career among males is therefore seen as problematic in two respects: firstly, male nurses tend to be attracted by higher paid positions and administrative positions in Jordan. They are also more likely to leave the country for better positions and salaries elsewhere than are female nurses (Al-Ma'aitah, et al., 1999; Jrasat et al., 2005). Such attrition constitutes a loss to nursing practice in Jordan. Secondly, it is culturally unacceptable for male nurses to work in female wards, maternity and paediatrics. This puts an extra burden on female nurses, and limits the practice opportunities and experience of male nurses. This has also created unemployment amongst male nurses. Through the directions of His Majesty King Abdullah the Second and HRH Princess Muna Al Hussein's continuing emphasis and support, a work plan was set to improve the quality of nursing services and to find a

mechanism to solve the current nursing challenges, mainly the problem of unemployed male nurses. Collaboration among different institutions (The MOH, Ministry of Higher Education and Scientific Research, JNC, Ministry of Labour, RMSs, and the Private Hospitals Association) resulted in hiring approximately 700 male nurses in different health sectors (JNC, 2008b).

In 1982, male nursing students formed 20% of all nursing students, whereas in 2005 male students formed 65% of nursing students (Ahamd & Alasad, 2007). Ahamd & Alasad caution that, unless this ratio is balanced, male nurses might outnumber female nurses in practice, exacerbating the problems discussed above. This concern is reflected in the narratives of a professional body representative who stated:

"It is not right to have 70% male and 30% female; it should be the opposite; nursing profession is for females…I am with females because we are facing a lot of problems in the clinical areas; they (male nurses) are not allowed in the maternity and the paediatrics." (Professional Body Representative 2)

Al-Ma'aitah and Gharaibeh (2000) report similar views. They caution that male nursing students in Jordan prefer not to work in paediatric wards because they perceive communication with children to be difficult. In part, this reflects a widely held cultural belief in Jordan as a society that it is the job of women to take care of children as they are the ones with 'maternal instincts'. Al-Ma'aitah and Gharaibeh (2000), however, emphasise that social constraints are also decisive factors in limiting the scope of male nurses' work domains. They indicate that around 98% of male students consider that working in paediatric units is culturally inappropriate because children are accompanied by their mothers all the time.

Female nurses are thought to be preferred by patients to male nurses in general. Ahamd and Alasad (2007) reported that, in their Jordanian study, two-thirds of female patients (n=435) preferred female nurses, while only one-third of male patients (n=484) preferred male nurses. The fact that female nurses are preferred by both men and women creates problems in assigning posts to male nurses.

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The potential for male nurses to improve the image and status of nursing is widely debated. Some nurse scholars suggest that increasing the number of men in nursing might enhance nursing's power, autonomy, and professionalism (Hallam, 2000; Miers, 2000). The findings of my study do not indicate that an increase in the number of male nurses, though relatively recent, has played a significant role in improving nurses' own perceptions of the image of nursing. Though it is possible that this effect may increase with time:

"the male nurses know that when they graduate they will find jobs. It is also easier for him to leave the country as a male nurse." (Professional Body Representative 3)

In the UK, the entrance of men into nursing has been argued to have largely been of benefit to male nurses (Rayan & Porter, 1993; Evans, 1997, Hallam, 2000; Meirs, 2001). Evans adds that most of the men currently in the profession occupy administrative and elite speciality positions, a situation that is becoming increasingly common in Jordan. There is no indication that the tendency noted in the UK has changed.

8.4.1.3.   Theory-practice gap

The poor communication between professional bodies, nurse educators and nurses that has been illustrated in this study has helped in creating, or at least sustaining, a gap between education and practice. The research element of Master's courses was seen by participants as having the potential to enhance M-level nurses' roles and the nursing profession in general, and as an opportunity to demonstrate the value of integrating theory and practice. Most M-level nurses stated that at university they were trained to implement elements of ANP, as discussed previously in chapter 6. However, following completion of their Master's degree, they were not placed in positions which enabled them to exercise the skills that Master's education had provided them with.

In addition, M-level nurses saw nurse educators as an elite group, lacking awareness of the difficulties involved in practice. There was, therefore, some concern about their involvement in the work of the JNC:

*"They are always away from the field, and they don't know about nurses in practice. The majority of JNC members are from universities. They are the decision makers, and they think they are superior to the nurses in the field." (*M-level nurse 11)

The tension between education and practice was also acknowledged by members of the professional bodies and the universities:

*"we have to strike a balance between education and practice" (*Professional Body Representative 3)

"Academic people can sometimes be very abstract and they tend to do lots of research that's not relevant to the service needs." (Nurse Educationalist 3)

The gap between theory and practice in nursing was also highlighted by AbuGharbieh and Suliman (1992). They reported that, although faculty members in Jordan are well-prepared theoretically, they lack training and experience in clinical nursing. As a result, nurses in practice settings regard them as theoreticians rather than 'real' nurses. The authors explain that this has led faculty members to leave clinical instruction to teaching assistants who are less familiar with the principles of American nursing practice that inform educational programmes in Jordan and consequently less able to implement the professional practice model which forms the basis of programme philosophies. However, an educationalist suggested that it was students who did not possess the necessary skills to integrate theory and practice because they lacked a role model in the clinical setting not because of any gap in their teachers' knowledge:

"The only problem that I am concerned with is the application of their knowledge... It's not been felt in the clinical areas because they don't have a role model in the clinical areas." (Nurse Educationalist 5)

It seemed that these educationalists were implying that their positions and working conditions did not allow them to play key roles in the clinical setting, and for advanced practice to happen, a clinical mentor who could integrate theory and practice in the work place would be necessary. These mentors could be qualified nurses who were willing and able to spend time with the students, or clinical instructors who would devote time to each student. From this perspective, the absence of effective clinical mentorship and role models appears to be a contributing factor to a continuing practice-theory gap. For example, at the university hospital there are only two preceptors or mentors for M-level students; the only requirement for this role is having a Master's degree in nursing (Dr. R. Zeialni, personal communications, 23rd February 2009):

"What I think they need is more clinical time to apply what they learn." (Nurse Supervisor 1)

"the focus on clinical work is not enough. You need to spend more time on it." (Nurse Educationalist 3)

AbuGharbieh (1993) puts forward a possible reason for this discrepancy between theory and practice. She draws upon her personal experience of the US and Jordanian educational systems to suggest that the philosophy statement of the nursing faculty in Jordan reflects contemporary American nursing practice and the course textbooks are those she herself had used in America. She questioned the appropriateness of these courses for the Jordanian context, noting that there is incongruity between the reality of nursing practice and the models described in the classroom. For example, student nurses are taught the 'unique functions of nursing' which emphasise individualism, science, and secular rationality although these are incongruent with the values of Arab society. This is still the case as Shuriquie et al. (2007) raise similar concerns regarding the appropriateness of the American nurse education system for the Jordanian context.

Gerrish (2004) emphasises that international collaboration in curriculum design enhances the core elements of nursing. However, she stresses that the values that underpin the nursing curriculum in one culture might not be applicable to other cultures. Al-Ma'aitah et al. (1999) note that American nursing practice is based on acknowledgment of the unique function of nursing, autonomous practice and empowering patients. In contrast, Jordanian culture places greater emphasis on religion and family ties; as this relationship is inevitably and fundamentally influenced by cultural norms, the way that nurses relate to Jordan will be different to the way that nurses relate to patients in the USA.

Hijazi and Al-Ma'aitah (1999) also note the gap between theory and practice in Jordan; they attribute this to the fact that improvements in nursing education have been isolated from nursing practice. Students are prepared for a role as a professional nurse, with professional standards and policies of practice; emphasis is placed on the importance of nursing power, autonomy, and decision making, and on collaboration between health care professionals. However, in practice, the role of the nurse is still task-oriented and

based on following physicians' orders, as reflected in the narratives of M-level participants in this study.

8.4.1.4.   *Nurse turnover and migration*

As a result of the lack of recognition as M-level nurses by nursing's professional bodies and hospital management, and the heavy workloads that they experience, many M-level nurses choose to move away from direct patient care. Some move to education and management:

"It is noticed that some of the nurses with higher degrees move away from direct patient care and they try to provide their services through management and education." (Professional Body Representative 3)

"lots of them work outside the country; yes they are attracted and they are wanted in the region (rich Gulf Countries) --- they work in a good environment, so policies and rules make a lot of difference when you work in a very healthy environment where people believe in you and your capabilities; they set clear guideline, frameworks and scope of practice for your profession that make   you more productive." (Nurse Educationalist 1)

This tendency is also reflected in the broader nursing literature. Gibbon and Luker (1995) note that many advanced practice roles have developed in a way that takes nurses away from the bedside: teaching and management are still the dominant routes for nurses to advance in the profession. Indeed teaching has been noted to be the dominant career pathway for nurses who have completed a Master's degree (Whyte et al., 2000). This trend is also evident in other professions where graduates with higher degrees tend to occupy high status positions (Santos et al., 1998; Green et al., 2008; Beeston, et al., 1998; Gosling, 1999).

As discussed previously, M-level nurses receive no official recognition in practice as M-level nurses. As a result, they move into education or management, areas which require higher qualifications than those held by staff nurses. Interestingly, Drennan (2008) reports different findings in a survey of 322 graduates from Master's degrees in nursing in Ireland. Drennan found that the majority of Master's graduates saw their degree as an integral part of their continuing professional education which was firmly related to clinical practice. This was explained by the author in terms of the promotion

opportunities for nurses in ANP roles and the encouragement of the Irish government for nurses to pursue clinical career pathways.

In this study, moving to education was not seen as 'a waste' by one nurse supervisor, but as having value in its own right. The shortage of qualified nurse academics and the increasing number of nursing schools and students meant that M-level nurses are the proper candidates to teach or act as teaching assistants in the school of nursing at the universities. M-level nurses who leave clinical practice to become educationalists will be the ones who will introduce and shape the future of the next generation of qualified nurses. A nurse supervisor suggests that, as long as M-level nurses are not being appropriately remunerated and the universities keep on graduating huge numbers of M-level nurses who do not find the working conditions that they are seeking, then those nurses will have little choice but to move and seek career opportunities as educationalists:

"I don't think it's a waste; people need to work and get higher salaries. I don't think we are losing Master's holder nurses when they go to universities because in Jordan University, the nursing faculty accepts 400 to 500 students every year. What can we do with all these numbers? They need qualified nurses to teach them." (Nurse Supervisor 1)

"we can't say that we lost some of them for education because there is a huge growing number of universities and they recruited them." (Nurse Educationalist 6)

Other nurses move away from direct patient care for better working conditions, higher salaries, and better positions both inside and outside Jordan.

Shuriquie (2006) reported that the presence of considerable incongruity between nurses' training and their roles in practice is also a contributing factor for nurses in Jordan to leave the profession, and again, this is reflected in the narratives of M-level nurses in this study. The discrepancy between what M-level nurses have been taught and what they actually do in practice is considered a challenge for these nurses. One staff nurse commented that some M-level nurses want to get managerial positions, and when there are no vacancies, they leave:

"if you come and want to change things, it is not easy; you have to comply with hospital policy. That's why some people don't stay here; others want to get a position." (Staff Nurse 1)

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"the reason why they leave is that the hospitals are unable to attract them; they don't satisfy them. The nurses are really working hard; they work night shifts and go to the university in the mornings so they could get something in return. Now they graduated but they got nothing from the institution they worked in for years; why is that? These nurses are qualified people and they deserve better positions and better salaries." (Staff Nurse 2)

The tendency and the desire of M-level nurses to move away from direct patient care to non-direct care in the hospital was criticised by the vast majority of nurse managers who thought that M-level nurses were only concerned with promotion upon graduation. When M-level nurses' expectations were not met, there was concern that they could become disenchanted, and that this disenchantment could influence their performance:

"nurses become frustrated because they have one fixed idea of improving their personal status. When they can't do that, they get frustrated and this affects their performance in practice." (Deputy Director of Nursing 2)

Glen and Waddington (1998) note that frustration can be identified as an early stage of role development. This may be related to organisational culture, working in an unfamiliar environment, or encountering resistance to change from medical and nursing staff. In this study M-level nurses expressed their frustration about the lack of recognition of their qualifications. They also reported lack of clarity about what is expected of them and were unclear as to how to meet these expectations. Such feelings were noticed to increase the level of stress these nurses have:

"I don't know what they want me to do, I feel tense when I don't know what to do." (M-level nurse 5, field observation)

Glen and Waddington (1998) report that stress is mainly related to role conflict, role ambiguity, and role overload. They explain that role conflict occurs when different people have different expectations about what the role holder should do. Role ambiguity occurs when there is a lack of clarity regarding what those expectations are.

Interestingly, when M-level nurses were asked where they saw themselves in five years time, 71% of survey respondents cited moving to education. Amongst the ten M-level nurses that I interviewed, one nurse wanted to move to education, but the remaining nine would prefer to remain in practice provided that their qualifications were recognised

and they received the privileges that they felt should accrue to them, such as an appropriate job description, accreditation, and a higher salary. Migration or turnover of nurses was noticed throughout the fieldwork. By the time I started data collection, five M-level nurses had left their employing hospitals. By the end of the first stage, three had resigned (all left to go to Saudi Arabia for teaching posts). By the end of the study, three more nurses had resigned (one moved to a teaching post in Jordan, and two left to work in Saudi Arabia).

Highly educated nurses have raised expectations of their work and career: they expect to be able to work in a supportive work environment with adequate professional opportunities (Mrayyan, 2005). If such an environment is not available, they may prefer to leave direct patient care for better opportunities in other educational settings or outside of Jordan (Mrayyan, 2005; Al-Ma'aitah et al, 1999).

8.4.2 Managerial issues

The majority of participants were concerned about a range of organisational factors that they felt had placed significant constraints on M-level nurses' practice. These were related to patronage, and relationships with other nurses and with physicians.

8.4.2.1 *Patronage and hospital power*

Nursing's professional bodies in Jordan were perceived by most participants as being relatively powerless and unable to exert any effective pressure for change on government and hospitals. As a result, some participants thought that the real authority seemed to lie within the hospitals. However, participants did not see nurse managers as approachable, sympathetic or supportive; chains of command had to be rigidly respected, and any attempt to do otherwise was unwelcome. A lack of communication was also perceived between M-level nurses and their management with regard to assigning them new roles that fit their Master's qualifications:

"the problem is the limitations; people around you don't help, and there is no support from management-…You know if this role is not supported 100% by the management, it will never succeed." (M-level nurse 24)

"The problem here is that you have to follow proper channel of communication, so if you want to see the manager you have to go through many people and they don't have time to see us." (M-level nurse 1)

The majority of nurses assigned particular significance to their lack of access to the Director of Nursing because of the very rigid hierarchy imposed on them. The reality of the situation could be that both, nurses and managers, may have limited awareness of the pressure exerted on each other:

"In government hospitals there is bureaucracy and centralisation, and this does not help the role of the Master's degree nurse. If you want to make any change, you have to follow a chain of decision makers." (M-level nurse 24)

Moreover, nurses have not established themselves as an independent powerful group that has a coherent voice at the level of decision making:

"it is the rigidity of the rules and bureaucracy; nurses do not influence decision making." (M-level nurse 19)

Bureaucracies exert pressures that undermine the independent status of professions. The historical role of the nurse as a handmaiden to the doctor, and the hierarchical structure of health care organisations, have rendered nurses as largely powerless. Moreover, the perceived authority of, and adherence to directives from, physicians and hospital authorities, and the threat of disciplinary actions, contributes to this feeling of powerlessness (Schwirian, 1998). The bureaucracy emphasised by participants was also highlighted by Shruriquie et al. (2008) who assert that the government sector in Jordan has large centralised organisational structures, bureaucracy and organisational rigidity, leading to an unsupportive work environment for nurses.

Bureaucracy might seem less evident in the more fragmented private sector in which each hospital has its own localised organisational structure, rendering it more sensitive to its employees' needs. However, participants coming from both sectors reported issues related to bureaucratic constraints. In Jordan, the MOH management is highly centralised; the rules may become particularly rigid when they relate to the department of nursing, according to Hijazi and Al-Ma'aitah (1999). This is due to the perceived subservient role of nurses and nursing in Jordan and their lack of power to influence decision making in healthcare settings (Oweis, 2005; Shuriquie, 2008).

Salvage (1985) described the structure of the nursing workforce in the UK as akin to a pyramid, and this structure is also evident in the Jordanian context. Salvage explains that authority is vested from above in those lower down, with wages as well as power over others rising as you move higher up. Yet the higher up you are, the more removed you are from direct contact with patients. Salvage ironically notes that those who move away from direct patient care are rewarded in money, status, and authority. The people at the bottom have little contact with people above and, when they do, it tends to be unpleasant. Despite the fact that Salvage's work was carried out some time ago, it has continuing resonance in the contemporary Jordanian context. Awareness of a power hierarchy within nursing was evident in participants' narratives. Some M-level participants pointed out that power over others rises as you move higher up the hierarchy. Correspondingly, the presence of a supportive nurse manager is a key factor in recognising M-level nurses:

*"the director of nursing holds a Master's degree in nursing and she is a PhD holder, so she supports us; it is possible that the people in the general hospital management might hinder our role." (*M-level nurse 11)

This finds support in Bousfield's (1997) claim that the power of nurses is dependent on recognition from the nursing manager of their competence as advanced practitioners, and that without this support and recognition the role will be in jeopardy. Other nurses felt that their ability to make change in practice was influenced by the positional power they held within an organisation: this participant, for example, suggests that, because she was a charge nurse, she was able to effect change locally:

"I was talking about myself because for me my position is power. I can play this role because I am the head nurse and I am accountable to the director of nursing and she is empowering me as a head nurse and empowering me as a Master's holder. I don't expect if I was a staff nurse to have all the privileges that I have as a head nurse." (M-level nurse 11)

However, a great sense of frustration and disenchantment on the part of M-level nurses was also evident:

"the university teaches you how to be APN, but in practice there is no opportunity to apply anything. After I graduated from Master's I am still the same, nothing has changed for me, unfortunately this gives you frustration, because those around you always try to suppress you especially that we are in government hospital." (M-level nurse27)

This frustration stemmed from M-level nurses' need to be heard, recognised, and appreciated as different from non-M-level nurses. Demonstrating this difference without clearly demarcated roles or titles is particularly problematic:

"actually for a person to have a Master's degree does not mean he should fulfil a certain job. ---it does not mean he will be called, for example, an advanced practitioner or a clinical nurse specialist. The M-level nurse could be a head nurse or a shift supervisor; he could be in the nursing education and training office and could be just regular staff nurses, so they could hold any post." (Director of Nursing 2)

And indeed, nurse managers made it clear that it was not in their remit to create a special title or job description for M-level nurses:

"in Jordan we still don't have the title of clinical nurse specialist; it is not in the hands of nursing management nor the nursing council. Nursing management does not have the power to do so. This is a collaborative work that has to be done in our country." (Director of Nursing 1)

This view again reflects the poor inherited image of nurses and nursing in Jordanian society and their subservient role in the health care system.

8.4.2.2   Relationships with others

Relationships with other health care professionals can also facilitate or hinder M-level nurses' performance. The following section will discuss M-level nurses' relationships with other nurses and physicians.

8.4.2.2.1   Relationship with other nurses

Survey findings indicated that the majority of M-level nurses felt well integrated with their nursing colleagues. Contrasting views were reported by other participants with regard to their relationship with M-level nurses, reflecting their varied practice-based experiences. For example, some participants had found M-level nurses to be approachable, helpful and willing to do jobs similar to those undertaken by other nurses:

"we have M-level nurses who do the same work other nurses do, and they really work very hard." (Practical Nurse 2)

Others saw them as arrogant people who did not like to do jobs assigned to them and who were trying to undermine other colleagues:

"some M-level nurses undermine other nurses. I don't know why; may be it is related to their personality, or may be it is the Master's which does this to them." (Staff Nurse 2)

"I have had a bad experience with someone who had a Master's degree. He had a problem with all of the team here, so many clashes and so many problems. He was very stressed. He acted in a way that showed he knew more than you know; you have to appreciate him all the time." (Nurse Supervisor 1)

Such negative attitudes displayed by some M-level nurses created conflicts between them and their colleagues. Moreover, it was a matter of concern to some nurses that their M-level colleagues were requesting privileges (e.g. flexible working hours, specific shift patterns, days off, study days, etc) that were not included in their contracts. Granting privileges to M-level nurses without providing their work place with substitute nurses was felt to disadvantage other nurses as they were usually asked to cover the shifts not done by Master's students and M-level nurses. This may lead non-M-level nurses to feel that there is lack of 'equal opportunities' and may also create feelings of resentment towards M-level colleagues and management:

"Why should I ask them (non-Master's level nurses) to work at times they don't like or to do jobs their colleagues should do. Bachelor degree nurses complain about a Master's degree nurses. Bachelor degree nurses also have rights." (Director of Nursing 1)

Resistance to the role of the advanced nursing practitioner if taken by M-level graduates was anticipated from non-M-level nurses. Concern was also expressed that nurse managers might feel threatened by nurses with a Master's degree:

"you might find some resistance from their nursing colleagues and from their managers. They will feel that this nurse is having higher degree than them, and this will lead to tension between them." (MOH Representative)

"this role is not going to be easily accepted because it will require higher grade than the bachelor level which means conflict with bachelor degree nurses." (Nurse Educationalist 5)

A small number of M-level nurses felt that resistance is already evident in practice:

"It is how I work that makes me different from them, but I don't really differentiate myself from them. There is resistance, you feel it, and you feel there is something wrong. I think other nurses especially diploma nurses are concerned because they think we will take their places, my direct supervisor is diploma, our director of nursing is diploma, there is always that fear." (M-level nurse 27)

Resistance to ANP roles has been reported in the broader literature (Lloyd Jones, 2005; Ketefian et al, 2001; Woods, 1998a). Resistance from within the profession is most frequently cited. Literature on ANP suggests that nursing colleagues may feel threatened and deskilled. This feeling may be born out of fear, distrust, jealousy, or disagreement with the concept of the advanced nurse practitioner (Woods, 1998a). Managers with less advanced credentials as well as physicians might also feel threatened by these nurses taking some authority around patients. The negative attitudes from M-level nurses that some participants reported are also further evidenced in the work of Bowler and Mallik (1998) and Woods (1998a) who reported that senior nursing respondents in extended or expanded roles seemed to have adopted an elitist position in relation to junior staff. The findings of Reay et al. (2003) reveal that managers were aware of some experienced registered nurses being resentful of the introduction of advanced nursing roles. Moreover, Ball and Cox (2004) emphasise that building up relationships with fellow nursing staff is key to the acceptance of ANP roles.

8.4.2.2.2 *Relationship with physicians*

In this study, nurses were described as being generally unable to make decisions without reference to a medical practitioner; this was seen as a barrier for any development of autonomous nursing practice:

"here the physicians do not allow nurses to do everything. Nurses here follow orders." (Deputy Director of Nursing 2)

"everything we do have got to do with following physicians' orders." (M-level nurse 27)

Some M-level nurses felt that physicians were aware of their M-level education, but there was no recognition of the new knowledge that these nurses possessed. This could again be related to the inherent stereotyping of nurses within the Jordanian society:

"doctors know that we are studying, and when we have a discussion with them, it is based on evidence. But they don't accept it from us…. Sometimes you hear from some doctors things like they like to work with this nurse; he is good and he knows what I want for my patient, but you don't hear them say this nurse has knowledge and his practice is research based." (M-level nurse 20)

Shuriquie (2006) investigated the role legitimacy of medical surgical nurses in Jordanian hospitals. She concluded that nurses in Jordan lacked autonomy and had

limited scope for decision making. In her findings, Shuriquie also reported that the overwhelming majority of physicians and patients that were surveyed attributed low autonomy to the nurse than to the physician. They believed that physicians should be involved in drawing up standards and policies of care for nursing practice. The dominant methods of care delivery were task oriented, operating within a team nursing approach. Nursing care has not yet, therefore, developed to a level where the focus would be holistic patient care. This dominant form of care delivery might also help to explain the difficulties that many participants in my study had in distinguishing between different levels of nursing practice.

However, observing nurses in practice and studying their interactions with physicians revealed that they could sometimes make decisions in an indirect manner. The following excerpts from my field observations illustrate this process:

"In the ICU, one patient was admitted following respiratory arrest. The patient was intubated and sedated in the Emergency Room and after arriving at the ICU, she started coming around; she was very restless and hyperventilating. The doctor was writing the orders and waiting to make a decision about whether to put her to sleep or extubate her. The nurse supervisor was observing the patient and saw that her breathing was laborious and ineffective, so she came to the doctor at the station and said "doctor, the patient is not breathing properly, do you think that she needs sedation?" The doctor went to see the patient and decided to sedate the patient."

Similarly, in another hospital:

"A child was admitted after a major road accident. His family wanted to transfer him to another hospital; the child was on a ventilator and in such cases he would be escorted by a doctor and a nurse. The unit was short of staff, and the nurse in-charge (M-level nurse) thought that if the patient was going to be escorted by another member of staff (assistant anaesthetist) then there was no need for the nurse escort. She called the doctor and informally said "do you think it is necessary for the nurse to go with the patient? You have the anaesthetist with you, and I shall prepare everything needed for the transfer. The doctor agreed that there was no need for her to send a nurse as two of them were enough."

These excerpts illustrate what Porter (1991) has termed 'covert decision making' "whereby nurses show respect for physicians and refrain from open disagreement with them or making direct recommendations or diagnosis, while at the same time attempting to have input into the decision making process" (p.731). This was first described by Stein

(1968) as the physician-nurse game. The relationship between physicians and nurses has, of course, never been simple (Jones, 2003). Stein (1990) revisited the nurse-physician game and argued that nurses had decided to stop playing. This he attributed to an increasing number of female physicians and male nurses. It is also, arguably, a reflection of the decrease in power differentials between men and women in Western society. In Jordan, the game is still being played, though some complexity in relationships was noted by many of the participants in this study. A profound awareness of power relations and the physician/nurse hierarchy was articulated by the overwhelming majority of participants both male and female. Hence, male nurses reported feelings of powerlessness similar to their female colleagues, a finding that is reflected in other studies (Shuriquie, 2006). This might be related to the sustained Jordanian cultural view that nursing is more of a female profession.

8.4.2. 8.4.3 Personal attributes

The participants associated certain personal attributes with M-level nurses. They suggested that these attributes derive from the process of undertaking a Master's degree. They relate to personal growth, confidence, and individual responsibility.

8.4.3.1 Personal growth and maturity

M-level education is believed to foster personal change and the development of certain positive characteristics. An M-level nurse's ability to work independently and establish collaborative relationships was emphasised by some participants:

" they have all the knowledge; they have the power with their knowledge and they have the experience to work independently and collaboratively with other health care and to work as nurses not as other careers such as physicians. " (Nurse Educationalist 3)

They were also considered as mature and capable of, and responsible for, determining their own professional development. One way of doing this was by keeping updated with the latest developments in the field:

"the Master's graduates are updated; they feel as mature graduates and they know how to get knowledge and how to keep updated. They feel responsible." (Nurse Educationalist 5)

M-level nurses also highly valued the personal attributes that they believed had derived from their completion of the M-level programme. They perceived that these attributes enabled them to be more mature, calm, alert, and organised, which eventually equipped them with the potential to achieve more and organise their time in a better way:

"Master level nurse sees things from different angles and tries to apply knowledge to practice; she does not waste or misuse time, so her achievement is better. I talk about all Master's nurses in our hospital; they are different in the way they work and their achievement is better." (M-level nurse 27)

Similar findings are reported in the UK where maturity and being responsible were considered essential characteristics of nurses with new roles (Read et al., 2000; Ashworth et al., 2001)

8.4.3.2 Confidence

Another important feature and personal attribute of M-level graduates that was frequently cited by participants was their confidence, and their ability to convey this confidence in practice in a way that enhanced trust between themselves and their clients:

"the characteristics of an advanced nurse is 'confidence' and how to convey this confidence so that your client can trust you and the system can trust you." (Nurse Educationalist 6)

Some participants noted that nurses became confident after getting their M-degrees. Nursing colleagues were especially likely to comment upon this confidence as they worked closely with them before, during, and after they had their Master's degree.

During fieldwork, I talked to nurses holding different posts. They noticed that the knowledge gained through Master's education enabled M-level nurses to act in confidence; underlying this confidence is their ability to present rationales for their actions with patients and to question practice:

"When you work with them, you feel they are more confident in practice. They know why they are doing things." (Staff Nurse 5)

Other participants linked confidence with other attributes such as leadership and good teaching skills:

"I feel that they became more confident; they act as team leaders." (Staff Nurse 3)

Ashworth et al. (2001) and Lloyd-Jones (2005) report similar findings elsewhere where confidence is considered to be a discerning feature of M-level performance and ANP.

8.4.3.3　Individual responsibility

In the absence of support from professional bodies, or local organisational support, most of the nurses interviewed conveyed a strong drive to change nursing from the bottom up; as a result, M-level nurses were under tremendous pressure to show that they could make a difference.

Several participants indicated that M-level nurses should be able to work on their own, and should share their knowledge with others by providing advice to their colleagues or by applying their knowledge and skills to practice. All nurse managers claimed that they encouraged M-level nurses to take responsibility for improving services, conducting in-service training, and conducting research, but perceived that the M-level nurses had done little that impacted upon clinical practice:

"we talk with them. I myself met with them and I always do. We encourage them to improve services in the hospital; few of them try to do so, but until now no one has done anything to impact the nursing care. May be because they are still new graduates and they are still shocked because they did not find what they expected; they expected positions." (Deputy Director of Nursing 1)

Within this perspective, therefore, M-level nurses are positioned as change agents: professional development and self-improvement are seen to be the responsibility of the individual nurse:

"We try to present the staff with updated knowledge like research articles and so on. We try to discuss issues related to nursing practice; we say that there is a new trend in dealing with it and we try to work accordingly." (M-level nurse 24)

As one nurse educationalist points out, a high academic qualification is expected to be matched with motivation and proactivity. The university only provides students with a foundation for practice that they have to build upon:

"I am convinced that there is no academic programme that can produce an expert whether it is Master's or PhD. The human can develop through experience and

motivation. We provide our students with building blocks, and they have to develop themselves if they work in their specialty areas." (Nurse Educationalist 4)

This nurse educationalist was convinced that professional development may take many forms, and that an academic degree might not be enough to master the specialty. However, it was thought that, if postgraduate qualifications were accompanied with experience and a high level of motivation, then the result would be the development of expert practitioners.

8.5. Conclusion

This chapter provided an overview of the role expectations of nurses with M-level education from the perspectives of different groups of participants. M-level nurses were associated with educational and managerial roles in clinical practice. Despite the movement of M-level nurses away from direct care, nurses in such roles have the potential to shape the healthcare environment by developing appropriate standards of practice. There was a widespread perception that their teaching role could enhance the knowledge of their nursing colleagues. Moreover, their research skills could be utilised in evaluating and applying research findings.

There were multiple factors that could hinder or facilitate the extent to which M-level nurses can apply their knowledge and skills in practice. A need for professional bodies' recognition of the new roles of M-level nurses has been emphasised. Respondents also noted that employers need to consider the location of M-level nurse in the organisational hierarchy and develop clear role definitions and objectives that are realistic and framed within the constraints of bureaucratic organisations. This may help in retaining M-level nurses who have the potential to move away from direct patient care or migrate to other countries.

Developing new roles in practice was also dependant on the relationship of M-level nurses with others. To reduce the likelihood of role resistance, and to prevent role ambiguity, the purpose of the new role should be developed and communicated to relevant groups.

The relatively undesirable image of nursing in Jordanian society was seen as an important factor in shaping the role of nurses. Improving nursing's image through media campaigns, increasing nurses' self-confidence in their career and enhancing certain personal attributes to M-level nurses could be seen as an integral part in the healthcare system and may create a more positive image of nursing in the Jordanian society.

A discrepancy between theory and practice was also noted. The concerns expressed by respondents suggest that there is a need for national, culturally nuanced debate in order to begin to explore manifestations of, and responses to, a theory practice gap in Jordanian educational and health systems.

The next chapter discusses the findings of the study, pinpointing its limitations and implications to nursing education and practice.

Chapter 9

Discussion and Conclusion

9.1. Introduction

For the purpose of this study, it was essential to explore the meaning of M-level education and ANP from the perspectives of different stakeholders. The intention of this final chapter is not to reiterate the substance of previous chapters but rather to examine significant issues arising from the research and consider its overall contribution to, and implications for nurse education and practice in Jordan. However, before examining the implications of this study, I shall consider the study's limitations.

9.2 Limitations of the study

The objective of the study was to identify and clarify the concepts of ANP and M-level education within the Jordanian context and to draw theoretical inferences on which further studies could be based. In considering such an issue, it must be taken into consideration that the study was set at a time when ANP and clinical Master's degrees in Jordan were still relatively new, and educational reforms were still recent.

The study was conducted in five hospitals reflecting the different health sectors in Jordan. The Royal Medical Services sector (RMSs), which also provides health care services in Jordan, was not included because it has a distinct military system. The views of those working for the RMSs might have been different from those of nurses recruited to this study as the RMSs use their own system of military ranking that applies to all, including their nurses. Public and private hospitals also have different contexts that may facilitate or hinder nurses' autonomy. Because of the relatively small sample size, and in order to maintain confidentiality and anonymity of participants, I was unable to explore how the practice context of these different sectors may have influenced findings of the study.

My plan was to use a purposive sample; however, at the time of data collection, decisions on recruitment were made for pragmatic reasons. The limited time available to conduct the study also made it problematic to use purposive sampling. It is possible that, in making the decision, a range of alternative perspectives may not have been captured. Moreover, the views of the small number of respondents might be different from those who did not respond or did not participate in the study.

In two hospitals, I relied on M-level nurses to identify colleagues whom I could interview. This had the potential to introduce a degree of subjectivity as they might only have selected colleagues that they thought would provide a favourable account of their work. However, this appeared not to be the case as I managed to gather a range of different perspectives on M-level nurses from participants. In particular, I was not able to interview one head nurse despite repeated efforts, and was therefore unable to access the experience of an M-level nurse who is working in a managerial post. The findings also indicate a dominance of critical care Master's courses and respondents working in ICUs over other specialities (all M-level nurses who were interviewed, except one nurse, were working in ICUs). This also meant that the experiences of M-level nurses working in other areas could not be captured. Therefore, some of the findings should be interpreted with caution.

The different methods used in generating data provided an opportunity to explore in depth various perspectives on the same issue. Interviews and observation, for example, provided opportunities to clarify and further explore some issues that were not clear in the questionnaire. However, the data collection methods may also have given rise to some limitations. Some responses to a small number of questionnaire items may reflect weaknesses in the questionnaire design. For example, in the knowledge item, respondents were provided with more positive than negative statements. This may have led to a response bias. I tried to minimise the significance of this bias through further exploration in the interviews.

The challenge in qualitative research is to demonstrate that the findings are an accurate account of the participants' representation of the topic and not due to the

subjectivity of the researcher. My effect on the research process has been considered in various sections of this thesis. In order to reduce this influence, I employed reflexivity to ensure that the findings were not idiosyncratic.

As with much qualitative research, the small sample size raises questions about the generalisability of findings. Mason (2002) notes two forms of generalisation: empirical and theoretical generalisation. In the former, the researcher is able to make generalisations from one empirical population to a wider population on the basis of a study population that is statistically representative of that wider population. In the latter, insights and general inferences that are relevant to the broader concerns of nursing can be drawn. The purpose of this study was not to enable empirical generalisation: rather it sought to examine the topic under study in depth rather than in breadth, thus, although this was a small scale study, it is possible to make broader theoretical generalisations from the study that are of relevance to wider concerns in nursing practice and education as Mason (2002) suggests.

9.3 Is there evidence for advanced nursing practice in Jordan?

The findings clearly show an understanding of the way in which hierarchy and power structures within Jordanian society in general, and nursing in particular, have fundamentally influenced the development of education and the practice of M-level nurses in the clinical field. Over time, societal factors and changing requirements and demands that are driving changes in the Jordanian health care system have led to several reforms of nurse education. As noted in chapter 2, nursing in Jordan has witnessed an increase in the number of students in general, and an exponential growth in the number of male students in particular, at both undergraduate and postgraduate levels. At postgraduate level, emphasis was placed initially on preparing nurse educators; later, the emphasis shifted to preparing nurses for clinical roles.

M-level education and preparation for advanced practice roles were the focus of the study. M-level nurses undertook Master's degrees which were intended by nurse educationalists to provide them with knowledge and skills that could support ANP and holistic nursing care, and enable practitioners to move nursing beyond the performance of

technical, delegated tasks. Nurse educationalists were cautious about expanding the M-level nurse role to become a more sophisticated physicians' assistants. Rather, there was emphasis on collegial relationships and cooperation between nurses and physicians in order to maintain and further develop a discrete identity for nurses and to enhance the professionalisation of nursing.

Overlap and tension between M-level education and ANP were evidenced in the difficulties that many participants experienced in talking specifically about ANP without talking about M-level education. It was similarly very difficult to undertake a conceptual analysis of ANP in the Jordanian context at that point in time. It was difficult to derive a coherent account across different groups of participants of the drivers for change and the development of ANP.

On reflecting upon Ketefien's et al.'s (2001) framework for the development of ANP, similar elements of significance were noted in the Jordanian context. It is within this context that the drivers recognised by the participants for educational change in nursing and for the emergence of elements of ANP were articulated as: globalisation and the increasing technologisation of healthcare, the perceived needs of the country, and expanding opportunities for continuing nurse education. However, although not mentioned directly by participants, issues related to inter- and intra-professional collaboration and support, which were seen by Ketefian et al. as precursors to such development, were relatively lacking amongst Jordanian nurses. Although there is support from HRH Princess Muna, Jordanian nursing requires substantive support and binding regulations from the government, as evidence shows that government commissions, such as the report of the Irish commission on nursing 'A blue print for the future' (Cowman, 2001; Joyce & Cowman, 2007, Drennan, 2008), and the appearance of the policy document 'Making a Difference' in England, which encouraged nurses to take on new and more complex roles were also significant in the development of ANP in these countries.

Health care reforms and the attempt of the Jordanian government to implement 'health for all' (Hijazi & Al-Ma'aitah, 1999), in addition to its focus on primary

healthcare, could create an environment for community Master's graduates whose skills are not currently being used. Despite the fact that the Community Master's programme has been available for more than 10 years, it is difficult to identify practice potential for these nurses within current community healthcare settings. Specialisation within community nursing was suggested as one potential strategy of increasing the prestige of this practice area. This may suggest a particular value system in which specialist practice is subject to super-valuation while generic nursing practice is under-valued. This super-valuation threatens to undermine efforts to introduce effective community healthcare services by fragmenting provision in terms of speciality inputs. Health care systems which give predominance to tertiary care are inevitably unable to realise the potential of preventative, community and public health services to reduce the incidence of ill-health in the population as a whole.

As recruitment into Masters courses is dependent on nurses' GPA, some nurses did not have free choice over which Master's course they could enrol on. This should draw the attention of recruiting universities and the educational system in Jordan to their academic entry requirements, which give higher priority to overall marks rather than to the individual's clinical interest, and experience, or educational preferences. Individuals who enrol in certain programmes because they have no other options available may not be the most committed or productive nurses once they graduate. This may not only impact on the delivery of quality healthcare but may also, ultimately, lead such nurses to seek other employment alternatives away from nursing.

The lack of consensus on what constitutes ANP is universal, and as discussed in section 2.4.1, each country sets its own legal and professional boundaries for such roles. The findings of this study suggest that there is a need for nurse educationalists, employers, and professional body representatives to collaborate to establish parameters for ANP in Jordan. The promotion, development, and understanding of M-level nurse education and its link to ANP need to be achieved through effective partnerships between different stakeholders. The titles 'advanced nurse practitioner' and 'clinical nurse specialist' require careful consideration within the Jordanian context, embedded as they

are in an American model of advanced practice which has no congruence in the Jordanian health care system.

The findings of this study further suggest that Master's level education was seen as a strategy for professionalisation of Jordanian nursing. However, enhancement of the caring role of nurses and benefits to patients were rarely mentioned. This might be related to the tendency amongst Master's level graduates to move away from direct patient care to posts in management and education. Although this could be framed as a negative element, this move may be an appropriate direction for M-level nurses to take in the contemporary healthcare system where they can train the next generation of nurses as Ashworth et al. (2001) suggest. However, the perception that M-level nurses are liable to move away from direct patient care created dissatisfaction amongst managers who emphasised the need for nurses who can make a more visible impact on practice. This led some participants to question the necessity for M-level education for nurses, which in turn draws attention to the appropriateness of course design and its relevance to contemporary practice. Uncertainty about M-level education suggests the need for commitment at governmental level and commitment from educational institutions to strengthen employers' involvement in M-level education curriculum design.

9.4 M-level nurses' role expectations

M-level nurses were seen to have a role to play in practice either directly, through the care they deliver, or indirectly, by helping to develop practice environments and nursing colleagues. The nature of the role was dependent on individual nurses as variations were seen amongst M-level nurses in the same hospital and across different hospitals.

M-level nurses were also seen to have a role to play in bridging the theory-practice gap that was perceived to characterise contemporary Jordanian nursing. The theory-practice gap is universally recognised as a major problem within nursing (McSharry, 1995). M-level nurses could be argued to be addressing this issue through their individualised attempts to develop evidence-based practice, applying what they learnt through their Master's education to practice, and sharing their knowledge with

their colleagues. However, it has been argued that the traditional theory-into-practice notion is problematic.

Lathlean (1994) notes that theory and practice are different in two important ways: first, practice involves dealing with individuals in complex contexts, while academic knowledge, which is open to scrutiny and examination, has to take on more generalisable form. Second, there is the ideal/real distinction. Theoretical formulations of what should or ought to be happening are made in terms of ideal conditions where time and resources are available. In practice, many constraints exist, which makes it necessary to modify theoretical suggestions. For these reasons, Lathlean argues that it is then inevitable and appropriate that theory and practice should be thought of as different parts of nursing, each important in its own right. From this perspective there is no necessity for theory to be imposed on practice or vice versa.

Thompson and Watson (2005) argue that the link between theory and practice does not necessarily have to take place either in the hospital or at the university. They propose alternatives to direct classroom teaching such as advanced skills laboratories and web-based clinical teaching. However, Thompson and Watson's proposal may prove to be hard to attain in Jordan as such activities are not available. This again calls for an attempt to try to reach an agreement on how to enhance the partnership between theory and practice, though internationally debated.

The findings of the study did not clearly identify the potential impact of M-level nurses on clinical practice. Rather, it illustrated aspects of M-level nurses' work in clinical practice. There was a range of understandings amongst participants about the value of M-level education for nurses and nursing practice. The findings suggest that M-level education adds to nurses' knowledge, but does not necessarily improve their clinical skills. However, this finding should be interpreted with caution. M-level nurses who participated in this study were working in the ICU, where they did not feel that M-level education had added much to their clinical skills; nurses who were working in other areas, and who might have had different perspectives, were not included in the second stage of the study.

A Master's degree alone was widely considered to be insufficient; nurses were considered to need clinical experience and personal development to earn the status of an ANP. Therefore, short term courses in speciality areas were suggested as alternatives to Masters level education as these placed greater emphasis on specific than generic outcomes.

The tension between participants' understandings of ANP and of specialisation in nursing calls for raising awareness about the nature of ANP and specialisation courses, and calls for an ongoing evaluation of Master's programmes in nursing from the perspectives of nurse educationalists and employers and the health care system more generally.

Acquisition of theoretical knowledge was seen as important for M-level nurses, but it must be complemented and enhanced with experiential knowledge. Experience was mainly linked with knowledge and skills gained from clinical practice (experiential knowledge) rather than from formal education (propositional knowledge). Oweis (2005) argues that a unique body of knowledge is important to nurses' practice, but nurses must also have an appropriate skill level so that this knowledge can benefit and serve the public. The lack of clinical experience of some M-level nurses was a worrying issue for some participants, in particular nurse managers and physicians. Academic entry requirements are largely dependent on the students' academic ability rather than clinical experience. Although this might be seen as a disadvantage to practice settings, universities are market institutions and recruitment to Masters' courses is a financial necessity for them. Although this might be seen as a disadvantage, it cannot be denied that university education is a huge market that strengthens the financial situation for universities.

 It is important for nurse educationalists to collaborate with service providers and to establish service requirements for postgraduate entry. Such collaboration could enable nurse educationalists to develop curricula to meet the needs of students as well as the health services. This could also inform the destination, employability, and utility of M-level nurses in practice.

It was evident from this study that the majority of M-level nurses self-funded their postgraduate study, and that they found it difficult to negotiate a balance between their studies and their jobs as full-time nurses. Nurse managers also found it difficult to provide self-funded nurses with study days. The findings suggest that nurse managers decide on whether these nurses will be facilitated or not in terms of study days and work scheduling. Full sponsorship by employers might improve the retention of M-level nurses and establish a body of clinical preceptors for future undergraduate and M-level students. Such support may, therefore, result in a growth in the number of M-level nurses working in clinical settings, and enhance opportunities for them to influence Jordanian nursing practice. This could also help the profession to develop formalised advanced clinical practice roles for those nurses who remain in practice.

Several educational challenges have been emphasised. Relying mostly on lectures as a way of teaching and on formal examinations as a way of assessing students was criticised as negatively affecting the educational outcomes of students. M-level nurses suggested that nurse educationalists should be encouraged to develop teaching and assessment strategies in a way that will reflect effective student involvement in the learning process. This might suggest that nurse lecturers would benefit from enhanced teaching skills as the majority do not receive pre-service teaching training before commencing their jobs. Drennan (2007) points out that the ability of lecturers to make their subjects interesting and clear, and the ability of teaching staff to motivate students and give feedback to students were highly rated by M-level nurse students in his study.

Moreover, assessments that emphasise understanding over recall and assignments over examinations can lead to the development of higher-order thinking skills as Drennan (2007) recommends. These thinking skills were noted by M-level nurses and nurse educationalist in the current study as outcomes of M-level education. It was not clear how M-level nurses developed such skills, and I could not pursue the issue further as it was outside the remit of the study to evaluate educational outcomes. This is, however, an issue that I would consider for further research. The findings of this study suggest that nurse lecturers need to develop an understanding of students' needs and the learning process. This will help them to identify the teaching and assessment methods that

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students find most effective. However, the increasing number of students enrolling in Master's level programmes, and the need to cover the credit hours required for the students, might hinder any attempts to change teaching practice.

9.5 Role transition

How educational institutions, healthcare organisations, and nursing professional bodies define ANP is likely to have significant implications for how advanced practitioners are educated and how they realise their roles in clinical practice. It is therefore necessary to understand the transitional process that these nurses may experience when training to become advanced nurse practitioners, and how they alter their practice and identity during this process.

The work of Woods (2000) provides a framework suitable for analysing the transition of M-level nurses in the Jordanian context. Woods' framework provides a coherent account of the transition into work roles which are 'new' to both the individual and the organisation, and a comparator for discussion of findings from this study in the Jordanian context where the roles of M-level nurses as potential advanced nurse practitioners were new to both the M-level nurses and their hospitals. I, therefore, use this as frame of reference against which to assess the progress of role transition in Jordan. The advantage, in the Jordanian situation, of Woods' model is that it represents only the early stages in ANP role development, and may be modified, or further stages may be identified, at a future date.

The framework consists of three operational outcomes of practice reconstruction: practice replication, practice fragmentation, and practice innovation. In practice replication, practitioners fail to develop new clinical skills or experience new ways of organising and delivering nursing care. They also have little control over the scope of practice development. This results in minimal change in the work role and a lack of apparent advanced level practice. Woods points out that, in a practice replication context, advanced nurse practitioners experience low levels of novelty in their role due to the contingent conditions which prevent them from developing new and novel practice.

Similar to Woods's, M-level nurses in my study perceived some degree of personal and cognitive development with minimal changes to clinical skills. However, there was no new role for the majority of M-level nurses in this study; the majority of M-level nurses performed the same job after gaining their Master's degree. Consequently, role development in the sense of role change can be considered low. Woods (2000) suggests that low levels of novelty are associated with individuals using their existing knowledge and skills in the performance of new roles. Although the current study provided little evidence of novelty in the practice of M-level nurses, it cannot be concluded that this represents a failure to implement new roles in their practice. What may seem to be low levels of novelty in their practice is likely to be due to a range of (real or perceived) cultural organisational and professional factors and personal attributes of the M-level nurse which posed significant constraints on the way M-level nurses worked, rather than to the inability of the individual nurse.

Practice innovation, on the other hand, includes the reconstruction of practice parameters requiring the development of new skills and activities which result in increased practice independence and autonomy and changes in personal qualities. According to Woods, role development is an indicator of practice innovation, and involves largely new and novel practices designed to enhance and benefit the delivery of nursing care both directly and indirectly. In the current study, although some participants suggested that M-level nurses were perceived to have gained new knowledge and cognitive skills, and some did suggest that they had made some impact on clinical practice either directly or indirectly, M-level nurses could not demonstrate tangible outcomes of their practice. As there were no established parameters for the M-level nurses' role in practice, it is not possible at this stage in time to evaluate such outcomes.

Woods (2000) points out that a further outcome of role transition is establishing a new professional identity. The evidence from this study suggests that M-level nurses expressly sought to gain recognition for their practice development. They expressed dissatisfaction and disenchantment at the lack of recognition for their qualifications. In their attempt to gain recognition, M-level nurses sought to establish a new and different identity from that of their nursing colleagues. Woods explains that advanced nurse

practitioners' attempts to establish a new professional identity, in the UK context, is derived from their desire to become more autonomous, to gain authority, and to influence the scope and boundaries of their practice. Woods points out that advanced nurse practitioners' experience a conflict in their own 'nursing' identities which is usually associated with disenchantment and dissatisfaction with traditional nursing roles. This can lead them to distance themselves from that traditional identity in order to be recognised in their new capacity, though there may be no intentional devaluing of nursing or nursing colleagues. This dissatisfaction during the transitional period from experienced nurse to advanced nurse practitioner (usually during the educational programme and the first 6-9 months in clinical practice post graduation) led nurses in Woods' study to seek alternative employment. This was related to their inability to implement the advanced nurse practitioner role as desired and expected.

In the Jordanian context, though M-level nurses sought recognition of their credentials at national level, acknowledgement of a change in their status within the organisation, and change in work title and job description, they were not proactive in seeking such recognition. Dissatisfaction with their current status prompted a number of these nurses to seek alternative work inside and outside Jordan. The bureaucratic healthcare system in Jordan and its associated hierarchy and power structure and the absence of an open-door policy might have hindered these nurses from being proactive and influenced their practice. Seeking to be different might explain why some non-M-level nurses felt threatened and described some M-level nurses as being arrogant. It might also explain the desire of nurses to move away from direct patient care and seek other employment alternatives. Understanding this stage of transition is, therefore, crucial in developing more collegial relationships.

Woods (1999) points out that multiple interpretations of the concept of ANP, which are socially constructed by dominant stakeholders within an organisation, shape both the conditions and the context for role transition. Woods (2000) argues that the transition from experienced nurse to advanced nurse practitioner involves the reconstruction of a series of personal and practice domains: cognition, skills, behaviour, roles, affect, relationships, and identity. M-level nurses in my study were sometimes

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subject to high expectations of what the M-level nurse could do. Woods (1999) describes this as the 'idealistic view' where M-level nurses are expected, through their transition from experienced nurses to advanced nurse practitioner, to meet a variety of practice and organisational demands. Consequently, advanced nurse practitioners who are perceived to fail to achieve this 'idealistic' view of their role develop a sense of conflict between themselves and their organisations, and are likely to develop a sense of frustration. The unrealistic expectations could lead to a significant degree of role ambiguity and lack of clarity amongst stakeholders regarding role objectives, the scope of practice, individual responsibilities, and the anticipated outcomes of practice. The reasons why this phenomenon may have occurred, as Woods points out in his work in the UK, relates to the novelty and ambiguity of the whole concept of ANP. As a result, defining the parameters of practice becomes extremely difficult and ultimately appears to be contingent upon prevailing organisational conditions. This is similar to the situation in Jordan, and there is therefore a need to arrive at a framework which defines the parameters of ANP in Jordan. Employing hospitals need to consider the location of the M-level nurse in the organisational hierarchy and to develop realistic role objectives framed within the constraints of real practice.

Following an initial period of idealism, advanced nurse practitioners in the UK context entered a phase of negotiation with managerial and medical staff to establish the goals and parameters of their new role within certain physical and financial constraints. It was at this time that the contingent nature of reconstruction began to emerge fully and the process of 'organisational governance' was imposed by higher management. At this stage, the advanced nurse practitioners experienced the 'reality shock' that their initial expectations regarding their work role transition were unlikely to be met; moreover, they were expected to meet a variety of practice and organisational demands other than those they were prepared for, which resulted in a sense of conflict and frustration. The findings of my study clearly suggest incongruity between nurses' preparation and their actual performance in clinical setting. For a variety of reasons, what was being taught in the academic course did not match with the reality of practice. M-level nurses, in the Jordanian context, were undertaking tasks similar to those performed before gaining their Master's degree. Nevertheless, they were expected to apply what they had learnt in their

postgraduate study to practice, improve practice and transfer their knowledge to non-M-level nurses through teaching and in-service training, as well as undertake research or utilise research findings.

The findings also suggested differences in the perception of nurse educationalists and nurse managers. Nurse educationalists emphasised theoretical knowledge which would ultimately impact on practice, while nurse managers placed more emphasis on educational outcomes that would enable M-level nurses to bring about tangible changes. There was also emphasis from nurse educationalists on moving from task-oriented nursing practice to patient-centred nursing practice with the rejection of a 'medical model' of nursing. The majority of M-level nurses had remained in the same job and, in few cases, recognition of the Master's degree took the form of employing M-level nurses to undertake tasks related to in-service education or management. Employers, as the principal funders, would be able to become more involved in determining the content of educational programmes to meet the needs of the health service, not just the educational and professional needs of the nurse.

The third stage that advanced nurse practitioners experience as a result of the contingent nature of role transition has been termed by Woods (1999) as 'resolution'. Resolution in this context does not necessarily signal arrival at a point of mutuality between the advanced nurse practitioner and the organisation, but reluctant acquiescence and acceptance on the part of the advanced practitioner. Chronologically, this stage was found to emerge during the second year of implementation. It was at this point that advanced nurse practitioners, in the UK context, acknowledged the limitations to role enactment imposed through organisational governance. Arrival at this phase indicates the passage from idealism, through the exploration, challenges and conflicts characterized as responses to organisational governance, to final acknowledgement and acceptance that idealised goals are unattainable and that control is maintained by the institution. At this stage advanced nurse practitioners become resigned to the reality of their specific situation. This is also similar to what M-level nurses face in Jordan. Many M-level nurses were prepared to accept their situation, and those who could not, intended to look for other employment alternatives.

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9.6 Understanding of cultural change

An explicit expectation of M-level nurses in this study is that they assume the role of change agents. There was also clear evidence that, although the majority of M- level nurses had no job description, they were expected by nurse managers and colleagues to do many things to change and develop practice. This imposes considerable demands upon M-level nurses who, as individuals, have limited ability to effect change in such a hierarchical context. Change theories provide a theoretical framework for understanding cultural change in the Jordanian context. This can be looked at in terms of a theoretical understanding of facilitators and inhibitors of the contribution of M-level nurses to develop and change practice.

The majority of participants in the current study viewed the M-level nurse as someone who could lead practice change. This expectation placed M-level nurses in an unenviable position: on one hand, they were required, in the absence of support from professional bodies or local organisational support, to change nursing from the bottom up. This requirement places individuals under tremendous pressure, (as evidenced in the narratives of M-level nurses as well as those of their colleagues), to show that they could make a difference. On the other hand, this is a change that is being attempted in a very patriarchal and very hierarchal environment where most decision making is physician-driven.

M-level nurses felt that they were not valued by their managers, while managers saw this in a rather different light. M-level nurses deemed nurse managers to be inflexible, unapproachable and reluctant to support nurses in general and M-level nurses in particular. Nurse managers, on the other hand, at all levels of the organisational hierarchy, reported limited control over their own work and limited power to make fundamental changes or to participate in decision-making in practice areas. Both managers and nurses were under pressure to 'get the job done'. The pressure was imposed from higher management on nurse managers, and from nurse managers on nurses. M-level nurses could not approach the directors of nursing because of the very rigid hierarchy common in Jordanian hospital organisation. Neither nurses nor managers

indicated any awareness or appreciation of the pressure that each experienced, and there was a clear sense of division between them.

There is no clear cut solution to resolve the division between M-level nurses and nurse managers. However, both parties need to communicate to resolve their differences. This may require breaking down the existing status hierarchy between practitioners and managers. For example, nurses could shadow managers to understand the nature of their work and the pressure they feel in assigning tasks and doing managerial jobs. In return, managers could do practice days of M-level nurses to familiarise themselves with M-level nurses' skills and their potential.

Moreover, some participants suggested that nursing professional bodies and nursing managers would be unable, on their own, to effect change and influence decision makers, and they perceived the need for support from the government as well as senior management in the process of change. In the light of the current hierarchical structure, cultural change is most likely to be effective through a top-down approach. In a top-down approach, changes are often enforced by those in authority who have legitimate power to introduce change; on the other hand, in a bottom-up approach, it is believed that those most likely to be affected by change should be involved in the change (Mulhall, 1999). In either event, change may challenge cultural norms and question beliefs, attitudes, and practices (Mulhall, 1999). Mulhall points out that change might also alter the balance of power, challenge the way nurses perceive things, question their professional skills, modify their relationships with colleagues and patients, or change the entire nature of their work and the social structure of health care organisations.

One of the most frequently cited theories of change is Lewin's force field analysis (Garside, 1998). It conceptualises organisational change as a process shaped by the interaction of driving forces for change and restraining forces impeding change. For organisational change to occur, there must be a strengthening of the driving forces, for example through legislation or economic imperatives, or a weakening of the restraining forces such as traditional practices, organisation culture, and job insecurity. It is argued that the most effective strategies for change rest on reducing the restraining forces. The

presence of HRH princess Muna and the Minister of Health in the JNC Board can help in driving the forces of change for the benefits of nurses and nursing in Jordan. The influence of such important figures in Jordanian society can change public and professional perceptions of nursing. Nurses can also have a more significant role to play deciding their own policies and standards. The inherited poor image of nursing can be improved through national campaigns and the media that raise public awareness of the role of nurses in the Jordanian society.

Taking into consideration the control of physicians over healthcare decisions in Jordan and their tremendous influence on the extent to which nurses are able to exercise autonomy, the findings suggest that physicians in this study can be appreciative of the M-level nurse's knowledge and experience; it is, therefore, important to utilise this acknowledgement to develop and implement roles for M-level nurses in practice. For example, in practice settings, orientation sessions and joint meetings with physicians can be held to discuss the introduction of such roles.

As Garside (1998) suggests, change needs to be driven by a vision of what is to be accomplished. The results of this study suggest the need for those leaders who speak for the profession to establish and convey a shared vision for nursing which recognises and encourages its continuous development. Moreover, focused attention is needed on the process of implementing change. Hart and Fletcher (1999) note that change is not a linear, ineluctable process; unforeseen events may be encountered, which may require the objectives set at the outset to be reviewed in the light of changing circumstances. For example, participants in this study identified several factors that facilitate or hinder the M-level nurse in practice. Taking these factors into consideration might help in identifying restraining and driving forces for change and assist service providers, educational institutions, and nursing professional bodies in introducing change.

9.7 Contribution to nursing theory and knowledge

This study was the first to explore the concept of ANP and to examine M-level nurses perceptions of their role in Jordan. The study helps to further understanding of the

internationalisation of nursing, and the way in which professional development is contingent upon specific socio-political and cultural contexts.

The study has demonstrated the way in which hierarchical power structures within Jordanian society in general, and Jordanian nursing in particular, have fundamentally influenced the development of M-level education and the experiences of M-level nurses in the clinical field. The study, therefore, also affirms the theoretical utility of, and provides empirical extension for Ketefian et al.'s (2001) framework, which illustrated variability across different socio-political contexts and identified several critical elements that have shaped the development of advanced nursing practice in the international nursing community. Insights that are gained from the comparative analysis with Ketefian et al's framework will benefit nursing globally. This study has contributed a unique, culturally specific perspective on ANP as well as demonstrating commonalities with the broader international nursing community. In the Jordanian context, professionalisation and the pursuit of nursing autonomy has been the principal driving force towards ANP. The challenges that are faced by nurses in the Jordanian context are not, therefore, dissimilar to the challenges that continue to threaten the development and implementation of ANP roles in the international community. Just as Jordanian nursing can learn from the international nursing community, so the international nursing community can learn from the experiences of nursing in Jordan as it pursues the development of ANP roles.

This study has demonstrated the critical importance of clearly defining M-level nurses' roles in order to delineate their responsibilities and define appropriate educational preparation, which takes into consideration the location of M-level nurses in organisational hierarchies. It has also demonstrated that role definitions and objectives must be realistic and framed within the constraints of the relevant bureaucratic organisations. The long established hierarchical relationship between doctors and nurses in which physicians have tremendous influence on the extent to which nurses are able to exercise autonomy, in addition to the lack of power on the part of nursing professional bodies and their inability to enforce regulations for nursing practice call, in the Jordanian context, for a top-down approach to effect cultural change and governmental support. Nurse educationalists need to plan strategically as well as inform future students of the

academic and professional value of the Master's degree. This will also inform the employers of patterns and trends in employment of M-level nurse. A number of recommendations are therefore outlined in the following section.

9.8 Vision for Jordanian nursing and recommendations of the study

- It is recommended that there be an ongoing evaluation of Master's programmes in nursing from the perspectives of nurse educationalists and employers of M-level graduates in clinical settings. Educators need to determine whether the degree is meeting the needs of the students as well as professional practice. There is a need to demonstrate to key stakeholders that the degrees have an impact on the development of already highly skilled nurses.

- Concern has been raised with regard to entry requirements to the Master's degree with respect, in particular, to the level of clinical experience of the nurse. It is, therefore, important for nurse educationalists to collaborate with service providers to establish their views and requirements for entry to the degree and to tailor programmes appropriately.

- It is also recommended that there should be more support of M-level graduates with continuing education programmes, especially those related to developing research skills.

- It was evident from this study that the majority of M-level nurses had self-funded their studies. It is recommended that these nurses have the opportunity to further their education with financial support from their employers. This might help in retaining these nurses and, subsequently providing clinical preceptors for future M-level students.

- Nurse educationalists are encouraged to develop teaching and assessment strategies in a way that will enable effective student involvement in the learning process.

- It should be clear whether the main function of M-level nurses is to provide direct patient care or to facilitate others to provide that care or both. This needs to be followed by the development of a systematic process for informing service providers, managers, other health care professionals and patients with whom M-

level nurses interact, in order to make clear the purpose and boundaries of the M-level nurses role.

- M-level nurses should be given an up-to-date job description, and this should be reviewed regularly.

- It is also recommended that nursing's professional bodies establish registration of M-level nurses as advanced practitioners and identify their scope of practice. Different stakeholders need to collaborate and establish a definition for ANP in Jordan.

- Future research is recommended into the clinical effectiveness of M-level nurses, once there is greater clarity about what their role/s should be.

9.9 Areas for further research

As with any study, this research has raised as many questions as it answers. In relation to education, further research is recommended to explore M-level nurses' experiences of their course of study and their experiences of research. Evaluation research could be undertaken for this purpose, and to measure educational outcomes from M-level education. This could help in designing Master's programmes in a way that is most effective for the students. Moreover, it could help employers and universities to work collaboratively in a way that serves both educational and clinical settings. In relation to practice, comparative studies could be conducted between nurses with specialist courses and nurses with M-level education to establish if there is any significant relationship between practice performance and educational preparation. Comparative studies also could be conducted between nurses with M-level qualifications and experienced nurses *without* either M-level qualifications or specialist courses to establish if there is any significant relationship between practice performance and educational preparation and experience. This may help in answering questions about the necessity for M-level education and its worthiness in preparing qualified nurses whose quality of work is distinguished from that of other nurses.

9.10 Conclusion

The study aimed at examining the extent to which ANP is evident in Jordan, with a particular focus on the contribution of M-level education. It was clear from the outset that there is no clear notion of what ANP is, although participants describe a number of different elements of advanced practice. Taking this into consideration, nurse educationalists, professional bodies and employers need to collaborate to identify a framework for ANP in Jordan. Issues related to scope of practice, regulations, person specifications, and appropriate educational preparation need to be considered thoroughly.

Several factors were seen as facilitating or hindering the development of potential M-level nurse role in practice. These were related to professional factors, managerial factors, and personal attributes. Professional bodies need to formally recognise the role of M-level nurses. Employers need to provide a supportive environment for M-level nurses and consider their location in the organisational hierarchy by developing clear role definitions and objectives that are realistic and framed within the constraints of bureaucratic organisations. This may help in retaining M-level nurses in practice and reduce the tendency for them to move away from direct patient care or migrate to other countries. To prevent role ambiguity, the purpose of the new role should be developed in liaison with and communicated to relevant groups.

Data suggest that clinical Master's programmes were established in Jordan for a variety of reasons. M-level education is seen as a key strategy to professionalisation which is thought to give nursing a legitimate stand in relation to medicine. The data also suggest that a change of job title or job description, after gaining a Master's degree, reflects the movement of M-level nurses away from direct patient care to non-direct patient care. This tendency, though potentially disadvantageous to health care practice, can be utilised to shape the healthcare environment and assist management in setting up practice standards and in the utilisation of research findings. M-level nurses would also contribute to educating the future generation of nursing students and junior nurses.

There was also tension between the specific and generic outcomes of the Master's programmes. This raises a challenge for nurse educationalists and employers to achieve a

balance that serves the nursing profession, the students, and ultimately patient care. Nurse managers raised a concern about the lack of clinical experience of M-level students, which may also call for reviewing and revising the academic entry requirements for postgraduate nursing programmes.

Finally, I hope the findings of this study have filled a gap in understanding the nature of M- level education in Jordan and the potential role of M-level nurses in practice. Taking into consideration the country's unique cultural context, I also hope that the findings will guide policy makers, employers and educationalists into promoting and enhancing M-level education and taking actual steps to help these nurses overcome the enormous challenges they face to legitimise their potential roles in practice.

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Appendices

Appendix 1: Search strategy

- Several mechanisms were used to retrieve the relevant literature:
- A manual search of the relevant literature (Journals, books and unpublished theses) was undertaken.
- A systematic search of the electronic databases (Medline, CINAHL, Index to Theses, British Nursing Index, Cochrane Library, and Web of Knowledge) were undertaken.
- Websites of professional bodies: the Jordanian Nursing Council, Jordanian Nurses and Midwives Council were also searched. Search engines on the World Wide Web such as Google and Google Scholar were also used to access grey literature.
- Only those items written in English or Arabic were accessed.
- The search found published materials such as research articles, policy documents and reports, experiential accounts and anecdotal literature.
- An additional strategy for identification of further literature involved examining the reference lists of identified papers to retrieve other key papers and author searches to ensure a comprehensive search.
- The search terms employed were: advanced nursing practice, advanced clinical roles, nurse practitioner, clinical nurse specialist, Master's level education, educational preparation, facilitating factors, inhibiting factors, nursing in Jordan, health systems in Jordan, Jordanian nursing, role implementation and role competencies.
- Combined search was used to retrieve relevant items and reduce number of hits
- The review was regularly updated as new items entered the public domain

Appendix 2: Features of advanced practice according to Ketefian et al. **(2001, p.157)**

Feature	Brazil	Thailand	UK	USA
Socio-political environment	Shorter hospital stays, in turn stimulating home care. Technological and scientific development. Governmental initiatives	Health care reform. Proposal for new specialists under consideration	Shorter hospital stay. Health care reform, increased focus on primary care. Technological and scientific development. Governmental initiatives	Shorter hospital stay. Health care reform. Technological and scientific development. Governmental initiatives
Health needs of the society	Access, poverty, inequality, quality of care	Access, inequality, quality of care,	Changes in profile of general practice, increase in community-based services	Access, equality, quality of care, high cost
Health workforce supply and demand	Insufficient nurses and physicians, maldistribution	Insufficient nurses and physicians, maldistribution	Workforce planning tied loosely to health need and government priorities	Supply sufficient, maldistribution a problem and varies regionally.
Government policy and support	Nursing practice under legal authority, expanded roles encouraged. No regulations for ANP. Limited funding	Nursing practice under legal authority, expanded roles encouraged. No regulations for ANP. Funding available for education and training	Nursing practice under a license. Funding is available for education and training, and for vacant staff positions. expanded roles are encouraged	Nursing certification by professional group. Funding available for some training and research
Intra-and inter-professional collaboration	Active nursing organisations. Leadership active in support of graduate education and research	Active nursing organisations. Leadership active in support of graduate education and research	Support for graduate studies and clinical specialisation. Active nursing organisations.	Support for graduate studies and clinical specialisation. Active nursing organisations.
The development of nursing education	Specialisation courses and/or Master's level	Not required	Special training or advanced education is not yet compulsory for all roles	Master's level education is required
The effectiveness of advanced roles	Evidence does not exist	Evidence does not exist	Growing body of research on quality, cost effectiveness, competence and career pathways	Research on quality and cost-effectiveness of APN compared to others

Appendix 3: Jordan Map (with permission from John O. Moen, Managing Director, www.graphicmaps.com, www.worldatlas.com)
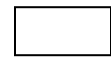
School of Nursing and Midwifery

**The contribution of Master's level education to the development of advanced
nursing practice in Jordan**
A survey of Master's level nurses

This questionnaire is being sent to nurses with Master's level qualifications in private and
public hospitals. I anticipate that the questionnaire will take 30 minutes to complete.
Please answer the questions as best as you can. I hope that you are able to answer all of
the questions, but if any prove difficult, please leave these and complete the rest.

Yourself

1. Please indicate if you are

          Female   ☐   Male   ☐

2. Please indicate your age---------------- years
3. In what year did you first gain a nursing qualification? -----------------------------
4. When did you get your Master's degree (year)? ---------------------------------------
5. Where did you get your Master's degree (country)? ------------------------------------
6. What Master's qualification do you have (speciality)? ------------------------------

Your current post

7. What is your job title? ---
8. What is your current area of practice? ---
9. How many years of experience do you have in your current role? -------------------years
10. What span of responsibility do you have in your current role? Please tick one box
only which best describes your responsibility.

Single ward/unit   ☐
Several wards   ☐
Whole hospital   ☐
Other-please specify---

11. I would like you to describe what the term 'advanced nursing practice' means to you?

----

12. Has your job title changed after you gained Master's qualification?

         Yes   ☐   No   ☐

13. If you answered 'yes' please explain how?

----

14. If you answered 'no' please explain why?

----
15. Has your job description changed after you gained Master's qualification?

Yes ☐ No ☐

16. If you answered 'yes' please explain how?

----
17. If you answered 'no' please explain why?

----

18. Has your area of practice changed after you gained Master's qualification?

Yes ☐ No ☐

19. If you answered 'yes' please explain how?

----
20. If you answered 'no' please explain why?

----

21. Are there any differences between your previous role and your current role (after you gained Master's qualification)?

Yes ☐ No ☐

22. If you answered 'yes' please explain how?

----
23. If you answered 'no' please explain why?

Education and training
24. Has Master's qualification equipped you with specialised skills and knowledge?

Yes ☐ No ☐

25. If you answered 'yes' please explain how?

----
26. If you answered 'no' please explain why?

I am interested in the ways you work after you gained Master's qualification. Please indicate the extent to which the following activities feature your current role by ticking the appropriate statement below:

Activities feature in your current role

	Minor component	Major component	Does not feature
27. Providing direct care to patients	☐	☐	☐
28. Teaching staff	☐	☐	☐

29. Health education (patients) □ □ □

30. Health education (families) □ □ □

31. Function autonomously □ □ □

32. Undertaking research □ □ □

33. Bringing about change in your workplace □ □ □

34. Develop policies and protocols □ □ □

35. Develop your own practice □ □ □

36. Develop practice in general □ □ □

37. Assist other nurses to solve clinical problems □ □ □

38. Act as a resource to other nurses for clinical information □ □ □

39. Discuss research findings (in general) with other staff □ □ □

40. Examination of patients □ □ □

41. Undertake ECGs □ □ □

42. Cannulation □ □ □

43. Venepuncture □ □ □

44. Defibrillation □ □ □

45. Ordering X-rays □ □ □

46. Catheterisation □ □ □

47. Make referrals to other professionals □ □ □

48. Assume leadership and Management responsibilities □ □ □

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49. Order different tests ☐ ☐ ☐

50. Interpret different results ☐ ☐ ☐

51. Please describe what tests you undertake?

----
52. Please describe what results you interpret?

----
53. Please describe any other activities that you perform

I am interested in your perception of the knowledge you possess. Please tick the boxes that best describe you.

Knowledge	Strongly Agree	Agree	Neither agree nor disagree	Disagree	strongly disagree
54. I am up-to-date with current research knowledge in my field	☐	☐	☐	☐	☐
55. I have good understanding of evidence-based practice	☐	☐	☐	☐	☐
56. I am confident in using research evidence to inform the clinical decisions I make	☐	☐	☐	☐	☐
57. I am knowledgeable about guidelines and protocols relevant to my field	☐	☐	☐	☐	☐
58. I actively seek out evidence based information	☐	☐	☐	☐	☐
59. I am confident in using my professional judgment to inform the clinical decisions I make	☐	☐	☐	☐	☐
60. I am not permitted to carry out research in clinical practice	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	strongly disagree

61. I am not permitted to apply research to practice ☐ ☐ ☐ ☐ ☐

62. I find it difficult to establish collaboration with other health professionals ☐ ☐ ☐ ☐ ☐

Impact on quality of care

I am interested in your perceptions of the impact you have on the care provided and how effective are the methods of working in creating quality care for patients. Please consider the following statements with regard to the overall impact of your role and tick the appropriate boxes

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	strongly disagree
63. Information and advice I provide to nurses influences how patients are managed/cared	☐	☐	☐	☐	☐
64. Information and advice I provide to patients influences their approach to managing their condition	☐	☐	☐	☐	☐
65. Information and advice I provide to patients influences how nurses manage their care	☐	☐	☐	☐	☐
66. Nurses and other health care professionals actively seek information, support and advice from me	☐	☐	☐	☐	☐
67. I have helped create a culture in which nurses feel able to challenge and question care	☐	☐	☐	☐	☐
68. I actively draw upon experience of patients in making decisions to inform their care	☐	☐	☐	☐	☐

69. My work load is too heavy to be able to carry out a holistic nursing assessment of patients

☐   ☐   ☐   ☐   ☐

70. I am not permitted to initiate and lead practice development

☐   ☐   ☐   ☐   ☐

71. I am not permitted to make decisions without reference to medical practitioner

☐   ☐   ☐   ☐   ☐

72. I lack the authority in the work place to change practice

☐   ☐   ☐   ☐   ☐

73. There are not sufficient resources to change practice

☐   ☐   ☐   ☐   ☐

74. Has the education/training you have received so far prepared you sufficiently for your current role?

Yes   ☐   No   ☐

75. Do you feel that any further education/ training is important for your role?

Yes   ☐   No   ☐

   If you answered 'no' to question 75, please go to question 79

76. If you answered 'yes' to question 75 what sort of education/training you feel you might need?

   ----
77. Are there any barriers to obtaining that education/training?

Yes   ☐   No   ☐

78. If you answered 'yes' to question 77, what are those barriers?
           (Please tick any that apply)
   Cost is too high   ☐

   Funding is not available   ☐

   Lack of time   ☐

   Long distance/need to travel   ☐

   Hospital unable to cover my absence   ☐

   Hospital does not think it is relevant   ☐

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No appropriate course available ☐

Other (please specify) ---

79. Have you undertaken any research in your current role?

Yes ☐   No ☐

If you answered 'no' to question 79, please go to question 82

80. If you answered 'yes' were you working as a part of research team as a research nurse or undertaking research of your own? or in another capacity (please specify.

----

81. Have you published your research?

Yes ☐   No ☐

82. Have you ever presented at a conference a paper related to your role or work?

Yes ☐   No ☐

Managerial issues
83. Do you have a job description?
Yes ☐

No ☐

Not sure ☐

If you answered 'no' please go to question 86
84. Do you feel your job description reflects your current role?
(Please tick one box only)
Very well ☐

Reasonably well ☐

Not very well ☐

Not at all ☐

Not sure ☐

85.When your job description was last updated?
(Please tick one box only)

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Within the last year ☐

More than a year ago ☐

Don't know ☐

86. Do you work to protocols in any aspect of your role?
Yes ☐ No ☐

87. If you answered 'yes' to question 86, who wrote those protocols?
(Please tick all that apply)

Yourself ☐

Nursing manager ☐

A business manager ☐

Medical manager ☐

Don't know ☐

Other (please specify---

88. How would you describe your relationship with other nurses?
(Please tick one box only)

Very well integrated ☐

Reasonably well integrated ☐

Somewhat isolated ☐

Very isolated ☐

89. How would you describe your relationship with other health professions?
(Please tick one box only)

Very well integrated ☐

Reasonably well integrated ☐

Somewhat isolated ☐

Very isolated ☐

90. Can you identify the most important factors which help you to work effectively in your current role?

                (Please tick all that apply)

Support of medical staff   ☐

Support of nursing staff   ☐

Support of nurse managers   ☐

Increased knowledge and confidence   ☐

Increased autonomy   ☐

Expanding the range of skills possessed   ☐

Good staffing levels   ☐

  Other (please specify)---

----

91. Can you identify the most important factors which hinder you to work effectively in your current role?

                (Please tick all that apply)

Being expected to develop advanced role whilst   ☐
 being counted in the nursing staff

Poor levels of nursing staff   ☐

Lack of resources (IT, computer, library)   ☐

Nursing colleagues' feelings threatened, resentful,   ☐
   and non accepting the role

Lack of understanding of the role by others   ☐

Not be graded/financially rewarded for the job   ☐

Conflict with nurse managers

                                ☐

Opposition by medical staff   ☐

Being used as junior doctor replacements   ☐

Absence/incomplete protocols   ☐

Other (please specify--

Your future career

92. Where do you see yourself in five years' time?

(Please tick one box only)

Still in this post   ☐

In a similar post elsewhere   ☐

In a more traditional professional role   ☐

Moving into clinical management   ☐

Moving into general management   ☐

Moving into education   ☐

Taking a career break   ☐

Leaving the profession altogether   ☐

Retired   ☐

Don't know   ☐

Other (Please specify) ---
----

93. Do you think Master's education enhanced your career development?

(Please tick appropriate box)

Yes   ☐

No   ☐

Not sure ☐

Please explain your answer--
----
94. Do you think Master's education enhanced your job satisfaction and sense of achievement?

(Please tick appropriate box)

Yes ☐

No ☐

Not sure ☐

Please explain your answer--

In what ways did Master's level education affected you clinical practice?

95. I am better able to apply research to practice

Yes ☐   No ☐

96. I am better able to plan patient care

Yes ☐   No ☐

97. I am better able to give quality care

Yes ☐   No ☐

98. I am more able to evaluate care

Yes ☐   No ☐

99. I am better able to apply wider knowledge and skills to practice

Yes ☐   No ☐

100. I am better able to improve my teaching skills

Yes ☐   No ☐

101. I am better able of questioning/challenging of practice

Yes ☐   No ☐

102. I am very grateful for your help in answering these questions. If there is anything else you would like to add in connection with any of the questions or if you would like to make any further comments, please use the space provided.

Please read the next section before returning the questionnaire (overleaf)
Future research

After completion of this questionnaire, I plan to undertake some case studies of nurses working in advanced clinical roles.
I would like you to indicate whether you might be interested, if selected, to participate more fully in the study. This would involve at least one in-depth interview about your role, and possibly, depending on your further collaboration, observing your everyday practice in order to gain an understanding of different aspects of your role. If you express an interest, I will provide you with more details of what your participation would involve and answer any questions you may have about the study before you make a final decision about whether to take part. If you then decide to participate I will ask you to sign a consent form.
Please tick the appropriate box to indicate your interest in continuing to participate in the study:

Yes, I am interested in the possibility of participating further in the study ☐

No, I do not wish to be involved further in this study ☐

If yes, please could you enter your name and contact details below and I will then send you further information. I would like to reassure you that if you provide your name I will not use this information when I analyse the questionnaire. I will also 'separate this contact information from the questionnaire responses and not link them in any way'.

Name--
Work address--
Telephone number---
E-mail address---

Thank you for sparing the time to complete the questionnaire. Please return your completed questionnaire within three weeks of receipt in the enclosed freepost envelope to:

Zainab Zahran
P.O Box 211092
Amman 11121 Jordan

Appendix 5: Interviews schedule

In order to focus the interviews, a number of questions are devised. These questions will not be asked verbatim, nor will be presented in any particular order. Stage two interviews will be influenced by the earlier stages of the research.

Interview Schedules: Stage one- Educationalists

I am interested in your experience in teaching Master's programmes in clinical nursing and the development of advanced clinical roles in Jordan. I would like for you to take some time to reflect upon these experiences and share with me your perception of the nursing role as it is being implemented in the hospitals. You can share any thoughts, feelings, and ideas about your experiences. Feel free to talk about whatever comes to mind.

Examples of probes/questions to facilitate the interview

1. Please can you tell me about your role?
2. What involvement have you had in the development and teaching on Master's level programmes for nurses?
3. Why were these programmes developed? (explore drivers for the development)
4. What is the overall aim / intention of the programme(s)?
5. What knowledge, skills and competencies do Master's level graduates exit the programme(s) with?
6. What sort of clinical roles are Master's level graduates expected to fill?
7. From your own experience, can you tell me about the roles that some of your graduates have taken up? Have any of these roles been advanced clinical roles?
8. How appropriate do you think Master's level education is for nurses taking up advanced clinical roles?
9. What factors a) facilitate, b) inhibit the development of advanced clinical nursing roles?
10. How do you think that Master's level education can influence the nurses' power, autonomy and status?
11. What kind of impact do you think Master's level graduates have on patient outcomes / care delivery / professional practice?
12. What is your future vision for advanced clinical roles in nursing?
13. Are there any changes you would like to see in the health care system to enable advanced clinical nursing roles to develop?
14. Are there any other comments that you would like to share with me about Master's level education and the development of advanced clinical nursing roles.

Interview Schedules: Stage one- other stakeholders

I am interested in your experience in the development of nurse education and practice. I would like for you to take some time to reflect upon these experiences and share with me your perception of your nursing role as it is being implemented here. You can share any thoughts, feelings, and ideas about your experiences. Feel free to talk about whatever comes to mind.

Examples of probes/questions to facilitate the interview

1. Please can you tell me about your role?
2. Understanding of advanced clinical roles in Jordan
3. Current roles occupied by Master's level graduates

4. Policy development and legislation to support advanced clinical roles in Jordan
5. Educational preparation of nurses for advanced clinical roles
6. Role of regulatory bodies in the development of advanced clinical roles
7. Collaboration between educational institution, regulatory bodies and health care organisations in the development of advanced clinical roles
8. Factors inhibiting/facilitating advanced clinical role development

Interview Schedules: stage two- Nurses

I am interested in your experience as a nurse who holds a Master's level education. I would like for you to take some time to reflect upon these experiences and share with me your perception of your nursing role as it is being implemented here. You can share any thoughts, feelings, and ideas about your experiences. Feel free to talk about whatever comes to mind.

Examples of probes/questions to facilitate the interview

1. Why did you decide to continue studying at a Master's level?
2. Is the preparation of your role adequate for an effective role? Do you need further training? What educators could do to better prepare nurses at Master's levels?
3. What sort of clinical roles are Master's level graduates expected to fill?
4. How do you think that Master's level education can influence the nurses' power, autonomy and status?
5. What kind of impact do you think Master's level graduates have on patient outcomes / care delivery / professional practice?
6. Should nurses with Master's education be considered as advanced nurse practitioner?
7. What do you do that is different from other nurses?
8. Tell me what advanced practice means to you?

Interview Schedules: stage two- Stakeholders

I am interested in your experience as a manager who employs a Master's level education nurses who might perform an advanced clinical role. I would like for you to take some time to reflect upon these experiences and share with me your perception of the nursing role as it is being implemented here. You can share any thoughts, feelings, and ideas about your experiences. Feel free to talk about whatever comes to mind.

Examples of probes/questions to facilitate the interview

1. Please can you tell me about your role?
2. Can you tell me something about your hospital (the main focus of activity: general, teaching, medical/surgical, others, size, number of nurses)?
3. How many M-level nurses are in your hospital? What titles do they use?
4. What are their daily activities? (teaching, clinical practice, consultation, management, research)?
5. Do they provide direct patient care? or do they facilitate others to provide that care? or mixture of both?
6. To whom are they accountable? Who decides on roles nurses may assume?
7. Identify any positive/negative outcomes on nursing services or wider organisation?
8. Does your hospital have any educational requirements for advanced roles? If so what are they?
9. Do they have any Job description?

10. How these roles understood by other nurses, other health care professionals patients and families?
11. What strategies and/or changes would be required in the health care delivery system to make this type of role possible?
12. Are there any other comments that you would like to share with me about how your role is implemented in this hospital?

Interview Schedules: healthcare professionals

I am interested in your experience as someone who works with a Master's level education nurses who might perform an advanced clinical role. I would like for you to take some time to reflect upon these experiences and share with me your perception of the nursing role as it is being implemented here. You can share any thoughts, feelings, and ideas about your experiences. Feel free to talk about whatever comes to mind.

Examples of probes/questions to facilitate the interview

1. Please can you tell me about your role?
2. Could you describe how do you perceive nurses with Master's education?
3. What sort of clinical roles are Master's level graduates expected to fill?
4. Tell me what advanced practice means to you?
5. What nurses with M-level education do that is different from other nurses?
6. Have you experienced any changes in practice with M-level nurses?
7. Do you feel confident about the ability of these nurses to manage independent patient care?
8. Has this affected your relationship with these nurses?
9. Has M-level nurses affected nurses' relationship with patients?
10. Do you think these nurses could benefit from additional knowledge and skills?
11. How has M-level nurses changed the way you look at nursing practice?
12. What strategies and/or changes would be required in the health care delivery system to make this type of role possible?
13. Are there any other comments that you would like to share with me about how your role is implemented in this hospital?

Appendix 6: the pilot interview

To pilot the interview process, I interviewed two colleagues of mine. One was a Jordanian nurse who at the time undertaking a PhD degree in the United Kingdom. I chose her because she had similar characteristics to the population being studied, and she used to work in contexts similar to the context of the study. I hoped through this interview to both highlight the clarity of the questions and to develop experience using the audio recorder. I also hoped to develop my skills as an interviewer. The other colleague was an English nurse who was working as a clinical nurse specialist in the UK and was at the time undertaking a PhD degree. Because the goal of this interview was to develop an understanding of the role of clinical nurse specialist, it was vital for me to develop a good rapport with the person I intended to interview. Despite the fact that we had known each other for a while and developed respect for each other, our relationship was limited to our meetings in the lecture room. This interview was part of one assignment on a qualitative research methods module. My colleague was kind enough to volunteer to be my 'sample', and she expressed her pleasure in being part of my study. Her experience as a nurse and a student facilitated our communication and made it easy for me to generate data from her. In fact, this interview brought us closer and provided me with a person with whom I could discuss my research. To document her oral approval of being interviewed, I asked her to sign a written consent in which I explained the purpose of the interview. Analysis of the pilot interviews provided me insights on how to analyse qualitative data.

Appendix 7: Ethical approval documents

The
University
Of
Sheffield.

Zainab Zahran
School of Nursing and Midwifery
301 Glossop Road
Sheffield
S10 2HL

Dean
Anne M Peat

Bartolomé House
Winter Street
Sheffield
S3 7ND

7 September 2006
Reference number: ERP62/06

Telephone: +44 (0) 114 222 8291
Fax: +44 (0) 114 222 8288
Email: a.m.cowan@sheffield.ac.uk

Dear Zainab

**The contribution of masters level education to the development of
advanced nursing practice in Jordan**

I am pleased to inform you that on 7 September 2006 the School's Ethics Reviewers **approved** the above-named project on ethics grounds, on the basis that you will adhere to and use the following amended documents that you re-submitted for ethics review:

- Research ethics application form (1.9.06)
- Participant information sheets (1.9.06)
- Participant consent form (1.9.06)

If during the course of the project you need to deviate from the above-approved documents please inform me. The written approval of the School's Ethics Review Panel will be required for significant deviations from or significant changes to the above-approved documents. If you decide to terminate the project prematurely please inform me.

Best wishes

Amanda Cowan
Ethics Administrator

Cc   Professor Roger Watson – ERP Chair (acting)
       Professor Kate Gerrish (supervisor)

وزارة الصحه – مستشفى البشير

لجنه أخلاقيات السلوك الطبي

Ethics Committee

موافقة على أجراء بحث علمي

التاريخ:الاثنين، ١٥ كانون الثاني، ٢٠٠٧

تحيه طيبه وبعد

يسمح للباحثه: زينب عبد القادر زهران – طالبه دكتوراة ، جامعه Sheffield

بأجراء البحث العلمي التجريبي / الغير تجريبي

بعنوان: دور الممرضين عن حمله درجه الماجستير عن تطور مهنه التمريض في الأردن

شريطه المحافظة على على التعليمات المعمول بها في وزارة الصحه و لمدة ٢ شهر من كانون الثاني ٠٧

الفئة المستهدفة: الكادر التمريضي والاداري في مستشفيات وزارة الصحه

حجم العينة: ثلاثين مقدم خدمه صحيه

المحافظة على حقوق الفئة المستهدفة بالبحث ،تنفيذ تعليمات لجنــه Ethics Committee ،قيام الباحث بتوفير الموارد اللازمة لتنفيذ البحث (قوى بشريه، معدات، نفقــات) ،التنسيق الكامل مع رئيس القسم وبطريقه لاتعيق العمل، ايقاف عمليه جمع العينات في حاله حدوث رفض من الفئه المستهدفه، تزويدنا بنسخه عن نتيجه البحث .

واقبلوا فائق احترامي

مدير مستشفى البشير

رئيس لجنه أخلاقيات السلوك الطبي

الدكتور محمد سعيد الروابدة

الخاتم الرسمي للجنة السلوك والأدب الطبي

AL - BASHIR HOSPITAL
ETHICS COMMITTEE

Dear Dr Kate Gerrish ,

In regard to your letter you sent us for your doctoral student Zainab Zahran, we welcome her to do her research in our hospital about the nursing practice in Jordan and we are willing to present her all the help and support she may need in her project .
we have answered her questioner, and would like Ms Zahran to contact Mr. _____
_____ the acting manager of the Nursing department in our hospital.

Thank you for being interested in our hospital.

Yours sincerely.

General Manager Dr. Prof._____ . __

cc.Zainab Zahran

Date: March 7, 2007

Ms. Zainab Zahran

<u>**RE: The development and implementation of advanced nursing practice in Jordan**</u>

<u>**PROTOCOL NO.: 07**</u>

Dear **Ms. Zainab,**

We have received the following documents on March 4, 2007:

- **Research Proposal**
- **Request for submitting a new research proposal**
- **English Questionnaire**
- **Cover letter nurses' interview**
- **Cover letter survey**
- **Cover letter health care professionals**
- **English participant Information Sheet for health care professionals –Interview**
- **English Participant Information Sheet for health care professionals -Interview**
- **English Participant Information Sheet for Nurses-Interview and Observation**
- **Consent Form for Nurses and Health Care Professionals**
- **Interview Schedule**

The IRB of _____ has reviewed the above mentioned documents. The IRB approves the protocol titled: **The development and implementation of advanced nursing practice in Jordan** (PROTOCOL NO.: 07 _____ -E 03) and the documents attached and listed here above.

Kindly note that if the study extends beyond one year you have to submit a renewal form and an interim update on the study. At the end of the study, you are requested to submit end of study report to IRB.

Please inform the IRB office of the date of completion of the study and any publications/ abstracts that may result from this research.

On behalf of all members of _____ IRB, I would like to wish you a very successful study.

Ref : ....
Date : ....

الأخت زينب عبدالقادر زهران – المحترمة

السلام عليكم ورحمة الله وبركاته

بناء على طلبك الخطي بإجراء البحث العلمي بعنوان " دور الممرضين من حملة درجة الماجستير ومدى تأثيرهم على تطور مهنة التمريض في الاردن " .

فانه يسرني اعلامك الموافقة على طلبك بإجراء البحث المذكور أعلاه وذلك ضمن الانظمة والتعليمات المعمول بها في المستشفى والالتزام بالزي الشرعي الاسلامي .

متمنيا لك التوفيق.

والسلام عليكم ورحمة الله وبركاته

الـمـديـر الـعـام

نسخة الى :
الملف العام
٩٤ - الاخ المدير الفني
الأخ رئيس قسم التمريض
م.ق/م خ

282

Ref: 15/2006/1504
Date: 24/4/2006

Miss Zainab AbdulQader Zahran

Alsalamu Alaykum

It gives me pleasure to inform you that your written request to undertake a research entitled 'the contribution of Master's level education to the development of advanced nursing practice in Jordan' has been approved, provided that it is carried out in accordance with the rules and regulations of the hospital.

Wishing you all the best

General Manager

الجـامعـة الأردنيـة
كليـــة التمريـض
٩ أيـار ٢٠٠٦

الرقم: ٣/٢/٥
التاريخ : ٢٠٠٦/٥/

رقم الوارد: ....
رقم الملف: ....

THE UNIVERSITY OF JORDAN

الأستاذ الدكتور نائب الرئيس لشؤون الكليات العلمية

تحية طيبة وبعد ،

فأرفق طيه صورة عن البريد الالكتروني الذي تلقته الكلية من طالبة الدكتوراه زينب زهران ومشرفتها الدكتـورة Prof .Kate Gerrish من جامعة شيفيلد في المملكة المتحدة ، بشأن طلبهما المساعدة في مقابلة الزملاء أعضاء هيئة التدريس في الكلية كجزء من متطلبات دراستها لإعداد اطروحتها الجامعية عن التعليم التمريضي في الأردن.

أرجو الإطلاع على البريد الالكتروني المرفق والتكرم بالموافقة على طلبها باعتبار هذه التجربة تفتح مجالاً للإطلاع على البعد الأكاديمي لبرنامج الدكتوراه في الجامعة المذكورة ، إضافة إلى ما تتيحه هذه الدراسة من بيانات عن التعليم التمريضي ومنهجيته في الجامعة الأردنية.
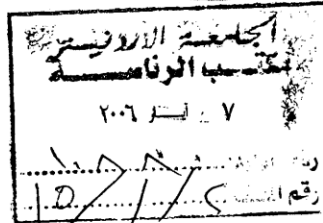
وتفضلوا بقبول فائق الإحترام،،

/عميدة كلية التمريض

(د. سميحة جراح)

from "Dr. Muayyad Ahmad" <mma4@ju.edu.jo> -----

Date: Thu, 18 May 2006 14:36:31 -0800

From: "Dr. Muayyad Ahmad" <mma4@ju.edu.jo>

Reply-To: "Dr. Muayyad Ahmad" <mma4@ju.edu.jo>

Subject: Approval

To: nrp05zaz@sheffield.ac.uk, k.a.gerrish@sheffield.ac.uk

Dear Ms. Zainab

I am writing on behalf of our Dean regarding your request to do interviews with our nurse educationalist who are involved in teaching master students, under your PhD project "The contribution of master's level education to the development of advanced nursing practice in Jordan." We are glad to inform you that your request is being approved by the University of Jordan Vice President for Academic Affairs. Wishing you all the success, and looking to see you in Amman soon.

Regards

Muayyad Ahmad, PhD, RN

Associate Professor

Chairperson, Clinical Nursing Dept.

Faculty of Nursing

University of Jordan

Amman 11942 Jordan

http://www.ju.edu.jo/ecourse/mahmad/index.htm

«Title» «FirstName» «LastName»
«OrganizationName»
«Address»
«City» «PostalCode»
«Country»

Date

Dear «Title» «LastName»,

Research project: the development and implementation of advanced nursing practice in Jordan

The School of Nursing and Midwifery - University of Sheffield is one of the top rated nursing research centres in the United Kingdom. The School has an established international programme of research focusing on the development of new roles in the nursing professions and health care development. In addition to undertaking commissioned research in this field, we also have a number of doctoral students who are taking forward important research on new role development.

We are writing to you to seek your support and assistance for one of our post-graduate students from Jordan, Zainab Zahran. Ms Zahran's doctoral research is examining the development of advanced nursing practice in Jordan with a particular focus on the contribution of master's level education. It is hoped that the findings from the study will help inform policy guidance on the development of new nursing roles in Jordan and may therefore be of interest to your organisation.

As part of the study we would like to undertake a survey by postal questionnaire of nurses working in hospital settings who have a master's degree. We hope to survey nurses working in all hospitals in Amman and Irbid in order to find out more about their role and the extent to which masters' level education has influenced their practice. Subsequent stages of the study will involve interviewing nurses who hold a masters degree, health care managers in hospital settings and educators who teach on master's programmes. This will enable us to explore in more depth the contribution of master's level education to developing advanced nursing practice in Jordon.

In order to consider the feasibility of undertaking the survey we would be most grateful if you could inform us whether you currently employ any nurses with master's qualifications within «OrganizationName» and whether you would be supportive, in principle, of these nurses being invited to complete the questionnaire.

We hope to be able to undertake the survey in approximately 10 months time and would need your assistance in identifying those nurses who hold a masters qualification. Once the questionnaire is developed we would be pleased share it with you so that you are aware of the content.

Please could you assist us by completing and returning the attached proforma indicating whether you are able to assist us in this important research. We would be pleased to provide more information on the study if it would be helpful and will provide you with a report of the findings from the survey once it is completed.

Thank you for considering this request. We look forward to hearing from you.

Yours sincerely

Dr Kate Gerrish   Zainab Zahran
Professor of Nursing Practice Development   Doctoral student

Research project: The development and implementation of advanced nursing practice in Jordan

Please answer the following questions:

	Please circle answer	
Nurses with masters level qualifications are employed within this hospital	YES	NO
If YES		
Please indicate the approximate number of nurses who hold a master's qualification		
I am supportive in principle of nurses with master's qualifications being invited to participate in the survey (more information on the questionnaire will be made available in due course)	YES	NO

Thank you for your kind assistance

Please return this slip in the enclosed pre-paid envelope to:

Zainab Zahran
P.O. Box 211092
Amman 11121
Jordan

C/O Dr. Mohammad Zahran

Cover letter

Nurse educationalists/interview

Date

Dear colleague

The contribution of Master's level education to the development of advanced nursing practice in Jordan

I am writing to invite you to participate in a research study exploring the development of advanced nursing practice in Jordan and the contribution of Master's level education. My name is Zainab Zahran. The research is being conducted for a PhD I am undertaking at the University of Sheffield. I have obtained ethical approval for the interview from the ethical committee at the University of Sheffield as well as your seniors' permission to invite you to take part in the study.

The findings from the study will provide greater understanding of the contribution of Master's level education to the development of advanced nursing practice in Jordan. It is anticipated that the research findings will provide insight into how advanced nursing practice roles might be further developed. On completion of the study I will forward a summary of the findings to you.

I would like to invite you to be interviewed by me in order to explore the contribution of Master's level education to the development of advanced nursing practice in Jordan. I would like to emphasise that you are under no obligation to participate in the study but your contribution would be much appreciated. A copy of an information sheet which provides further details of the study is enclosed. Please read this in order to help you decide whether you wish to take part. If you have any questions regarding the study, please contact me (Email: nrp05zaz@sheffield.ac.uk, Amman-Jordan Tel: +962 6 5670078, P.O Box 211092, post code 11121). I will contact you shortly by telephone to find out whether you are interested in taking part, discuss what your participation would involve in more detail and answer any questions you may have.

Thank you very much for your consideration of my request and I look forward to your participation.

Yours sincerely

Zainab Zahran-

Date

Dear colleague

The contribution of Master's level education to the development of advanced nursing practice in Jordan

I am writing to invite you to participate in a research study exploring the development of advanced nursing practice in Jordan and the contribution of Master's level education. My name is Zainab Zahran. The research is being conducted for a PhD I am undertaking at the University of Sheffield. I have obtained ethical approval for the study from the ethical committee at the University of Sheffield as well as your seniors' permission to invite you to take part in the study.

The findings from the study will provide greater understanding of the contribution of master's level education to the development of advanced nursing practice in Jordan. It is anticipated that the research findings will provide insight into how advanced nursing practice roles might be further developed in Jordan. On completion of the study I will send a summary of the findings to you.

I would like to invite you to be interviewed by me in order to explore the contribution of Master's level education to the development of advanced nursing practice in Jordan. I would like to emphasise that you are under no obligation to participate in the study but your contribution would be much appreciated. A copy of an information sheet which provides further details of the study is enclosed. Please read this in order to help you decide whether you wish to take part. If you have any questions regarding the study, please contact me (Email: nrp05zaz@sheffield.ac.uk, Amman-Jordan Tel: +962 6 5670078, P.O Box 211092, post code 11121). I will contact you shortly by telephone to find out whether you are interested in taking part, discuss what your involvement would involve in more detail and answer any questions you may have.

Thank you very much for your consideration of my request and I look forward to your participation.

Yours sincerely

Zainab Zahran-

<div align="center">**Cover letter**</div>

<div align="center">**Interview/observation with M-level nurses**</div>

Date
Dear (name)

The contribution of Master's level education to the development of advanced nursing practice in Jordan

Some months ago you completed a questionnaire as a part of the first stage of a research study that is exploring the development of advanced nursing practice in Jordan and the contribution of Master's level education. Thank you for your contribution. At that time you indicated that you were interested in the possibility of taking part in future stages of the study.

I am writing to you with further information in order to find out whether you are still interested in taking part. This would involve me interviewing you on two occasions and shadowing you for three to four days in order to gain a greater understanding of your role.

The findings from the study will provide greater understanding of the contribution of Master's level education to the development of advanced nursing practice in Jordan. It is anticipated that the research findings will provide insight into how advanced nursing practice roles might be further developed in Jordan. On completion of the study I will forward a summary of the findings to you.

A copy of an information sheet providing further details of the study is enclosed. Please read this in order to help you decide whether you wish to take part. If you have any immediate questions regarding the study please contact me:
(Email: nrp05zaz@sheffield.ac.uk, Amman-Jordan Tel: +962 6 5670078, P.O Box 211092, post code 11121).

I will contact you shortly on the phone number you have already provided to find out whether you are interested in taking part, discuss what your participation would involve in more details and answer any questions you may have.

Thank you very much for your consideration of my request and I look forward to your participation.

Yours sincerely

Zainab Zahran

Cover letter
A survey of M-level nurses

Date

Dear colleague

The contribution of Master's level education to the development of advanced nursing practice in Jordan

I am writing to invite you to participate in a research study exploring the development of advanced nursing practice in Jordan and the contribution of Master's level education. My name is Zainab Zahran. The research is being conducted for a PhD I am undertaking at the University of Sheffield. I have obtained ethical approval for the study from the ethical committee at the University of Sheffield as well as your seniors' permission to invite you to take part in the study.

The findings from the study will provide greater understanding of the contribution of master's level education to the development of advanced nursing practice in Jordan. It is anticipated that the research findings will provide insight into how advanced nursing practice roles might be further developed in Jordan. On completion of the study I will send a summary of the findings to you.

A copy of an information sheet providing further details about the survey is enclosed. Please read this carefully to help you decide whether you wish to take part. If you decide to participate, please complete the enclosed questionnaire, which I anticipate will take approximately 30 minutes of your time and then return it to me in the enclosed freepost envelope within 3 weeks of receipt. I would like to emphasise that you are under no obligation to complete the questionnaire but your contribution would be much appreciated. If you have any questions regarding the study, please contact me (Email: nrp05zaz@sheffield.ac.uk, Amman-Jordan Tel: +962 6 5670078, P.O Box 211092, post code 11121).

Thank you very much for your consideration of my request and I look forward to your participation.

Yours sincerely

Zainab Zahran-

Consent form

Title of Project: The contribution of Master's level education to the development of advanced nursing practice in Jordan

Name of Researcher: Zainab Zahran

Participant Identification Number for this project:

Please tick the box

1. I confirm that I have read and understand the information sheet/letter (delete as applicable) dated *[insert date]* for the above project and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. *Insert contact number here of lead researcher/member of research team (as appropriate).*

3. I understand that my responses will be anonymised before analysis. I give permission for members of the research team to have access to my anonymised responses.

4. I agree to take part in the above research project.

_____   _____   _____
Name of Participant   Date   Signature
(*or legal representative*)

_____   _____   _____
Name of person taking consent   Date   Signature
(*if different from lead researcher*)
To be signed and dated in presence of the participant

_____   _____   _____
 Lead Researcher   Date   Signature
To be signed and dated in presence of the participant

Participant Information Sheet for Nurse Educationalists -Interview
The University of Sheffield

"The contribution of Master's level education to the development of advanced nursing practice in Jordan"

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you require any further information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the project?
The aim of the study is to examine the development of advanced nursing practice in Jordan with a particular focus on the contribution of Master's level education. Specifically, the study will:
1. Identify factors that facilitate or hinder the development of advanced nursing practice in Jordan.
2. Illustrate how the identified factors have shaped advanced nursing roles in Jordan.
3. Explore the contribution of Master's level education to the development of advanced nursing practice in Jordan.
4. Examine the nature of the roles adopted by Master's level graduates in Jordan.
5. Consider the implications for nursing education and practice.

Why I have been approached?
You have been approached as someone who teaches a Master's degree in nursing. You are working in a University which has agreed to participate in the study. Therefore, you have been approached to see whether you wish to take part in the study.

Do I have to take part?
Participation is entirely voluntary. It is up to you to decide whether or not to take part in the study. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving any reason.

What will happen to me if I take part?
You will be interviewed by me. The interview will last approximately one hour and will be arranged for a mutually convenient time and a venue. The interview will be tape-recorded with your agreement, it will then be transcribed and analysed by me.

What other information will be collected in the study?

The study will comprise two stages. The first stage will involve interviews with educationalists and other stakeholders. You are being invited to take part in this stage.
This will be followed by detailed case studies of Master's level graduates working in clinical practice in approximately five Jordanian hospitals. The case studies will involve three methods of data collection:

1- A survey of Master's level nurses
2- Semi-structured interviews and observation of Master's level nurses
3- Semi-structured interviews with local stakeholders

What are the possible disadvantages and risks of taking part?
No disadvantages or risks are anticipated as a result of being interviewed.

What are the possible benefits of taking part?
It is not anticipated that you will experience any direct benefit as a result of participating in the study.

What happens if the research study stops earlier than expected?
If the study stops earlier than expected the reasons will be explained to the participant.

What if something goes wrong?
It is unlikely that anything will go wrong as a result of taking part in the study. If you wish to raise a complaint please contact the supervisor, contact details are given at the bottom of this sheet. If you feel your complaint has not been handled to your satisfaction you can contact the University's 'Registrar and Secretary'.

Will my taking part in this project be kept confidential?
Yes. All information obtained from the interview will be treated as confidential and not disclosed to anyone. The reports and publications arising from the study will not identify any individual who participated. The interview transcripts will not contain any information which could identify you, your colleagues or the university in which you work. Pseudonyms will be used where appropriate. Some short extracts from the transcripts may be used in the report and publications but these will remain anonymous.

What will happen to the results of the research project?
A summary of the main findings will be provided to each participating hospital and to research participants. The research findings will also be disseminated through conference presentations and publications in both Jordan and the UK. The doctoral thesis arising from the study will available via the British Library and the University of Sheffield library for wider reference. The data collected during the course of the project might be used for additional or subsequent research. You will not be identified in any report or publication.

Who is organising and funding the project?
This research is part of a wider research programme at the University of Sheffield/United Kingdom on the development of new clinical nursing roles. The research has been undertaken as part of a PhD and is self- funded.

Who has ethically reviewed the project?
This project has been approved by the Research Ethics Committee at the University of Sheffield in the United Kingdom, and the Ethics Committee in each participating university.

What if have further questions
You can contact the research team if you have any further questions.

Researcher

Zainab Zahran, MSc, BSN, RN, Doctoral Student

School of Nursing and Midwifery, University of Sheffield, United Kingdom

Email: nrp05zaz@sheffield.ac.uk ,Amman-Jordan P.O Box 211092,Post code 11121

 Tel: +962 6 5670078

Research Supervisors

Dr Penny Curtis – Senior lecturer and postgraduate tutor
 School of Nursing and Midwifery, University of Sheffield
        E-mail: p.a.curtis@sheffield.ac.uk
Dr Myfanwy Lloyd-Jones
 School of Health and Related Research (SHARR), University of Sheffield
        E-mail: M.Lloydjones@sheffield.ac.uk
Dr Tony Blackett – Senior Lecturer and E-learning coordinator
 School of Nursing and Midwifery, University of Sheffield
        E-mail: t.blackett@sheffield.ac.uk

Thank you for reading this information sheet. I hope it has answered any questions you may have.

Participant Information Sheet for health care professionals -Interview
The University of Sheffield

"The contribution of Master's level education to the development of advanced nursing practice in Jordan"

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you require any further information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the project?
The aim of the study is to examine the development of advanced nursing practice in Jordan with a particular focus on the contribution of Master's level education. Specifically, the study will:
1. Identify factors that facilitate or hinder the development of advanced nursing practice in Jordan.
2. Illustrate how the identified factors have shaped advanced nursing roles in Jordan.
3. Explore the contribution of Master's level education to the development of advanced nursing practice in Jordan.
4. Examine the nature of the roles adopted by Master's level graduates in Jordan.
5. Consider the implications for nursing education and practice.

Why I have been approached?
You have been approached as someone who has contact with nurses with Master's degree working in a hospital which has agreed to participate in the study. You have been approached to see whether you wish to participate in the study.

Do I have to take part?
Participation is entirely voluntary. It is up to you to decide whether or not to take part in the study. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving any reason.

What will happen to me if I take part?
You will be interviewed by me. The interview will last approximately one hour and will be arranged for a mutually convenient time and a venue. The interview will be tape-recorded with your agreement, it will then be transcribed and analysed by me.

What other information will be collected in the study?
The study will comprise two stages. The first stage involved interviews with educationalists and other stakeholders. This stage has been completed.
The second stage entails detailed case studies of Master's level graduates working in clinical practice in approximately five Jordanian hospitals, together with the main

stakeholders with whom the nurses have contact. The case studies will involve three methods of data collection:

1- A survey of Master's level nurses which has been completed
2- Semi-structured interviews and observation of Master's level nurses
3- Semi- structured interviews with local stakeholders. You are being invited to take part in this stage.

What are the possible disadvantages and risks of taking part?
No disadvantages or risks are anticipated as a result of being interviewed.

What are the possible benefits of taking part?
It is not anticipated that you will experience any direct benefit as a result of participating in the study.

What happens if the research study stops earlier than expected?
If the study stops earlier than expected the reasons will be explained to the participant.

What if something goes wrong?
It is unlikely that anything will go wrong as a result of taking part in the study. If you wish to raise a complaint please contact the supervisor, contact details are given at the bottom of this sheet. If you feel your complaint has not been handled to your satisfaction you can contact the University's 'Registrar and Secretary'.

Will my taking part in this project be kept confidential?
Yes. All information obtained from the study will be treated as confidential and not disclosed to anyone. The reports and publications arising from the study will not identify any individual who participated. The interview transcripts will not contain any information which could identify you, your colleagues or the hospital in which you work. Pseudonyms will be used where appropriate. Some short extracts from the transcripts may be used in the report and publications but these will remain anonymous.

What will happen to the results of the research project?
A summary of the main findings will be provided to each participating hospital and to research participants. The research findings will also be disseminated through conference presentations and publications in both Jordan and the UK. The doctoral thesis arising from the study will available via the British Library and the University of Sheffield library for wider reference. The data collected during the course of the project might be used for additional or subsequent research. You will not be identified in any report or publication.

Who is organising and funding the project?
This research is part of a wider research programme at the University of Sheffield/United Kingdom on the development of new clinical nursing roles. The research has been taken as part of a PhD and is self- funded.

Who has ethically reviewed the project?
This project has been approved by the Research Ethics Committee at the University of Sheffield in the United Kingdom, and the Ethics Committee in each participating hospital.

What if have further questions
You can contact the research team if you have any further questions.

Researcher

Zainab Zahran, MSc, BSN, RN, Doctoral Student

School of Nursing and Midwifery, University of Sheffield, United Kingdom

Email: nrp05zaz@sheffield.ac.uk

Amman-Jordan P.O Box 211092, Postal code 11121, Tel: +962 6 5670078

Research Supervisors

Dr Penny Curtis – Senior lecturer and postgraduate tutor
 School of Nursing and Midwifery, University of Sheffield
        E-mail: p.a.curtis@sheffield.ac.uk
Dr Myfanwy Lloyd-Jones
  School of Health and Related Research (SHARR), University of Sheffield
        E-mail: m.Lloydjones@sheffield.ac.uk
Dr Tony Blackett – Senior Lecturer and E-learning coordinator
 School of Nursing and Midwifery, University of Sheffield
        E-mail: t.blackett@sheffield.ac.uk

Thank you for reading this information sheet. I hope it has answered any questions you may have.

Date: 1/9/2006
Name of Applicant: Zainab Zahran

Participant Information Sheet for Nurses-Interview and Observation
The University of Sheffield

"The contribution of Master's level education to the development of advanced nursing practice in Jordan"

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you require any further information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the project?
The aim of the study is to examine the development of advanced nursing practice in Jordan with a particular focus on the contribution of Master's level education. Specifically, the study will:
1- Identify factors that facilitate or hinder the development of advanced nursing practice in Jordan
2- Illustrate how the identified factors have shaped advanced nursing roles in Jordan.
3- Explore the contribution of Master's level education to the development of advanced nursing practice in Jordan
4- Examine the nature of the roles adopted by Master's level graduates
5- Consider the implications for nursing education and practice

Why I have been approached?
You have been approached as someone with a Master's degree in nursing working within a hospital which has agreed to participate in the study. You have already completed a questionnaire as a part of the first stage of the study and I wish to thank you for this. On the questionnaire you indicated that you were interested in the possibility of being involved in further stages of the study. I am now approaching you to find out whether you wish to participate in the next stage.

Do I have to take part?
Participation is entirely voluntary. It is up to you to decide whether or not to take part in the study. If you decide to take part you will be asked to sign a consent form to keep. If you decide to take part you are still free to withdraw at any time without giving any reason.

What will happen to me if I take part?
You will be invited to be interviewed by me on two occasions. The interview will last approximately one hour and will be arranged for a mutually convenient time and venue. The interview will be tape-recorded with your agreement, it will then be transcribed and analysed by me.

With your agreement, the first interview will be based around some of the responses to the questionnaire you have already completed in order to build a better picture of your role. Following this, I would like to shadow you for 3-4 days, observing your everyday practice in order to gain an understanding of different aspects of your role. When observing, I will be sensitive to the care settings and will withdraw from situations in which you, or any of the people with whom you are interacting, prefer me not to be present.

Before undertaking a period of observation I will raise awareness of the study among individuals and groups with whom you may have contact and provide the opportunity for them to decline to be observed. In order that people with whom you have contact do not feel pressurised to be observed, I would ask that wherever possible, you obtain agreement in advance from anyone who you anticipate you might encounter during the period of observation. If this is not possible, then I would ask you to obtain agreement on an on-going basis during the period of observation. Every effort will be made in advance to draw the research to the attention of the patients and health care staff within whom you may interact. For example, by displaying posters about the study in clinical areas, attending ward meetings. Following the period of observation I will undertake a follow-up interview to discuss issues raised.

If you do not wish to be observed, or if it is not possible to undertake the period of observation during the time the research is being undertaken in your hospital, I will ask you to keep brief notes of the work that you do over a couple of days which will then form the basis of the follow-up interview. I would also like you to assist me to identify health care workers (other nurses, doctors) who might be interested in being interviewed for the study. In some instances I will ask you to make an initial approach to the potential participant to ascertain their interest.

I will then make a formal approach to potential participants to recruit them to the study. I will discuss with you exactly what this commitment would require and answer any questions you may have before you agree to take part in the study.

What other information will be collected in the study?
The study will comprise two stages. The first stage involved interviews with educationalists and other stakeholders which has been completed. This will be followed by detailed case studies of Master's level graduates working in clinical practice in approximately five Jordanian hospitals. The case studies will involve three methods of data collection:
 1- A survey of Master's level nurses which has been completed
 2- Semi-structured interviews and observation of Master's level nurses. You are being invited to take part in this stage
 3- Semi-structured interviews with local stakeholders

What are the possible disadvantages and risks of taking part?
No disadvantages or risks are anticipated as a result of being interviewed/observed.

What are the possible benefits of taking part?
It is not anticipated that you will experience any direct benefit as a result as a result of participating in the study.

What happens if the research study stops earlier than expected?
If the study stops earlier than expected the reasons will be explained to the participant**.**

What if something goes wrong?
It is unlikely that anything will go wrong as a result of taking part in the study. If you wish to raise a complaint please contact the supervisor, contact details are given at the bottom of this sheet. If you feel your complaint has not been handled to your satisfaction you can contact the University's 'Registrar and Secretary'.

Will my taking part in this project be kept confidential?
Yes. All information obtained from the study will be treated as confidential and not disclosed to anyone. The reports and publications arising from the study will not identify any individual who participated. The interview transcripts and notes of the period of observation will not contain any information which could identify you, your colleagues or the hospital in which you work. Pseudonyms will be used where appropriate. Some short extracts from the transcripts may be used in the report and publications but these will remain anonymous.

What if examples of unsafe practice are observed or raised during the interview?
It is possible that cases of unsafe practice which have not been remedied may be observed or reported to members of the research team during the period of observation or interview. In these situations I will act in accordance with the requirements of local hospital policy and my honorary contract with the hospital. Standard procedures specified in the contract will be instituted. This may involve reporting to appropriate authorities. Should this situation arise it will be discussed with the nurse before any action is taken.

What will happen to the results of the research project?
A summary of the main findings will be provided to each participating hospital and to research participants. The research findings will also be disseminated through conference presentations and publications in both Jordan and the UK. The doctoral thesis arising from the study will available via the British Library and the University of Sheffield library for wider reference. The data collected during the course of the project might be used for additional or subsequent research. You will not be identified in any report or publication.

Who is organising and funding the project?
This research is part of a wider research programme at the University of Sheffield/United Kingdom on the development of new clinical nursing roles. The research has been taken as part of a PhD and is self funded.

Who has ethically reviewed the project?
This project has been approved by the Research Ethics Committee at the University of Sheffield in the United Kingdom, and the Ethics Committee in each participating hospital.

What if have further questions
You can contact the research team if you have any further questions.

Researcher

Zainab Zahran, MSc, BSN, RN, Doctoral Student

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Thank you for reading this information sheet. I hope it has answered any questions you may have.

Date: 1/9/2006
Name of Applicant: Zainab Zahran

Participant Information Sheet for Nurses-Questionnaire
The University of Sheffield
"The contribution of Master's level education to the development of advanced nursing practice in Jordan"

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you require any further information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the project?
The aim of the study is to examine the development of advanced nursing practice in Jordan with a particular focus on the contribution of Master's level education. Specifically, the study will:
1. Identify factors that facilitate or hinder the development of advanced nursing practice in Jordan
2. Illustrate how the identified factors have shaped advanced nursing roles in Jordan.
3. Explore the contribution of Master's level education to the development of advanced nursing practice in Jordan
4. Examine the nature of the roles adopted by Master's level graduates
5. Consider the implications for nursing education and practice

Why I have been approached?
Your hospital has agreed to participate in the study. As someone with a Master's degree in nursing, you have been approached to see whether you are interested in taking part in a survey of Master's level nurses.

Do I have to take part?
Participation is entirely voluntary. It is up to you to decide whether or not to take part. Your consent to participate in the study will be confirmed by returning the completed questionnaire.

What will happen to me if I take part?
You are invited to complete a postal questionnaire enclosed with this information sheet. The questionnaire seeks information on current roles occupied by Master's level graduates, educational preparation at Master's level, career progression, the impact of Master's level education on practice, the scope of practice of the roles occupied by Master's graduates, working relationships with other health care professionals, issues of accountability, autonomy, and factors inhibiting or facilitating the role. The questionnaire will take about 30 minutes to complete. At the end of the questionnaire I will ask you to say whether you might be interested in participating in the next stage of the study, and if so provide your name and work details so that I can contact you to provide more information.

What other information will be collected in the study*?**
The study will comprise two stages. The first stage involved interviews with educationalists and other stakeholders and has been completed. In addition to this survey, the second stage will involve detailed case studies of Master's level graduates working in clinical practice. This will entail:
 1- Semi-structured interviews and observation of Master's level nurses
 2- Semi-structured interviews with local stakeholders

What are the possible disadvantages and risks of taking part?
No disadvantages or risks are anticipated as a result of completing the questionnaire.

What are the possible benefits of taking part?
It is not anticipated that you will experience any direct benefit as a result completing the questionnaire.

What happens if the research study stops earlier than expected?
If the study stops earlier than expected the reasons will be explained to the participant**.**

What if something goes wrong?
It is unlikely that anything will go wrong as a result of taking part in the study. If you wish to raise a complaint please contact the supervisor, contact details are given at the bottom of this sheet. If you feel your complaint has not been handled to your satisfaction you can contact the University's 'Registrar and Secretary'. You can withdraw from the study at any time and without any question

Will my taking part in this project be kept confidential?
Yes. All information obtained from the survey will be treated as confidential and not disclosed to anyone. The reports and publications arising from the study will not identify any individual who participated. If you are interested in participating in the next stage and provide personal information it will not be used to analyse the findings of the questionnaire. All questionnaires will be kept in a secure storage. The data collected from the questionnaire will be coded so that responses remain anonymous.

What will happen to the results of the research project?
A summary of the main findings will be provided to each participating hospital and to research participants. The research findings will also be disseminated through conference presentations and publications in both Jordan and the UK. The doctoral thesis arising from the study will available via the British Library and the University of Sheffield library for wider reference. The data collected during the course of the project might be used for additional or subsequent research. You will not be identified in any report or publication.

Who is organising and funding the project?
This research is part of a wider research programme at the University of Sheffield/United Kingdom on the development of new clinical nursing roles. The research has been taken as part of a PhD and is self funded.

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This project has been ethically approved via the Research Ethics Committee at the University of Sheffield in the United Kingdom, the Ethics Committee in each hospital.

What if have further questions
You can contact the research team if you have any further questions.

Researcher

Zainab Zahran, MSc, BSN, RN, Doctoral Student

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 School of Nursing and Midwifery, University of Sheffield
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Thank you for reading this information sheet. I hope it has answered any questions you may have.

Date: 1/9/2006
Name of Applicant: Zainab Zahran

Appendix 8: M-level course modules at Jordan University of Science and technology

Programme	M.Sc. of Nursing - Adult acute care – Thesis	M.Sc. of Nursing - Community health nursing - Thesis	M.Sc. of Nursing - Maternal newborn nursing – Thesis
Department compulsory requirements 15 hours	Theoretical foundation for nursing	Theoretical foundation for nursing	Theoretical foundation for nursing
	Advanced health assessment	Advanced health assessment	Advanced health assessment
	Adult acute care. theory(i)	Advanced community health nursing. theory (i)	Advanced maternal and newborn nursing. Theory (i)
	Adult acute care clinical (i)	Advanced community health nursing. clinical (i)	Advanced maternal and newborn. Clinical (i)
	Advanced research in nursing	Advanced research in nursing	Advanced research in nursing
	Seminar	Seminar	Seminar
Specialisation compulsory requirements 9 hours	Master's thesis	Master's thesis	Master's thesis
Department elective requirement 10 hours	Pathophysiology	Reproductive counselling	Reproductive counselling
	Advanced clinical pharmacology and therapeutics		Advanced clinical pharmacology and therapeutics
	Principles of adaptation to acute illness	Women's health	Women's health
	Adult acute care (ii)	Advanced community health nursing. Theory ii	Advanced maternal and newborn. theory ii
	Adult acute care clinical (ii)	Advanced community health nursing. clinical ii	Advanced maternal and newborn. Clinical ii
	Nursing administration and health policy	Nursing administration and health policy	Nursing administration and health policy
	Program planning & evaluation for health	Program planning & evaluation for health	Program planning & evaluation for health
	Health promotion and education	Health promotion and education	Health promotion and education
	Special topics in nursing	Special topics in nursing	Special topics in nursing
	Analytical epidemiology and biostatistics	Analytical epidemiology and biostatistics	Analytical epidemiology and biostatistics
	Instructional design	Instructional design	Instructional design
			Endocrinology and reproduction

Appendix 9: tests which are performed and interpreted by M-level nurses

- FBC or CBC (Full Blood Count)

- Blood sugar

- Chemistry tests e.g. U&E (Urea and electrolytes), LFT (Liver function test), KFT (Kidney function test)

- ABGs (Arterial blood gases)

- PT (Prothrombin time), PTT (Partial thrombin time)

- ECG (Electrocardiogram)

- Interpreting Cardiac Catheterisation results

Other activities respondents reported included:

- Removal of sheath post cardiac catheterisation

- Removal of chest drain

- Dressing

- Care of patients on ventilators

- Weaning and extubation

- Performing chest physiotherapy

- Transferring patients to other units

- ECG