

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (PART B)

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Abstract

This study uses content analysis methodology to analyse a professional journal and open-ended interviews with two Australian nurse practitioner candidates (NPCs) over the 12-month period in implementing a dialysis nurse practitioner (NP) model to identify conceptual categories best describing the transitional experience.

Four themes with various sub-themes were identified: 'Finding a balance', 'The public face', 'Finding a personal version of the NP role' and 'Nurturing'. These themes were also consistent with the United States (US) and United Kingdom (UK) experience. However, unlike early international NPs, NPs in the current study were well supported by key stakeholders and encountered fewer political and organisational barriers.

The key themes identified in the study were used to make recommendations to assist role transition for future NPs in Australia. Exploring the experiences of pioneer NPs in Australia begins to fill a literature gap and equip nurses with knowledge to assist them in their professional and personal challenge to become an NP.

Discussion

This small study describing the very personal yet generally recognisable professional journey of new Australian NPCs implementing a dialysis NP role represents one of the few pieces of literature relating to NPs in the Australian health care context. Using content analysis methodology for the personal aspects of the story enabled similarities to international literature on student NP role transition to be identified. Some unique experiences only applicable to the new NP role in

Australia were also identified. Although the study has a limited focus and specialty context it provides some guidance for future NPs who are eager to challenge traditional doctor-nurse boundaries and extend other clinical nursing roles in this country, as well as to motivate further research on the subject.

A central theme of 'balance' or being suspended is applicable to most NPCs during their candidature year, both in their professional and personal lives (Brown & Olshansky, 1997; Cusson &

Key Words

nurse practitioner, transition, (haemo/peritoneal) dialysis, experience, novice

Viggiano, 2002; Brown & Draye, 2003). Throughout the NPC experience in the current study, an ongoing battle existed between the need to balance being an 'expert' or experienced nurse, with shifting into a medical paradigm where the NPC was a novice. Many of these new and difficult challenges represented 'tightrope moments' where the NPC needed to conquer the challenges and balance on the tightrope, or fall.

Colleagues and peers expected the NPC to immediately function proficiently as an NP. At the same time the NPC had to step outside her comfort zone into a foreign role, where there were no precedents, which carried increased responsibility. The dual role was referred to as the 'doctor-nurse dichotomy'. The NPC was expected to immediately don the title, skills and responsibilities of being an NPC before she had developed advanced assessment skills. Brown and Olshansky (1997) described this as the 'impostor phenomenon'. The impostor phenomenon emerged in the current study as a sub-theme in the 'public face' theme. The 'impostor phenomenon' was first described by Clance and Imes (1978) and then applied to clinical nurse

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specialists by Arena and Page in 1992 and Brown and Olshansky in 1997. The stability of the theme in the literature supports its validity as an essential element in NP progression.

The phenomenon is especially applicable to high achieving women in many different contexts. Clance and Imes (1978) studied 150 successful women over five years and found that despite their degrees and professional recognition they did not feel successful and considered themselves to be imposters who achieved results through either luck or error. Clinical symptoms such as generalised anxiety, lack of self-confidence, depression and frustration were frequently encountered and related to their inability to meet self-imposed standards and goals. Many studies, including the current dialysis NP study, recognised NPs as also being susceptible to the imposter phenomenon (Cusson & Viggiano, 2002; Brown & Olshansky, 1998).

Not only do NPs have internal drives toward perfection and competence, they also face external pressures, particularly pioneer NPs, to prove their worth to colleagues, employers and nursing (Roberts et al, 1997; Brown & Draye, 2003). NPs working in unsupportive environments found they had to mask their feelings of professional incompetence and anxiety at work to survive (Brown & Olshansky, 1998). Both the internal drive for perfection and external pressures to prove their worthiness equate to the NP's need to appear confident, in control, and keep up the 'public face'.

The NPCs in the current study described needing to be competent immediately, yet they spent most of their candidature 'winging it' or 'going with the flow'. The NPCs were thrown straight into the spotlight, required to speak in national public forums at the beginning of the

project, and were taken aback by the lack of transition from 'L plates' to 'P plates'. The public face of confidence was even more important in gaining their patient's trust and confidence in their ability.

The NPCs in the current study are pioneers in Australia and took on a role without guidelines, blueprints or role models to follow, which increased the burden of the public face. They felt they needed to 'make it up as they go'. The Department of Human Services (DHS) requires each Australian NP project it funds to be overseen by a multidisciplinary advisory committee, which benefits the professions of nursing and medicine, as well as patient care. However, many cooks stirring the broth, all with differing opinions about how the role should develop can lead to conflict. The NPCs in the current study found it difficult to balance the different role demands and felt they were often left skimming the surface of issues, and that many goals were unachievable.

The stress of multiple role demands is widely reported in the international literature, where several authors caution against overextending the NP role. Manderino, Brown, Peters and Wirtz (1994) surveyed 80 NPs practicing in Missouri and California and found that multiple demands on NP's time was their greatest stressor. Multiple role demands were a significant issue during the implementation of acute care NPs in the US. Conflicting clinical, administrative, research and educational responsibilities put pressure on new NPs already experiencing role confusion, loss of identity, professional burdens and problems fitting into the organization (Knaus et al, 1997).

By stepping out of the nursing domain and into one dominated by medicine the primary care NPs in Kelly and Mathews (2001) study found it essential to work according to the medical model of care,

at least initially. In the beginning NPCs in the current study found acquiring medical skills and knowledge all consuming. They put their nursing skills aside to focus on biomedical models of care and found themselves becoming increasingly task-focussed. Martin (1999) described NPs as being initially ready to discard one aspect of a role in favour of gaining experience and acceptance in the other. In the early stages of role development NPs are unable to balance their nursing skills and knowledge with their newly acquired medical skills and knowledge. Anderson et al (1974) described pioneer NPs in the 1970's in the US as being obsessively task-focussed in the early transition to NPs.

Many studies refer to the NP needing to learn 'medicine' as returning to novice status, similar to Benner's (1984) novice to expert theory with respect to learning 'nursing' (Jacobs & Kreamer, 1997; Roberts et al, 1997; Shea & Selfridge-Thomas, 1997; Brown & Olshansky, 1998; Cusson & Viggiano, 2002; Oliver & Butler, 2004). In many ways, Benner's theory is applicable to NPs. New NPs, like student nurses, are often taught about clinical situations through objective protocols, as was the case in the current study. Novice nursing students are also taught through objective measures, task-focussed and rule-governed behaviour that is context-free and supposedly applicable to all practice settings. These are extremely limiting, but important guidelines on which to build experience (Benner, 1984). Interestingly, Benner (1984) when applying the Dreyfus model of skill acquisition, argued that any nurse entering a clinical setting in which they have no experience, is reduced to a novice level of nursing skill (Dreyfus, 1982, cited in Benner, 1984).

This concept may also be true of novice NP students in the US where NP students rarely return to the same workplace or field of specialty after their

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NP studies. For example, Easom and Allbritton (2000) described most NPs working in nephrology as having a strong primary care background and graduate subspecialty expertise in nephrology was learned 'on the job'. Only a few NPs studied nephrology as part of their graduate education. It would be very daunting to face not only a new role with a new level of responsibility, but also a new workplace and specialty.

The NPCs in the current study were already employed by the agency in which they undertook their NP clinical experience and were already considered 'experts' in their chosen field by their peers and work colleagues before they took on the NP role. Therefore, the situational or context-dependent skill acquisition model Dreyfus described may not be as relevant to Australian NPCs at this point in time as it is to novice nursing students and NPs in the US (Dreyfus, 1982, cited in Benner, 1984). Woods (1999) highlighted the difficulty of comparing the transitional experiences of NPs new to the role and the institution, to those situations where individuals/organizations "have an established frame of reference against which to judge the progress of role transition" (Woods, 1999, p. 123).

The NPCs in the current study were already equipped with sound renal nursing judgement yet were presented with very prescriptive protocols to guide their medical decision-making. The NPCs worried very early in the project that the protocols would limit their clinical judgement and that patients would not always fit into the parameters covered by the protocols, yet having no experience changing and prescribing medications, they needed to follow guidelines. The NPCs worked against their own nursing philosophy of individualising care in order to practice according to protocols. They were placed in what seemed to be the unique dichotomous position of being deemed a

renal nursing 'expert', yet simultaneously, a medical nephrology 'novice'.

By disregarding the nursing aspects of patient care the NPCs in the current study invested time in learning medicine and in doing so, experienced a loss of identity. The NPCs felt they were no longer a nurse, nor were they doctors. They had become unique members of the health community but were unaware of where they belonged within the organization. Knowing one's place within the organisation is described as 'organisational fit'. Kelly and Mathews (2001) also found newly graduated NPs felt they did not belong within the organisation and were isolated from their peer groups. Lack of fit was often associated with less professional respect for the NPs by their peers and reduced participation in decision-making (Kelly & Mathews, 2001). These factors did not emerge in the current study. Brown and Olshansky (1997) also described issues with 'organisational fit' in their 'Limbo to Legitimacy' model, which outlined the transitional process of NP graduates into the NP primary care role. The 'Limbo to Legitimacy' model highlights an initial postgraduate period of identity confusion for graduates, where they experience 'liminality', "...being at the border and straddling two identities while not feeling part of either" (Brown & Olshansky, 1997, p. 51). Concepts such as these closely resemble the 'tightrope moments' described by the NPCs in the current study and represent difficulty balancing medical and nursing identities.

Important professional issues are often covered in NP Master's programs in the US, including autonomy in advanced nursing practice. Many contemporary programs acknowledge that teaching professional skills enables NP graduates to make a more realistic orientation into the professional NP role. NP students are encouraged to become involved in professional organizations and remain abreast of political issues

relevant to their field of practice (Black et al, 1998). Roberts (et al, 1997) argued that successful programs are those that are able to integrate new information into knowledge acquired by an 'expert' population where skill acquisition in some areas is at the novice level, yet is expert in others. Australian NP education is still in its infancy, therefore it is worth noting that including professional issues such as autonomy, coping with change, involvement in the wider community, mentoring and paradigm shifts would greatly benefit new NPs in their transition into the new role.

Another important sub-theme identified in the current study was a need to redefine professional, political and legislative boundaries. The NPCs were asked to complete many tasks and often needed to ask themselves, "Where does nursing end and medicine begin?" (Stanley, 2003, p. 28). As Harris and Redshaw (1998) stated, the NP role succeeds in redefining traditional doctor-nurse professional boundaries and shifting the traditional power-base. Challenging doctor/nurse stereotypes often leaves many health professionals feeling very uncomfortable and is described in many studies pertaining to the implementation of NP roles and the transitional experiences of novice NPs. Outright resistance is often encountered particularly from medical counterparts (Roberts et al, 1997; Brown & Olshansky, 1998; Tye & Ross, 2000; Kelly & Mathews, 2001; Brown & Draye, 2003).

In particular, pioneer NPs experienced obstacles from many sources including insurance providers, pharmacists, regulatory bodies and legislation (Brown & Draye, 2003). The more recent acute care NP movement in the US also highlighted organisational factors such as difficulty obtaining reimbursement, large caseloads and restrictions placed on the scope of practice, as major barriers to their role development and causes of stress (Kleinpell, 1999;

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Sidani, 1999). Professional jealousy and nursing resentment of the NP role was often mentioned in international NP studies, however, nursing jealousy was not encountered in the current study (Anderson et al, 1974; Kelly & Mathews, 2001; Brown & Draye, 2003). The implementation of the dialysis NP role was received enthusiastically with the attitude, 'if it's good for patient care, then why not?' All prescribing, diagnostics and referral processes were easily negotiated with the relevant stakeholder at a local level, which made the transition easier for the NPCs.

The themes, self-acknowledging that the NPC is making a difference, and internalising patient feedback, represented significant professional growth for the novice NPC in the current study when making the role transition to expert. These themes describe how one NPC forged her own version of the NP role in the absence of a mentor. She utilised her patient relationships and their trust to derive confidence, contentment and validation of her role. In doing so she successfully balanced two philosophies and found she still had the 'ability to nurse'. Similar themes were identified by other researchers (Brown & Draye, 2003; Roberts et al, 1997).

Toward the end of the project the current NPCs described being able to understand each patient's individuality and recognise significant changes in each patient's condition without relying on biochemical analysis. These 'intuitive' responses to patient illness are only possible by spending significant amounts of time with each patient and re forging nursing skills by forming patient-nurse relationships. The development of therapeutic patient-nurse relationships is most evident when caring for patients with chronic illnesses or in primary care specialties. It is often correlated with 'expert' decision-making and may not be present in less experienced nurses (Oliver

& Butler, 2004). Brown and Olshansky (1998) also found that NP confidence and competence increased with skill repetition and caring for people with the same clinical issues over time, which in turn enables the NP to clarify their role, utilise pattern recognition and reduces confusion and feelings of incompetence.

Brykczynski (1989) undertook an interpretive study to describe NP's clinical judgement and found attentiveness and knowledge were attained over time by NPs in primary care settings. She described how attentiveness to individuals increased the possibility of detecting significant problems early, often before symptoms develop, because disease-specific symptoms tend to be repeated in most patients and nurses become familiar with the patterns over time. The NP in primary care settings is able to develop considerable diagnostic acumen through spending time with patients, applying focussed listening and gaining experience in recognising subtle cues. The dialysis setting is comparable to that of a primary care setting where the focus is on maintaining wellness and preventing illness, and repeated patient-nurse encounters occur over time supporting pattern recognition and nurturing competence and confidence.

Other signs of professional growth and development for current NPCs was their ability to 'play the game' and 'learn the lingo'. By the end of the NPC's candidature year, around the time patient relationships were strongest, confidence had improved and they were able to separate the uniquely nursing contribution from the medically based aspects, balance each appropriately, and apply each aspect in relevant situations. NPCs began to recognise that when their medical knowledge was assessed in a formal sense, performing medical decision-making was only completing half the care.

The NPC was torn between being examined on medical knowledge and the urge to maintain nursing skills. The medical clinical reasoning process described by Oliver and Butler (2004) portrays the initial medical input and diagnostic process after which there is minimal interaction between the physician and the patient. In contrast, the nurse-patient interaction intensifies after the initial diagnosis through ongoing analysis of the patient's status and steering the individual toward regaining optimal health.

The schematic representation of medical reasoning and nursing reasoning is depicted in Figure One.

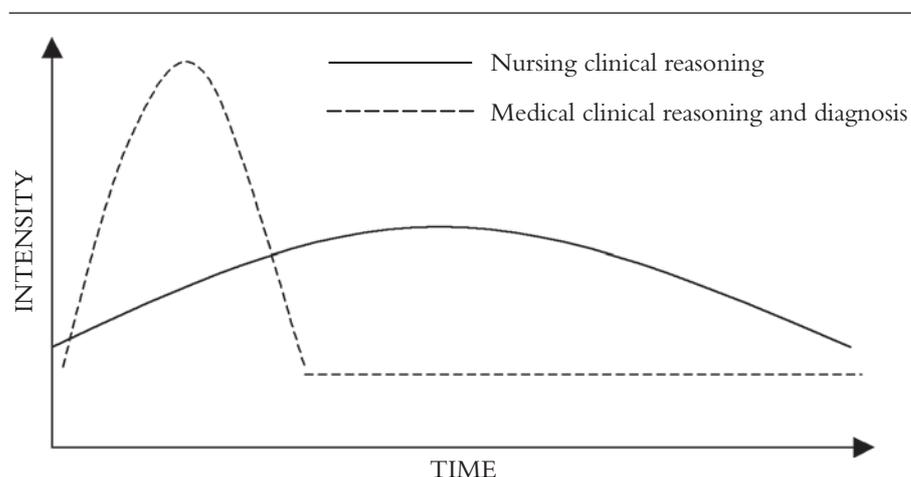


Figure 1: Nursing and medical reasoning process during an uneventful patient recovery (Oliver and Butler, 2004, p. 22).

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Oliver and Butler (2004) described a cyclical process, beginning with the medical diagnosis, then becoming dominated by nursing input through monitoring and responding to the patient's condition. The NPCs in the current study were examined on medical diagnosis and appropriate treatment plans but felt obliged to carry through with nursing responsibilities of monitoring the patient and responding to changes in their condition. These skills could not be assessed using a medical frame of reference.

To the author's knowledge, the NPCs in the current study were the only Victorian NPCs to have their medical knowledge evaluated in formal written and oral examinations. This experience is therefore quite unique and had a negative impact on the NPC's ability to effectively amalgamate and balance two professional frames of reference. It also intensified the NPC's need to successfully 'play the game' and 'learn the lingo', that is, act in a way to reassure medical colleagues that NPCs were safe whilst acknowledging that it was not how to respond to everyday nursing encounters with patients. These themes illustrate the NPC's need to assure critics of the NP role that NPCs are capable of successfully passing medical examinations of their knowledge and competence whilst at the same time, acknowledging their need to continue to deliver expert nursing care. During the examination process the two philosophies needed to be kept separate so they were distinctly recognisable.

The concepts of 'playing the game' and 'learning the lingo' also occur in the literature (Kosowski & Roberts, 2003). Once NPs become confident that they know the 'rules' of the game they can confidently 'play the game' and attempt to manipulate change, for example, steering a decision away from a protocol, once the NP knew that a doctor was receptive to their decisions. Often the NP waited until another doctor came

on the next shift in order to get a second opinion that would more closely validate their own.

At times, the NPCs in the current study felt they had to learn a new language and often needed to adjust how they presented a patient's issues to the doctors they collaborated with. Instead of using the 'soft' or intuitive language used with fellow nurses they discussed laboratory values, medication profiles, and related decisions directly to the protocols and algorithms when discussing patients with doctors. Despite 'playing the game' they tried to maintain holistic, individualised care. NPs in Kosowski and Robert's (2003) study also found that the intuitive nursing language NPs were accustomed to using was not good enough when they took on the NP role. They discussed how they needed to learn a new vocabulary and were told to "go by the numbers" (Kosowski & Roberts, 2003, p. 70).

Professional change often requires personal sacrifice or adjustments. The personal sacrifice required for the NPCs in the current study to complete the project is evident from the excerpts quoted from journaling and the interviews. Both NPCs mourned the loss of social activities, friendships and relationships throughout their candidature year. Social isolation had a major impact on the personal lives of the NPCs in the current study, and is also described by other pioneer NPs in the US (Kelly & Mathews, 2001). Pioneer NPs described the lack of time to invest in close friendships and the need to distance themselves from pressures outside of work and study, which resulted in feelings of isolation.

The NPCs in the current study present unique experiences because each NPC brings their own unique goals, values, ideas and personal strengths to the role that determine their destiny. There are also different personal demands on

the NPC's time outside their work commitments including child rearing and developing relationships, which may make it easier or more difficult to 'put in the hours'. Instances of varying degrees of personal sacrifice and the ability to cope with the demands of the NP role depends on having a network of friendships, family and peers. Looking from the 'outside in' at the NPC's life gives friends and family a more grounded perspective of the NPC's life balance. One NPC in the current study was separated from her husband who relocated to Sydney for work for the majority of the NP project and was unable to find replacement friends or family to monitor life's balance for her. Her journal states, "Every now and then I actually found myself wanting someone to tell me that I'd done enough study and that I could take a break" (Stanley, 2003, p. 56). A mentor may have been able to help her monitor life's balance for the NPC in the current study, but she could not find an appropriate one.

The majority of the modern literature on the NP role describes mentored or preceptored transitions to the NP role. Mentors were often physicians for pioneer NPs. Physician mentors have been accused of prolonging the submerging of the NP's nursing identity, and in the process, their competence and confidence (Anderson et al, 1974). Negative experiences are also described in studies comparing NP students who were mentored with students who had a preorganised preceptor. The negative experiences are characterised by poor communication, insufficient feedback and reduced confidence. They also provided the NP student with a role model they did not want to emulate.

Those studies pertaining to mentored experiences unanimously agree that a successful mentoring experience is crucial to the development of novice NPs. Mentors have assisted new NPs develop other components of the NP

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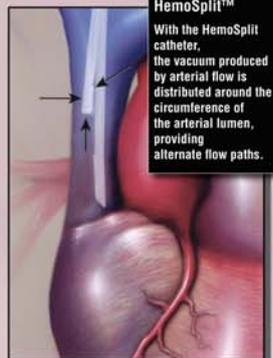
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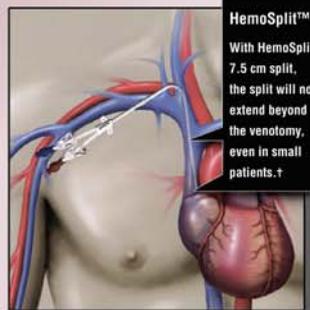


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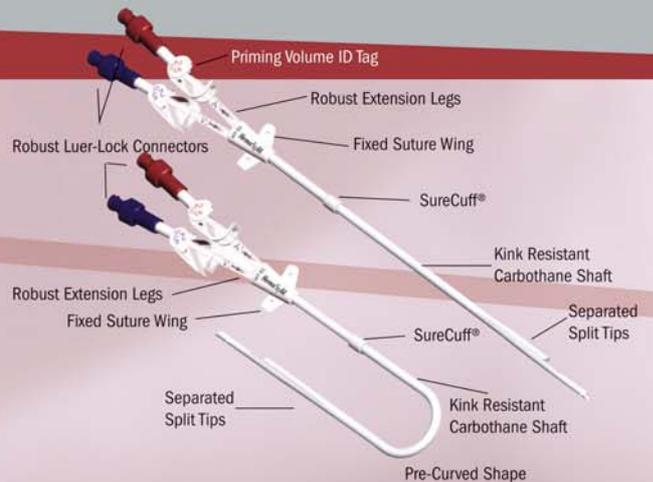


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† Twardowski, Zbylut J.; Seger, Richard M. Measuring Central Venous Structures in Humans: Implications for Central-Vein Catheter Dimensions. The Journal of Vascular Access 2002; 3:21-37.
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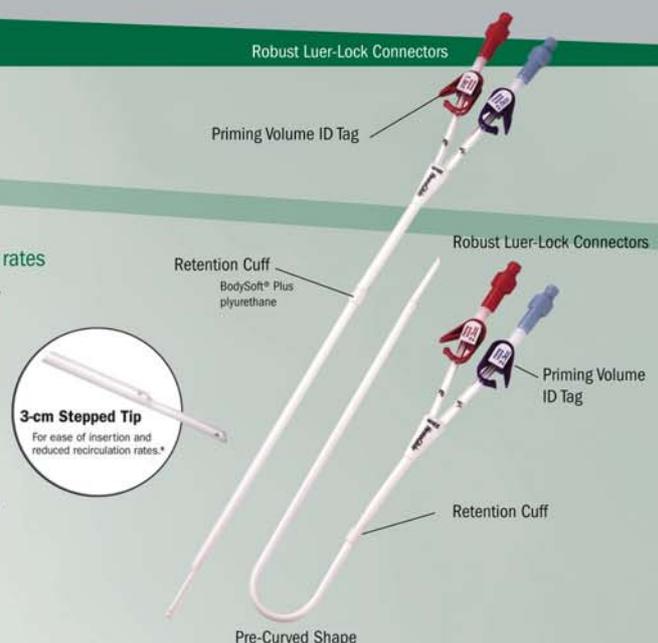
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role besides clinical competence and maintaining a nursing focus (Hayes, 1999; Hayes, 2001; Cusson & Viggiano, 2002). NP mentors were also seen as essential role models for developing essential NP behaviours such as autonomous decision-making, which is difficult to teach in a classroom (Black et al, 1998). Based on their transitional research of first year NPs, Brown and Olshansky (1998) indicated mentors provide 'reality checks' for new NPs that helps them adjust their expectations and were, therefore, critical to success in advanced nursing practice.

In absence of a suitable mentor, using reflective practice by keeping a personal, professional journal was extremely important in identifying transitional, life-changing issues as they occurred in the NPC's practice. Throughout the year the NPC considered journaling to be burdensome and yet another task to complete. Later, when the transition was made, the process of reflection was considered to be a priceless experience. Studies on reflective practice have described the process as an integral part of the healing process and an important way to seek meaning. When applied to the nursing context, Thorpe and Barsky (2001) describe the search for meaning as being consistently applied in nursing theories such as Watson (1985) and Newman (1994, cited in Thorpe and Barsky, 2001), whereby nurses listen to, and validate patient's stories to promote them on their journey toward healing. A relevant study by Glaze (2001) described reflection as a transforming process in which NPs were encouraged to keep a nursing focus in their practice rather than being consumed by medical models, free themselves from ideological constraints, and ensure a caring perspective.

It is interesting to note that during the journaling process, the NPC in the current study found using literature and other NP's experiences a way to

legitimise and feel comfortable that what they were feeling was 'normal' and transitional.

Amy (project officer) described what I was feeling as 'the black hole'. She said that Elaine (another NPC) and Linda (another NPC) went through exactly the same feelings at 9 months into the project – which is nearly where I am. She also warned me that the black hole could continue for quite a while and that I needed to stay focussed and be patient. I felt relieved that I wasn't unusual in what I was feeling and that these feelings were a common occurrence.

(Stanley, 2003, p. 49)

Thorpe and Barsky (2001) explored health, occupational, and life experiences of self-reflection amongst 138 female registered nurses in a large-scale survey using interviews. They described a struggle amongst female registered nurses when they were deciding whose needs to meet and when, which they called the 'Be-ing vs. do-ing' phenomenon. Female nurses are always faced with needing to balance caring for others, including patients, children, and partners, with caring for themselves. Self-reflective practices, such as journaling, allowed them the opportunity to find their own voices and therefore, balance. In using the 'Be-ing vs. do-ing' phenomenon, the NPC in the current study may have found reflection through the journaling process to be essential to finding a balance between their professional and personal responsibilities.

Recommendations

The findings of this study will be of use to future Australian NPs contemplating an extended clinical role in their area of specialty in order to gain an understanding of the level of commitment and dedication required to prepare for the NP role.

This study will also provide useful information to nurse educators and NP Master's program coordinators as the study highlights the value of reflective practice, successful mentoring and the importance of teaching concepts such as autonomy and paradigm shifts. NP education needs to encompass more than just adding new knowledge. It must assist the NP to make a successful transition to a new paradigm. This study recommends that NP Master's program success be determined by its ability to integrate new information into an already 'expert' population with unique needs.

The personal journey described in this study will help future Australian NPs to

- Recognise the stages of the transitional process to NP.
- Find a personal version of the NP role where nursing and medical aspects are successfully balanced.
- Re-define professional boundaries.
- Focus on successfully balancing professional responsibilities with personal needs.
- Reflect and grow from the experience.

Recommendations to assist NP Transition

1. Personal:

- Always have a person who is not a work colleague, looking from the outside in, to help maintain the NP's life balance during 'tightrope moments'.
- Have plenty of sleep and allow periods of 'me time'.
- Journal often, even though it may be a chore and appear to be of no immediate benefit. It does put the transition into perspective.

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2. Professional:

(a) Patient relationships

- Take immense pleasure in the company of patients. They give the NPC the most confidence and important feedback about success in the role.
- Patients control their own destiny – NPs will not be able to ‘make a difference’ with all their patients, and what NPs perceive to be best outcomes, may not be the same as the patients.

(b) Relationships with colleagues

- Get to know medical colleagues as human beings and realise the NP has a different but equal role.
- A mentor is an essential component of NP learning.
- Utilise NP networking opportunities for support.

(c) Personal, professional challenges

- Be reassured that although the nursing perspective may be hiding initially, it comes fighting back.
- The NP is not a ‘super nurse’.
- Many things happen that are outside the NP’s scope of practice and not the NP’s responsibility.
- Set realistic and achievable goals and review these often.

It is easy to apply the recommendations to assist NP transition to the general theme of balance highlighted by the current study. Balance forms the framework upon which the NPC negotiates each challenge they face. Challenges are presented as external, or relationship stressors, and internal or self-initiated stressors. The universal challenge is to maintain the balance of these stressors, and not let internal and external stressors outweigh each other. The recommendations listed above, applied to the ‘balance’ theme forms a model represented by Figure Two.

External Stressors (Relationships)

1. Seek a mentor
2. Immerse yourself in the company of patients
3. Seek collegiality with co-workers
4. Seek networking opportunities
5. Understand your role has limited scope
6. How your patients perceive you is most important
7. Seek guidance & reassurance when entering ‘black hole’
8. Learn how to ‘play the game’

Internal stressors (self-initiated)

1. Write a list of what you do best before you start
2. Seek someone to help you maintain life’s balance
3. Establish realistic and achievable goals
4. Your journal will be your best friend in the end
5. Prepare for ‘loss of identity’ & ‘imposter’ feelings
6. Allow plenty of sleep and ‘me time’
7. Find a stress management technique
8. Expect poor confidence and anxiety, acknowledge these feelings, and move through
9. Practice the same skill over and over to build confidence, then move to the next skill

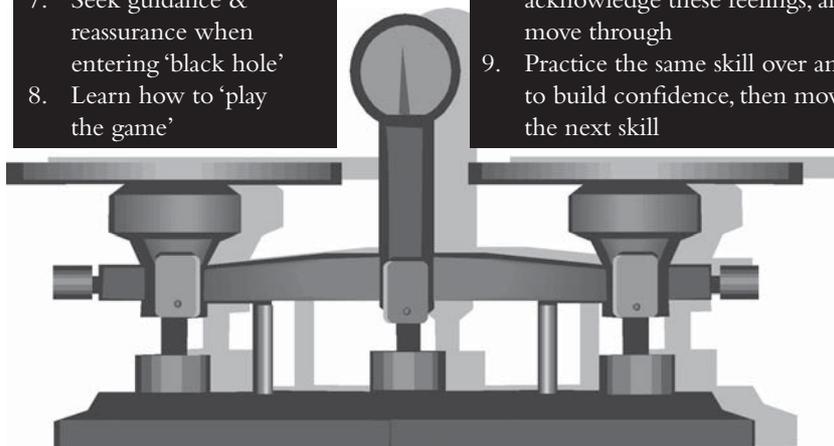


Figure 2: Transition model of ‘balance’ for new NPs in Australia

Conclusion

On the whole, themes identified from analysis of the experiences of the dialysis NPCs in this current study are surprisingly consistent with NP experiences in the US and UK. Despite differences in NP preparation between international and Australian NPs where international NPs are viewed as true ‘novices’, themes such as feeling like an imposter along with role confusion, loss of identity and lack of ‘organisational fit’ have been identified as global transitional issues. Reimbursement, large caseloads and legislative obstacles experienced by international NPs were not major causes of stress for Australian NPs who found organising extended practices extremely easy at local level with little resistance from colleagues.

A positive mentoring experience with educational preparation in autonomous practice and paradigm shifts would have been of great benefit to the Australian NP pioneers who made tremendous personal sacrifices and underwent intense scrutiny to implement the NP role. The sacrifices made and scrutiny endured by the current NPCs will help prepare future NPs for transition particularly in the primary care setting where patients are seen repeatedly over time. This study has demonstrated the importance of balance and reflective practice in personal and professional relationships and sets the universal challenge for future NPs not to let internal and external stressors outweigh each other.

A nurse practitioner model of care in maintenance dialysis: a personal and professional reflective journey. (PART B)

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