

Self-employed Nurse Entrepreneurs
Expanding the realm of nursing
practice:
A Journey of Discovery

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Abstract

Private practice as a career option for nurses has been slowly increasing since the 1980's. However, the reasons for this development have not been fully investigated so that it can be understood and placed within the changing contexts of health care and health services. The expansion and extension of nurses' roles is a contemporary topic in health care reform and therefore one that deserves investigation. The aims of this study were to develop a theory on private practice nursing and to describe the characteristics and work of the self-employed nurse in Australia. Nurses working in a variety of settings have been able to provide information on being self-employed. In doing so, this study was able to describe the persona of the nurse entrepreneur, explore the reasons why nurses and midwives in Australia establish private fee-for-service practices, identify the factors which have influenced this action and describe the scope of practice of nurses and midwives in private practice.

This combined Delphi technique and Grounded Theory study is the first in-depth study of Australian nurses and midwives in private practice. The study enables nurses to provide direct information on being self-employed and enhances the profession's ability to articulate about this area of nursing. The significance of the research is in increasing the understanding of this area of practice development and affords greater insight into its efforts to improve and maintain quality nursing services within the Australian health care system.

One hundred and six nurses and midwives were invited to participate in the study, in which participants completed two rounds of semi-structured postal questionnaires. Delphi technique was applied to rate responses on Likert scales to ascertain respondents' consensus on certain topics. Participants were also provided the opportunity to make additional comments. Results indicated that nurses in private practice are well experienced with an

average of 21 years nursing experience and hold several qualifications. Job satisfaction, being able to be more involved in achieving quality health outcomes and maximising skills and abilities are significant influences for private practice. These results suggest that private practice nursing can contribute effectively to broadening the range of primary health services available to the population and to addressing the issues of retention and recruitment of nurses. Self-employed nurse entrepreneurs push the boundaries of the profession and expand the realm of nursing practice.

Entrepreneurship is a path for the future of nursing as it offers expanded career opportunities for nurses and opportunities for increased ambulatory health services. In addition, the broad, expert knowledge nurses' hold on many aspects of health can be disseminated throughout the health sector to the advantage of corporate health partners. There is further development required in this innovative and expanding area of the nursing profession.

Candidate's Certification

THE UNIVERSITY OF ADELAIDE



This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University library, being made available for photocopying and loan.

Signed ...Anne Wilson.....
Anne Wilson

Date ...04/03/2003.....

Dedication

To my mother, who encouraged me to strive forward, and not to be held back.

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Finally, I acknowledge the dedication and commitment of the nurse entrepreneurs who generously gave their valuable time to this study. This thesis is their story and I hope they, as individual nurse entrepreneurs and their work are better understood as a result of this research.

Epilogue: Semi-Fictitious Story

Family life

The children have just come in from school, traipsing wet and muddy shoes over the laundry floor, which I cleaned only a few hours ago. Fortunately the biscuits and chocolate milk are on the kitchen table, just inside the door, so they don't need to walk all over the kitchen floor as well. As they eat, I unpack their school bags. Inside, apart from the remains of their lunch, are invoices for this term's extra resources and fees for school camp. These are added to the in-tray on the desk in the study for my husband to process later when he comes home from work. In the meantime, the children and I go out to feed the animals and bring the cows in for milking.

The barbecue

Sunday was Fathers' Day. The children are up early getting their surprise for their dad ready. Don's and my parents are coming around and we are going to have a lunch time barbecue. I am kept busy all morning preparing food. We all have good appetites. Don cooks a great barbecue and we all hoe in with gusto. Afterwards, the boys persuade their grandfather to play a game of tennis on the half court. Suddenly, over coffee, Don says the words that were to change our lives dramatically; "I won't be going in to work tomorrow". The seriousness on his face indicates he is not just having a day off. The bombshell drops. On Friday afternoon, he had received a golden handshake.

Family conference

Anxiously, we gather to discuss the crisis. The handshake was not so golden. What now we wonder? Three children with school to finish, a farm that is just getting on its feet and so

provides minimal income. I have no alternative but to return to work. But how will I manage? The thought of working in a hospital again and doing a hospital refresher course is just incomprehensible after having spent most of my nursing career in the community. In my final job, I had injured myself and after ten months off I had decided to take a break from nursing for a while to concentrate on the kids.

Looking at options

Sue and I meet for coffee when I go in to do the weekly shopping. It is good to air it all and talk to another woman, someone else my age and at my stage in life. The prospect of establishing a business does not seem so daunting. What are my skills? What do I have to offer?

I discuss my thoughts with Don and then the family. Don is supportive; my parents cannot conceive what I want to do. An analysis of my strengths, weaknesses, skills and qualities gives me confidence. Following preparation of a business plan I feel ready to proceed.

The big wide world

Reality is starting to hit. We are not the only farmers having trouble making ends meet and with a cash flow problem. Progress is slow. After all, health care is free isn't it? You do not have to pay for it. In six months, I have spent as much as I dare on advertising. Now I have to sit back and wait.

At last, I had a telephone call yesterday. She had kept my ad on the fridge for 5 months. It was starting to go yellow.

STAGE ONE : PLANNING THE JOURNEY

CHAPTER ONE ~ EXPLANATION FOR THE JOURNEY

There is no security on this Earth: there is only opportunity – General Douglas MacArthur

- Parker 1998-

Map of the journey's stages

This thesis on self-employed nurses in private practice describes the researcher's journey in developing a theory on private practice nursing. As a journey, it is presented in five major stages that represent significant points of the thesis and eleven chapters that describe episodes of activity. The journey reveals the path undertaken by nurses in changing their career paths and embracing a new direction as they confront challenge and opportunity. The stages guide the reader through the discovery process of assessment, planning (preparation), searching, interpretation and realisation.

Stage one gives the explanation for undertaking this particular area of research and provides the reader with general background and contextual information on the topic. This stage comprises three chapters which encompass the aims, objectives, purpose and context of the study. A conceptual model that was developed as a result of the review of the literature is described in chapter three.

Stage two overviews the philosophy that guided this investigation and the key elements underlying the inquiry. The rationale for the selection of the methods applied in this research is justified through their use in other studies presented in the second of two chapters.

Stage three comprises four chapters of which one describes the methods that were applied to seek out the information sought in the inquiry. The other three chapters describe how the information was gathered, analysed and interpreted.

Stage four tells the story of the experience of establishing a private practice nursing business and becoming a nurse entrepreneur. The chapter outlines the processes involved and proposes a substantive theory developed on the subject.

Stage five reflects on the original purpose of the study and what has been achieved. The implications of the results and limitations of the study are discussed in the chapter. Finally, the report concludes with the researcher's central thesis on this topic.

Why this study?

New expanded roles in nursing are developing in response to indicators in the community and health care system. Amongst this, there is a strong international trend to develop advanced practice roles for nurses in response to an increasing focus on ambulatory care (Whitecross 1999). Concurrently, nurses are establishing private practices located in community settings in an attempt to expand their roles and address gaps in health services. As private practice is a relatively new initiative, little in-depth research has been done to address the topic of this thesis (Schöen 1992). Statistics on the numbers of nurses in private practice are not readily available and thus, as a group they have not been examined in any significant detail.

Both nursing and health care in Australia have undergone considerable change in structure since the 1970s. Nurse education moved into the tertiary sector with subsequent changes in nurses' expectations for their careers. In conjunction, governments recognised the need for implementing financial strategies in health care (Schroeder, Trehearne and Ward 2000). In effect, the impact of economic rationalism has meant that Australian governments are looking

for ways to reduce the cost of public health while maintaining quality health services that are both effective and efficient (Averis, Brown and White 1997).

Pearson (2001) found that many nurses are discontent with working in the health system as it currently is structured. They would like to see improved health outcomes, improved working conditions, increased autonomy and independence. In addition, they would like to enjoy a balanced personal life that has the flexibility to allow work and family roles to occur simultaneously with minimal disruption. Continuing changes in workforce needs, structure and composition resulted in decreased availability of hospital-based jobs and increased opportunities for ambulatory care, home-care, case management and community health services (Chiarella 1998). It is important for nurses and others in the health care system to understand why non-tertiary care is ideal and possibly preferred by consumers and why this is so. Reports from the Australian Bureau of Statistics data show that from 1996-97 health and community services comprised 75.5% of all businesses (Australian Bureau of Statistics 1998). This data suggests that the nurses' expansion of role should be best directed toward meeting the needs of the health sector and serving the interests of the consumer.

Initiatives to address access to primary health care services influence the direction of nursing and present opportunities for nurses, doctors and other health care workers to collaborate in providing a new range of community services. The instigation of Nurse Practitioner roles for nurses in several states is one initiative that provides opportunity for nurses to utilise in-depth knowledge and advanced skills in a prescribed practice area. In addition, consumers are becoming increasingly more knowledgeable about health and have expectations about the type of health services that they wish to receive.

The trend to improve the range of services available by expanding and extending the role of nurses is occurring throughout the western world. In an endeavour to reduce health care

expenditure, Australia has sought to utilise funds more efficiently through decentralisation of health care while providing cost-effective and efficient services. This form of restructuring emphasised the need to review the types of services needed and many nursing specialities were lost from the public health system, providing opportunity for community based services to develop (Smith 1996).

As the largest single group of health care providers, nurses are being encouraged to expand their realm of practice and collaborate with other health professionals to provide appropriate and cost efficient services in the community (Whitecross 1999). However, maintaining sufficient numbers of nurses in the workplace has become a major issue for government and the profession to address. This has been the case worldwide and particularly in Australia where this study was conducted. Therefore, the questions of what are nurses looking for and what role do they play in the health care system are important for any retention and recruitment strategy. Examination of nurses in business and associated influences will identify some of the issues they face. This thesis offers new insight into an area of nursing which challenges traditional models of nursing and offers nurses career opportunities.

Nurses in private practice

In a nursing private practice the nurse is self-employed and practices on a free-lance or fee-for-service basis. As such, the nurse challenges traditional models of nursing. With the health care system changing there is a growing need for health promotion services and for ambulatory services as the population ages and hospital stays become shorter and less frequent (Barger 1991). Nurses are capitalising on this changing health care environment. In an attempt to utilise their nursing speciality, maintain professional values, fill gaps in health services and contribute constructively to the health care system, an increasing number of nurses are going into private practice and establishing a business. Self-employment provides nurses with the opportunity to improve their income, work conditions, opportunities for job

advancement and to escape bureaucratic politics (Still, Guerin and Bill 1990). The focus of the practice may be in any one or all domains of nursing, that is, clinical, education, management or research. Nurses' efforts to control their practice in order to maximise their capabilities for work satisfaction and further their personal and professional interests is a realistic move that supports nurse control over nursing practice (Magennis, Slevin and Cunningham 1999). Greater control over practice allows further development of personal and professional interests with the ability to respond to the changing needs and demands of health care.

Requiring different knowledge and skills than in employed settings, nurses in business combine a mixture of nursing knowledge and business skills to meet client needs (Keane 1996). In the Australian context, the private nurse consultant is an advanced practice nurse whose characteristics are not limited to those required to provide the psycho-social and physical aspects of traditional care (Smith 1996). Her/his skills extend to incorporate education, research, theory and small business knowledge. The nurse draws on a mix of professional and personal skills to design a product that fills a niche. In doing so, (s)he both supports health care services and satisfies personal vocational desires.

Aim of the study

This research study was undertaken to investigate a developing area of nursing practice in view of its potential impact for the health consumer, the Australian health care system and the nursing profession. The characteristics of autonomy, creativity and opportunity are the expectations of all self-employed nurses. Understanding the entrepreneurial experience may help to facilitate the development of nurses, their practice and the profession.

The aim of the study was to develop a theory on private practice nursing. In doing so, the characteristics and work of the self-employed nurse in Australia would be described. Nurses working in a variety of settings would be able to provide information on being self-employed. The study examines the factors identified as enhancing or inhibiting the delivery of services from the perspective of the nurses.

Objectives of the study

To achieve these aims, five objectives were developed as follows:

- To identify the personal and professional characteristics of self-employed nurses.
- To identify priorities for nurse entrepreneurs.
- To explore the scope of practice of self-employed nurses.
- To discover the factors that have influenced the trend to self-employment.
- To generate a substantive theory on nurse entrepreneurship.

Thus, this study will expand the scope of knowledge that is held about self-employed nurse entrepreneurs in business.

Significance

This thesis is original research and believed to be the first in-depth study of Australian nurses and midwives in private practice. The significance of this research is to offer new insights into private practice nursing and thereby increase understanding of an area of nursing about which little has been researched. In the 1995 Australian Bureau of Statistics National Health Survey, 155,000 people consulted a nurse in the two weeks before being interviewed for the survey (Australian Bureau of Statistics 1995). In addition, the areas of practise chosen by private practitioners have broadened beyond the previous traditional ones of education and midwifery and now include clinical, management, research and business consultancy (Magennis et al. 1999). It is hoped that expanding knowledge on the scope of private practice

nursing will help to identify how the services of self-employed nurses may contribute to improving the range of health services available in the community whilst improving access to health care. Nurses are increasingly extending and expanding their traditional roles, and often for reasons other than their own professional development (Magennis et al. 1999). It is anticipated that by identifying causal factors for nurses choosing self-employment, the profession will be better able to understand some of the reasons for nurses moving out of mainstream nursing. It is also anticipated that this thesis will provide recommendations for how this area of nursing can contribute to developing solutions to and address issues arising in nursing and health.

Researcher's position

Having been self-employed for some years, the researcher realised that many people in the community, as well as in the nursing profession, do not realise, nor understand, what self-employed nurse entrepreneurs do. It became apparent that research about Australian nurses in private practice was greatly needed for the development of professional understanding and advancement of this area of practice. Undertaking doctoral studies provided an opportunity to address this deficit in a way that could lead to nurses in private practice becoming more visible.

As a result of personal experience, this thesis began with the assumption that nurses' decisions to embark on private practice were influenced by redundancy and redeployment. This viewpoint is challenged throughout this thesis.

Definition of terms

Advanced practice: A nurse who is an advanced practitioner will be expected to have considerable experience, skills and expertise in a given area, advanced academic

qualifications and competence in communication (Magennis et al. 1999; Nurses Board of South Australia 1999; American Academy of Nurse Practitioners 2002).

Autonomy: The ability or tendency to function independently. The freedom of a work group to regulate and control its own work behaviour and/or practice (Henry 1998).

Clinical: Defined in the questionnaire, by the researcher as, practice involving the direct or indirect provision of care to individuals or groups. Includes counselling, and 1:1 teaching where health status and clinical improvement can be attributed to the outcomes of teaching / counselling processes.

Consultancy: Defined in the questionnaire, by the researcher as, provision of skills and resources to solve problems and issues of consumer clients such as businesses, industries, hospitals, universities, nursing homes, etc. Teaching may be involved, but less formally than in education. The general intent is active problem solving and framing rather than direct action to affect health status.

Education: Defined in the questionnaire, by the researcher as, where the aim is that nursing knowledge is transmitted rather than a change in the health status of the people being taught. Usually a course/session guide or curriculum is involved.

Entrepreneur: An individual who assumes the total responsibility and risk for discovering or creating unique opportunities to use personal talents, skills and energy, and who employs a strategic planning process to transfer that opportunity into a marketable service or product (Vogel & Doleys 1988 as cited in International Council of Nurses 1994:5).

Entrepreneurial qualities: Defined in the questionnaire, by the researcher as, those personal and professional characteristics that enable a person to undertake challenges and step outside the traditional framework.

Home based business: A business either operated from home with no premises other than the home of the nurse, or where most of the work of the business was carried out at the home of the nurse (Australian Bureau of Statistics 2000b).

Independent practice: The practice of certain aspects of professional nursing that are encompassed by applicable licensure and law and require no supervision or direction from others. Nurses in independent practice may have an office in which they see patients and charge a fee for service (Keane 1989; O'Brien 1996b).

Influencing factors: Defined in the questionnaire, by the researcher as, those factors, personal, internal or external that influenced your decision to become self-employed.

Nurse entrepreneur: For the purposes of this inquiry nurse entrepreneurs were defined as nurses who were self-employed and were paid fees directly or by a third party for services they provided. Inherent in the meaning of entrepreneur are the notions of 'stepping outside the norm', taking risks and seizing opportunities. The Registered Nurses Association of British Columbia (Vogel & Doleys 1988 as cited in International Council of Nurses 1994:5), defines the nurse entrepreneur as "a proprietor of a business that offers nursing services of a direct care, educational, research, administrative or consultative nature. The self-employed nurse is directly accountable to the client, to whom, or on behalf of whom, nursing services are provided".

Nurse(s) in business: Synonymous with **nurse(s) in private practice** and **self-employed**.

Nurse(s) in private practice: A nurse who conducts a private practice. The nurse in private practice assumes a multitude of roles directly linked to the professional and business aspects of the practice and provides a wide range of services. Services may include those such as clinical, education, consultancy, therapy, accountancy, marketing, case management and research. Work settings vary depending on public demand and include office space, private home, consulting rooms, clients' homes, teaching facility, health service, community centre and industrial setting (Bonawit and Evans 1996).

Nursing Product: That service or produce that the nurse identifies and articulates is for sale (Beckmann 1996).

Practitioner: A person qualified to practice in a special professional field such as a nurse practitioner (Glanze, Anderson and Anderson 1990).

Private practice: A nursing private practice is a private business that offers nursing services of a direct care, educational, research, administrative or consultative nature. The roles, services and work settings vary with public demands and are directly linked to the professional and business aspects of the practice (Smith 2002).

Research: Defined in the questionnaire, by the researcher as, fee for service scientific, social or market research of a quantitative and/or qualitative nature. The participant may be the chief investigator or an assistant involved in their own or another's research program.

Scope of practice: The range of activities, products and/or services nurses may undertake or in which they may potentially become professionally self-employed and expert (International Council of Nurses 1994). The products or services offered include nursing services, health

care products and devices, legal services, health care consultation and health care publications.

Self-employed: A self-employed person is one who is able to earn some or all of their income from freelance means (Still et al. 1990).

Small business: Defined as either a non-employing business comprised of sole proprietors and partnerships without employees or a business employing less than twenty people (Australian Bureau of Statistics 2000a).

A note on language: The researcher acknowledges that midwives are currently attempting to form a separate entity apart from the nursing profession. Rather than complicate the literary flow of the text in this thesis by using the terms 'nurse' and 'midwife' simultaneously, the terms 'nurse' and 'nursing' will be used to encompass both groups.

A note on gender: In order to provide equal acknowledgement to both genders, the pronoun “they” is used. Given the high percentage of females in nursing and to avoid awkward sentences, the researcher decided to use the female pronoun when the use of he/she or his/her was appropriate in the text.

Summary

This research study will explore the reasons for nurses’ move from employed positions to establishing fee-for-service businesses. It is envisioned that factors, which influenced this behaviour, will be exposed and the extent of practices undertaken by those nurses revealed. By doing so, it is hoped that knowledge and understanding of this group of nurses in relation to the wider profession and the provision of health services will be broadened. This thesis

will conclude with a number of recommendations in regard to this area of nursing practice. The following chapter will provide the context within which private practice nursing is positioned.

CHAPTER TWO ~ CONTEXT OF THE ISSUE I

This chapter examines some of the national and international literature within which private practice nursing is situated. This will provide background information to assist the reader understand the topic of this thesis. This chapter discusses the extension and expansion of nurses' roles in an endeavour to match trends in the health sector. As a result, it identifies that there is a gap in empirical research studies on private practice nursing.

Introduction

Social and economic factors have influenced trends in health care and nursing as far back as Florence Nightingale. Corporate downsizing, restructuring of the public health system and nurses' need for satisfactory, fulfilling employment are a few of the present day factors. As a result, a growing number of nurses are considering their options in advanced practice settings to achieve work satisfaction and continue their nursing career. By considering self-employment, nurses combine nursing knowledge and skills with business acumen to provide a range of specialist services incorporating health education, health management and clinical services to the community. This innovation in nursing practice increases the range of ambulatory health care services available and therefore provides benefits for the health system and consumer. Unfortunately, nursing does not receive the same recognition that is afforded to other self-employed health service providers such as speech pathologists, medical practitioners, occupational therapists and physiotherapists, whose services receive reimbursement by private health funds. Nurses moving to become entrepreneurial and extend their practice boundaries into the business sector has interesting implications in terms of health policy. Nurse entrepreneurs focus on the emerging health care trends in the provision of services and the need for nurturing change in nurses' employment opportunities and career expectations.

Historical accounts of nursing recall the activities of nurses and midwives who operated their own businesses by offering health care to the community (O'Brien 1996a). Women who had graduated from schools of nursing in the 1880s were highly sought after by private patients. They provided care in the home and before World War II many nurses were in independent practice as private duty nurses (Menard 1987). In time, with social and economic changes and with the development of large hospitals, specialist private duty nurses moved into hospital settings and out of community ambulatory settings (Sills 1983). In Australia, clinical specialities in nursing emerged in the 1970s and 1980s and produced expanded roles for nurses, which extended their scope of practice (Menard 1987; Bonawit and Evans 1996). De-institutionalisation of health care and the rationalisation of health costs in more recent times have resulted in greater emphasis being placed on ambulatory and community health services. Specialist nurse positions in hospitals have decreased, providing opportunities for entrepreneurial nurses to establish and provide services from a community setting. Consequently, there has been an increase in the number of nurses establishing private practices and the range of services offered by nurse entrepreneurs has expanded beyond those offered by consultants and educators to include clinical services (Walsh 1999).

Entrepreneurship offers a career option for nurses seeking autonomy in their practice. Nurse entrepreneurs face some distinct issues as they endeavour to offer a range of specialist nursing services from within a business structure. This development provides the health system with an opportunity to address needs within the health system by utilising the services of private nurse consultants and practitioners. Even though the numbers are indeed small, there is significant interest as indicated by the growth in membership from 60 to over 500 members, of the group Nurses and Midwives in Private Practice, Australia over three years from 1998-2001 (Royal College of Nursing Australia 2001).

Health sector change

The broad scope of today's health sector allows for a wide range of activities in which nurses may potentially become professionally self-employed and expert (International Council of Nurses 1994). To be successful, entrepreneurship must adapt to the legislative, financial and political realities and expectations of the country. Major contextual factors are the health sector's financial policies, and whether health care is a public or private service, or a mix of both (see Figure 1). The development of nurse entrepreneurs will therefore largely depend on the economic infrastructure and policies implemented at all levels.

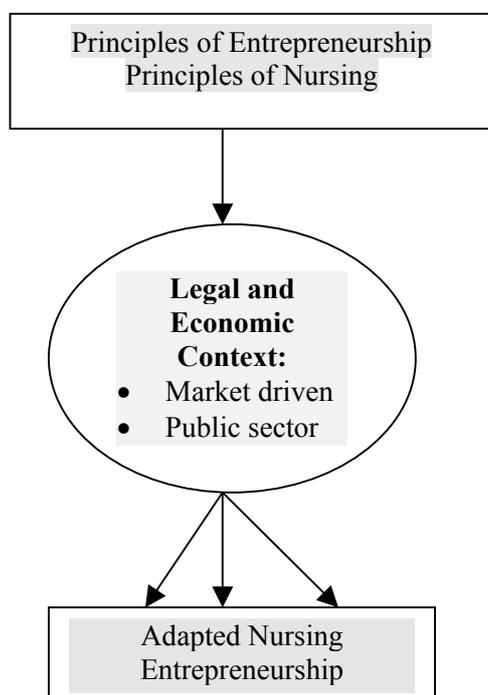


Figure 1: Nursing entrepreneurship and its evolution (ICN 1994)

The trend of corporate downsizing and restructuring has stimulated the establishment of entrepreneurs. The subsequent outsourcing of non-core activities and the products of independent practice being purchased by the public sector. In the health sector, this and other actions have influenced a rise in the number of nurses looking at different employment options. Self-employment as a career option for nurses may represent action taken to escape an unsatisfactory employment situation, redundancy, or as a strategy to improve one's

lifestyle. In the last ten years there has been an increased interest in self-employment as a career option. Nurses are rethinking their roles in response to cutbacks in public health services, disillusionment with financial rewards and with the standards of care expected in health services (O'Brien 1996b). Professional support groups for self-employed nurses and midwives were active in South Australia (Nurses in Private Practice, South Australia), New South Wales (Australian Visiting Nurses Association) and Victoria (Nurses in Independent Practice) until 1998. Since this time, a national group was formed within the Royal College of Nursing, Australia, so that their interests could be more strategically represented as Nurses and Midwives in Private Practice, Australia.

The review

To gather information on this topic, a literature search was conducted using Pub-Med, Medline and Cinhal. The key words were nurse practitioner, nurse entrepreneur, private practice, nurses in business, advanced nursing practice, clinical nurse specialist and self-employed nurse. The bulk of literature reviewed were journal articles that discussed private practice from an anecdotal perspective of individual nurses' stories on running a nursing business. Associated literature discussed the concepts of advanced practice, autonomy, responsibility and accountability for nurses (Hockenberry-Eaton 1996; American Academy of Nurse Practitioners 2002). Most of the literature reviewed was of American origin and referred to nurse practitioners working autonomously within employed advanced practice settings. One unpublished Australian research study on private practice nurses was found (Bonawit and Evans 1996). Their study aimed to investigate whether there had been an increase in numbers of nurse entrepreneurs in Victoria, to describe their practices and to elicit their thoughts on certain issues such as accreditation, indemnification and remuneration. Unfortunately, no theoretical studies that explore the persona or scope of practice of nurse entrepreneurs were discovered.

The increasing usage of a wide range of titles such as nurse practitioner, clinical nurse specialist, nurse consultant, and nurse clinician has created a great deal of confusion both within and outside the nursing profession. Ranges of terms are used in the literature to describe or define nurses expanded and extended roles. Terms used include advanced nurse practitioner, nurse practitioner, advanced practice nurse, clinical nurse specialist, independent nurse practitioner and nurse in private practice (Nurses Board of South Australia 1999). These terms describe nurses working at advanced levels, but the role and function of each may differ. Throughout this thesis, the terms nurse entrepreneur, private nurse practitioner, independent nurse practitioner, nurse consultant and business entrepreneur are interchangeable, recognising that self-employed nurses are frequently described by all these terms, especially in the North American literature. The researcher uses the term private nurse practitioner to mean nurse practitioners or nurse consultants who are self-employed and who offer service and information for a fee. The term 'practitioner' is used to refer to all nurses, regardless of their area of practice, recognising that private practice nurses frequently combine clinical, teaching, research and consultancy roles (O'Brien 1996). The term independent practice is taken synonymously with private practice, and not to describe nurses who work in settings of increased autonomy such as remote area nurses (Keane 1996). For the purpose of this thesis, a nurse entrepreneur is considered a person who develops, organises, manages and assumes the risks of a business, and as such is:

A proprietor of a business that offers nursing services of a direct care, educational, research, administrative or consultative nature. The self-employed nurse is directly accountable to the client, to whom, or on behalf of whom, nursing services are provided (ICN 1994:5).

The majority of the nurses reflected in the literature reviewed were female and it is interesting to note that statistics on the health workforce in Australia for 1999-2000 show that

of 328,000 people employed in health occupations, 151,200 (46.8%) were registered nurses and of these, 7.6% were males (Australian Bureau of Statistics 2001). Females comprised 72% of the total health work force, due to the predominance of females in the nursing occupations (Australian Bureau of Statistics 2001).

Advanced practice and expanded roles

Nursing in Australia is entering a new paradigm in health care in which nurses' current and future roles in the Australian health care system are being examined. In an endeavour to reduce health care expenditure while providing cost-effective, efficient health care services, the Australian Federal Government (New South Wales Health Department 1992) decided to review health care services. Feasibility projects investigating the efficacy of nurse practitioners to address the lack of access to primary health care services and assist health care reform have been implemented (Averis et al. 1997; Chiarella 1998).

With these developments, governments are willing to consider the individual consumer's right to choose their service provider and search for innovative ways to offer health care that is efficient, effective and economical, including those services offered by self-employed nurses in business (Smith 1996). Nurses who work in an advanced practice role, whether as an employed or private nurse practitioner are expected to possess the appropriate educational qualifications and experience to be experts in their specialty practice area, while recognising the limits of their knowledge and practice (Department of Human Services 1999a). Working with increased autonomy, responsibility and accountability, self-employment provides an advanced practice option for nurse entrepreneurs.

The concept of independent nurse practitioners appears to have originated with Florence Nightingale who provided private domicillary nursing services (Schöen 1992). The

momentum towards independent practice has increased since the late 1980s, as advances in nursing knowledge, increased opportunities for graduate study in nursing, consumer expectations, women's expectations and acceptance of specialised nursing roles have broadened the scope of nursing practise. Dinsdale (1998:12) reports that in France, 13% of the nursing workforce are self-employed, and in the U.K. there are 500 - 1000 nurse entrepreneurs who "want to use skills and abilities to create a successful business while assuming total responsibility and risk". In the Australian context, the independent, private nurse practitioner is an advanced practice nurse who uses "expert problem solving skills that are a result of complex reasoning, critical thinking, and analysis to form (clinical) judgement" (Smith 1996:561). Their characteristics are not limited to those required to provide the psychosocial and physical aspects of traditional care but extend to incorporate education, research, theory and small business knowledge (Parker 1998). Education is considered important for developing skills in "clinical-fiscal performance methodologies, whole brain thinking and whole system thinking" (Parker 1998:17). Collins (1991) considers these skills are necessary for entrepreneurialism and to develop autonomy.

Currently, there is considerable change occurring within the profession of nursing in Australia regarding the development and implementation of the role of the nurse at an advanced level. These changes include the scope of practice of the specialist nurse, and the identification of the role and models of practice for nurse practitioners. Due to escalating costs of traditional health care, governments are eager to consider avenues of health care access and provision that curtail the costs of health to Government (Smith 1996).

International Developments

The move toward nurses operating at an advanced level is a growing trend world-wide as more provision of care by nurses is becoming expected (McMillan, Andrews and Bujack 1996). A nurse who is an advanced practitioner will be expected to have considerable skills,

experience, expertise in a given area and advanced academic qualifications (Magennis et al 1999; American Academy of Nurse Practitioners 2002; Nurses Board of South Australia 1999). The American Nurses' Association (1995) has defined advanced practice as clinical practice with the essential characteristics of specialisation, expansion and advancement. Specialisation is considered to be focusing on one part of the field of nursing; expansion as referring to the acquisition of new knowledge and skills, and advancement as involving both expansion and specialisation. Magennis et al (1999) goes further and adds extension to describe overlap into traditional boundary areas of other health professionals.

The work by Benner (1984) identifies that there are nurses functioning at the advanced or expert level of competence within their area of specialty practice. Building on Benner's work Fenton and Brykczynski (1993) undertook an ethnographic study to identify the common competencies of the clinical nurse specialist in the United States of America. Over a period of six months, they interviewed and observed thirty Master's qualified nurses employed in a health care setting. Using the data analysis approach advocated by Benner, the researchers expanded and extended the domains and competencies described by Benner. From this study, Fenton and Brykczynski concluded that clinical nurse specialists in the North American setting were practising at an advanced level and, therefore, their status was justified.

In the United States, advanced practice is used as an umbrella term to encompass Nurse Practitioners and Advance Practice Nurses. Nurses practising at this level integrate advanced assessment skills and decision making, education, research, management, leadership and consultation into their clinical roles and have attained a Masters qualification (American Academy of Nurse Practitioners 2002).

Advanced clinical practice for nurses in the United States originated more than two decades ago from two directions – nurse practitioner and clinical nurse specialist. As Dunn (1997) notes the evolution of the nurse practitioner roles was in response to social demands for affordable primary health care. In contrast, the development of the clinical nurse specialist role was a response to patients needing increasingly complex and specialised care. However, recently the similarities and differences between these two roles have been discussed, with the suggestion that they could merge (Elder and Bullough 1990; American Nurses' Association 1995).

In the United Kingdom (UK), advanced practice roles for nurses have developed over the past 25 years, although confusion and difference of opinion exists about the role and its implications (Leonard 1999). The United Kingdom Central Council (1994) describes the advanced practitioner as one who combines five areas of competence, namely, clinical, research, teaching, consultancy and leadership. In addition, the nurse is functioning at a specialist level, having achieved expertise in a variety of practice settings, with specialised knowledge in at least one area.

These developments in the UK have been influenced by increased professionalisation of nursing and the reduction in medical practitioner hours, resulting in a crisis in medical manpower (Lorentzon and Hooker 1996). In addition, changes to the health care system and the need to offer cost effective care has brought about a shift from traditional nursing roles. This is highlighted in general practice where nurses have traditionally held the role of practice nurse. The introduction of the nurse practitioner (an advanced practice nurse, with an extended function) has provided evidence of efficient and effective care (Paxton and Heaney 1997).

During this time of change, nursing has become more independent in its thinking and practice, and has moved towards research-based holistic practice, resulting in a natural process of growth which has expanded nursing responsibilities (Leonard 1999). In response there has been the development of nursing theories, the production of nursing experts, autonomous practitioners and an expanding and evolving process for nurses that is positioned to continue. The expansion of nurses' roles therefore not only includes more commonly and frequently performed activities but has also extended into duties that have previously been medical interventions.

In New Zealand, the need for a national framework for nurses undertaking advanced practice roles was recognised. Through the development of this framework it was identified that a number of advanced practice roles have evolved and include clinical specialists, nurse practitioners and nurses who work to advance the knowledge, practice and effectiveness of nurses (Peach, Cooper-Liversedge, Russel and Haves 1990).

In Australia, the recognition of nursing practice at an advanced level has evolved from two directions. Namely from specialisation in nursing and the nurse practitioner movement. However, confusion and ambiguity of the role and titles of advance practice nurses continues (Bennett 1998; Hamilton 1998). As Sutton and Smith (1995) point out this confusion arises from the assumption that Australian nursing shares the same understanding, meaning and application of the terms with our North American colleagues.

Specialty practice at an advanced level in Australia

Traditionally it had been recognised that certain populations of patients needed care from nurses with expertise in specialty areas of clinical practice. In Australia, nursing specialties had originally developed in line with medical specialties, with a focus on groups of patients

with the same diagnosis, for example coronary care nursing, gastroenterology nursing, renal nursing, and diabetes educators (Bessant and Bessant 1991). More recently, specialties have also encompassed nursing practice with distinct populations of people, for example women's health, community health and rural and remote area nursing (Smith 1992; McMurray 1998). Many nurses in private practice are employed part-time, and possibly have approximately twenty years experience and education beyond a nursing diploma (Profile of a Self-Employed Nurse 1993). Pelletier, Donoghue, Duffield and Adams (1998), found in their study on the impact of graduate education on career pathways that education as expanding frame of reference, influenced career plans, facilitated job change, contributed to job satisfaction and influenced nurses' success in attaining career goals. Nurses' frustration and work dissatisfaction is commented on by Pelletier et al (1998) and Porter-O'Grady (1998) and considered responsible for some nurses leaving nursing or considering private enterprise.

A project commissioned by the Nurses' Board of South Australia (NBSA) to explore the public's and profession's views about the regulation of advanced practice recommended that authorisation for advanced practice should incorporate provision for the advanced generalist nurse as well as specialist nurse (Nurses Board of South Australia 1999). The concept of the advanced generalist nurse as an expert in nursing is a matter for the profession to consider further if nursing wishes to hold on to the core competencies within nursing that support the 'wellness health model', such as that care provided by community health nurses. The American Nurses' Association (1995) suggests that the scope of practice in nursing is dynamic and that "differences amongst nurses in their scope of practice can be characterised as intra-professional intersections across which collegial, collaborative practice occurs" (NBSA 1999:12). Elliot (1995, as cited in NBSA 1999), suggests that the scope of advanced practice incorporates clinical practice, research, management, teaching, to acting as a consultant in a comprehensive approach to nursing that extends the individual, regardless of which area they practice in.

Nurse Practitioner movement in Australia

The introduction of Nurse Practitioners in Australia had its genesis within the Women's Movement. In New South Wales during the 1970s, the first Women's Health Service was established. By the 1980s more than a dozen of these services had opened throughout Australia (Broome 1991). Funding was subsequently provided by the Commonwealth Government to support these services. A review of the services in NSW in 1985 recommended that a network of Women's Health Nurses be established to work within mainstream health services (Wass 1992). This resulted in the education of nurses, practising at an advanced level, to extend their practice and assume the role of Women's Health Nurse Practitioners.

In Victoria, in 1989, a project funded by VicHealth was established to determine the effectiveness of nurses to offer choice and access to women and to increase Pap smear screening. Ten nurses from rural and metropolitan locations participated in the program. The report highlighted the success and importance of nurse provided screening services for women (Springvale Community Health Centre 1991). This move to provide access and choice of provider for women was also supported by the National Women's Health Policy (Commonwealth Department of Community Services and Health 1989). This has resulted in a network of Well Women's Health Nurses throughout Australia.

In New South Wales, a Task Force was established in 1990 to examine the role and function of Nurse Practitioners. The report provided details of the development of the nurse practitioner in Australia and the variety of roles these nurses assumed (New South Wales Health Department 1992). These roles included, in addition to women's health nurses, midwifery practitioners, practice nurses in general medical practices, remote area nurses, and

a number of other primary care roles. Included in the recommendations were the piloting and evaluation of nurse practitioner models of practice.

These recommendations resulted in ten nurse practitioner pilot projects being evaluated (New South Wales Health Department 1995). The pilot projects included nurse practitioner models in rural and remote areas, midwifery, well women's screening, emergency services, urban homeless men service, and general medical practice. Each of the pilot projects included an extension in the scope of nursing practice, such as limited prescribing, initiating diagnostic imaging and pathology. The outcome of the evaluation found that these nurse practitioners were "feasible, safe, effective in their roles and provide quality health services" (New South Wales Health Department 1995: 64). Following the release of the nurse practitioner report, the department produced a policy statement and guidelines for nurse practitioner services. Included in the documents are amendments to legislation, limiting the title of "Nurse Practitioner" to registered nurses accredited by the Nurses Registration Board NSW. Accredited Nurse Practitioners have the right to "privileges" including limited prescribing and initiating diagnostic imaging and pathology.

In other States and Territories, the topic of nurse practitioner practice is being pursued (Norton 1994; Department of Human Services 1999b). In the Northern Territory and Western Australia, steering committees have been established and the feasibility of the role of Nurse Practitioners in rural and remote areas is being examined. In Queensland, nurses in three practice settings (isolated practice, sexual health programs, and immunisation programs) have been given extended authority in particular circumstances (Department of Human Services 1999b).

The establishment of the nurse practitioner project in South Australia in 1996 followed the release of the New South Wales Nurse Practitioner stage three report by the New South

Wales Department of Health. Its basis was to enable nurses to best serve their communities by functioning at an advanced practice level in areas where needs for services are greater than the current availability of health care professionals. The contribution of nurses in private practice was recognised by their inclusion in the membership of the Ministerial Advisory Committee (Department of Human Services 1999a). So that the diversity and the fundamental characteristics of this advanced practice role could be recognised, the ‘defining features of a nurse practitioner’ were developed (Department of Human Services 1999a). These defining features included sub-roles of educator, mentor, manager, and researcher within the context of need, setting, autonomy and education. The flexibility provided in these features enabled innovative practices to be implemented within the profession.

In late 1998, the Victorian Minister for Health established a Nurse Practitioner Task Force. Deliberations by the Task Force have resulted in the recognition of two elements in the practice of nurse practitioners. These elements are an advanced level of practice and an extension of practice. Recommendations, therefore, followed the lead set by NSW to protect the title “Nurse Practitioner” through legislation, and have been linked to the right to “privileges” (Department of Human Services 1999b). The incorporation of “privileges” or rights in the role and function of the Nurse Practitioner clarifies the term “practice extension” for this group of nurses.

Nurses' views

In a study of registered nurses perceptions of role expansion, Leonard (1999) found that nurses are divided in their approval for role expansion and extension. Some are concerned that vital aspects of nursing will be lost by role extension into functions, which were once, considered the exclusive domain of doctors, while others saw role expansion as a natural professional progression.

Magennis et al's (1999) study on nurses' attitudes echoed these concerns to the extension and expansion of their clinical roles. Nurses raised concerns that they were being exploited to perform mundane medical tasks previously undertaken by junior doctors, and, as a result compromise the quality of nursing (Magennis et al, 1999). Apprehension about increased vulnerability to litigation, exploitation, and fragmentation of their nursing role was expressed. Lyon (1996) distinguishes between the social mandates of medicine and nursing explaining medicine's mandate to diagnose and treat disease is distinctly different to that of nursing, which is to diagnose and treat symptoms. Magennis et al (1999) add to this by suggesting that role expansion appears to support those who advocate holistic approaches to health care and role extension seems to counter the argument of holism, eroding the boundaries between nursing and medicine and creating anxiety about the role change and a lack of appreciation of the true value of 'basic-nursing'.

In their article on the issue, Kelly, Chiarella and Maxwell (1993) discuss the intention of developing extended practice roles, emphasising that the extended role is not to replace the role of other health professionals but to offer additional health care options. Historically, depending on the environment, there have always been functions that have been performed by both medical and nursing staff such as nurses working in rural and remote areas, who often perform functions undertaken by junior doctors in metropolitan hospitals. This blurring of boundaries seems inevitable with developments in health care and a natural integration of roles in the delivery of health care (Kelly et al 1993).

However, nurses globally continue to seek recognition for their advanced practice roles either in specialty practice or as nurse practitioners. To assist in this process in Australia, the Royal College of Nursing, Australia released a Position Statement on Advanced Practice Nursing (Royal College of Nursing Australia 2000). Included in the definition is the recognition that:

The basis of advance 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. Nurses working at an advanced practice level are able to work autonomously, initiating the care process, as well as in collaboration with other health care professionals (p1).

The National Consensus Statement on the Recognition of Nurse Practitioners in Australia released by the National Nursing Organisations in October 2000 acknowledges that the role of nurse practitioners is complementary to that of other health care professions and an integral part of multi-disciplinary health care provision (National Nursing Organisations 2000). It is envisaged that this approach of practising in collaboration with other health care professionals and in complementary settings with them will provide greater access and choice to achieve population health.

Summary

This study is established as one link in a chain of knowledge that is developing and enlarging about advanced nursing practice and in particular, private practice nursing. The review of the literature revealed that there are numerous studies on advance practice and nurse specialists but no previous studies of the specialist area of this thesis and the priorities in private practice nursing. This thesis approaches the issues of private practice as an innovative advanced practice option. It takes the view that to understand the context of this role and the differing views surrounding it assists to clarify the issues and place for private practice nursing in the current and future of Australian nursing.

The review of the literature also uncovered several anecdotal reports from nurses who had established businesses. These were instrumental in assisting in the development of the statements for the Delphi survey and will be discussed in the next chapter.

CHAPTER THREE: CONTEXT OF THE ISSUE II

A Conceptual model

In the previous chapter, the review of the literature pertaining to the topic of this thesis was discussed. The review uncovered a number of articles and documents relating to self-employed nurse entrepreneurs' personal experiences of being in business. Although most of this literature does not provide empirical data on the topic, it was considered helpful to the context of this study. Thus, the researcher constructed a conceptual model describing the major aspects summarised from the literature (Figure 2).

The model was subsequently drawn on to inform the researcher in the construction of the Delphi statements for the first questionnaire and in doing so served as an informed panel. As utilised by Stewart et al (1999), this became equivalent to being the first round of the Delphi technique because of the fact participants had already been identified as eligible for inclusion in the study and willing to take part.

Conceptual model

The conceptual model summarises the factors reported on in the literature that affect establishing a nursing business. The researcher grouped these factors into representative categories. In the centre of the model is the self-employed nurse entrepreneur to whom all the other boxes relate. The model depicts the internal and external factors that influence a nurse's decision to undertake self-employment, the personal and professional rewards of being in private practice, the challenges of self-employment and the entrepreneurial characteristics of the nurse entrepreneur as they arose from the literature.

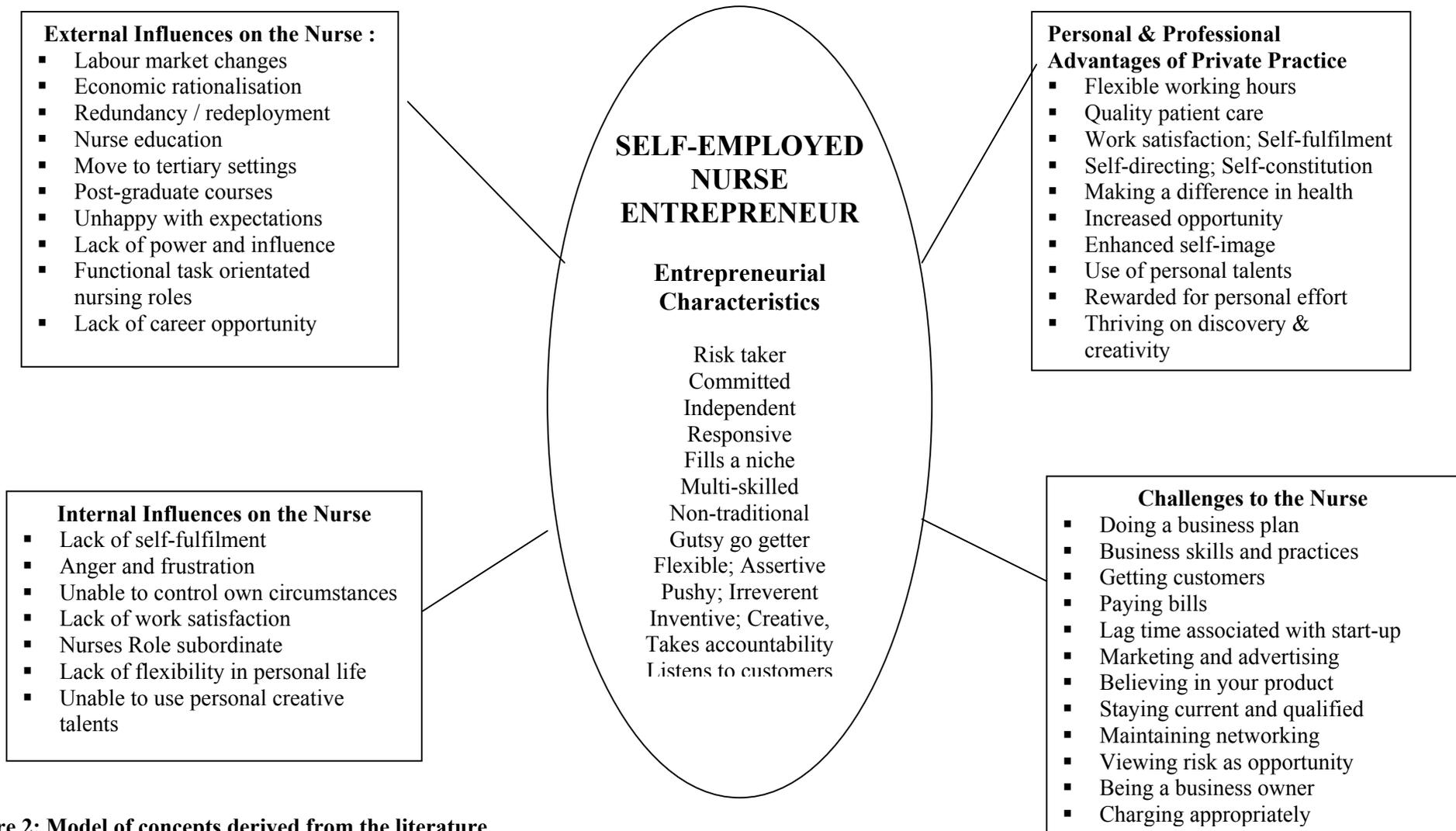


Figure 2: Model of concepts derived from the literature

Influences

In an increasingly uncertain world of employment, more nurses in the United Kingdom are deciding to set up business in order to achieve control over their careers, determine their own futures, and as a means of opting out of working in the National Health System to be their own boss (Dinsdale 1998). The reasons for nurses becoming self-employed are varied and include a mix of personal and professional reasons, or a desire for change (d'Allessio 1995). Some are confronted by labour market changes or early retirement or redundancy. Increased consumer awareness, changing demands in health sectors, a higher level of basic education and easier access to further education for nurses have contributed to encouraging the return to nursing entrepreneurship. Chronic dissatisfaction of nurses in the workforce due to unsatisfactory working conditions, poor public image, inadequate decision-making authority, inability to put into practice the knowledge and competencies acquired, redundancy and the reduction of nursing specialities have all contributed (International Council of Nurses 1994). Private practice is also a tempting opportunity for some nurses to fulfil a dream of envisioning themselves as owners of a healthcare related business (Bergman 1998). For others, self-employment is an opportunity not to have to fit in, to be able to develop their ideas to fruition and to practise independently (Bergman 1998).

Advantages

There are a number of advantages in being self-employed. Being able to utilise a range of personal talents and skills, contributing more effectively to a particular area of health, effecting health outcomes more directly, gaining a satisfactory and varied career, further developing skills and having the opportunity to choose different work are some (Hilton, Levick, Payne, Radley, Smith and Viant 1997). According to Hilton et al (1997), being master of your own destiny, your own boss and having freedom to choose work are strong advantages. For the nurse who is a parent or carer of other family members, private practice

provides flexibility with work hours while staying involved in nursing. Bergman (1998) values spending quality time with children without being away from home for long hours as an advantage of self managed work. Flexibility in the type of work performed and the variety of work is often found to be an advantage of being self-employed. Entrepreneurial roles may include different forms of consulting work, projects, or direct clinical work (Hilton et al 1997; Bergman 1998).

Challenges

A common theme of being prepared to face challenges emerged from the literature. Going into business is challenging in itself and Dinsdale (1998) stresses that the nurse will find the situation even more difficult without adequate experience in nursing or in the business product being offered. The start-up phase of any business is challenging. For nurses new to the area, there are the challenges of finding out about competition and accessing funding sources. This is a crucial component of self-employment and the information is often hard to find, requiring all of the nurses ingenuity (Bergman 1998). The benefit of a preceptor as often afforded to new nurses in employed settings is not available to nurse entrepreneurs. They must rely on networking effectively to promote sharing experiences with one another to provide support and stimulate ideas (Bergman 1998). Developing competence in marketing, accounting, legal, insurance and tax matters are important requirements for a successful business and require additional education for the professional nurse. Acquiring skills in communication and negotiation to deal with these and other issues appear high on the agenda (Dinsdale 1998). Learning to sell may be a significant challenge for nurses as many have come from being employees. Putting monetary value on their services and charging appropriately are significant challenges (Hilton et al 1997). Making the most of opportunities and always having 'one eye open' to find them are skills to develop. Inherent in being successful are good communication and networking skills, which assist with conflict

resolution and promotion of the nursing business (Bergman 1998). Higher education has encouraged nurses to form expectations of the health system, and some have found the greatest motivation to self-employment to be the rapidly changing face of health care (Bergman 1998). Taking a proactive stance opens the opportunity for new career paths, allowing the application of both nursing and business skills.

Entrepreneurial characteristics

According to Dinsdale (1998), nurses stepping out on their own must have a passion about their area of interest, be committed, be prepared to take risks, have a strong sense of self-image, self-confidence and believe in him or herself. If dealing with the public, a strong customer orientation is considered essential for success. Flexibility means willingness and ability to work anywhere and to different schedules (Hilton et al 1997). Critical thinking skills provide the entrepreneur with sophisticated methods to approach complex problems in a complicated health system that requires innovative creative solutions (Hockenberry-Eaton 1996). Taking responsibility with organising, planning and co-ordinating strategies to improve the quality of care in areas such as in diverse care settings or programs is required of entrepreneurs as they respond to perceived needs (Hockenberry-Eaton 1996).

Nurses in business

Nurses in business combine a mixture of nursing knowledge and business skills to provide client-focused services (Keane 1996). Continuing changes in workforce needs, structure and composition will result in decreased availability of hospital based jobs and increased opportunities for ambulatory care, home care, case management and community health services (Waxman 1998). This provides opportunity for nurses to identify career goals and assess those skills that they hold in order to develop and market their individual product to customers, who have a right to make informed choices about health care. The future of

private practice for nurses may rely on an understanding by all health stakeholders of why such care is safe, ideal and possibly preferred both by the consumer and the profession (Davis 1995; Johnston 1995). In addition, the value of experienced nurses as experts in health management and health education will be revealed.

Freedom, self-fulfilment and the right to be oneself are important to human beings who have an ability to adapt to changing environments so that human need, entrepreneurialism and freedom are maintained (Willis 1993; Crow 1998). In a critical analysis, Davis (1995), identifies several major themes of concern for private practice, including issues of autonomy, accountability and ideology of practice, all of which can be closely linked to the balance of power from social, political and gender perspectives. Nurses' attitudes toward controlling their practice in order to maximise their capabilities for work satisfaction and further their personal and professional interests, is a view supported by economic theory of consumer behaviour (Schöen 1992). Education, experience, age and career goals are considered major variables influencing the degree of personal success expected or achieved in business enterprise. Influences include career intentions, the individual's perceptions of their profession, educational level, length of time since initial registration, the nurses' age which reflects sensitivity to change and length of experience, marital status and parental status (Schöen 1992).

Small business in Australia

In recent years, a combination of pressures from industry, workplace, and social sectors have intensified the development of small businesses. Small businesses have a fundamental role to play in improving Australia's economic performance and meeting contemporary challenges, including competitiveness, in health care and professional services (Department of Industry, Technology and Commerce 1991). The small business sector is an important source of

innovation and by adapting quickly to changing market conditions, contributes to the flexibility and dynamism of the health industry. It provides the base of entrepreneurial spirit and a large part of the economic infrastructure necessary for industrial growth (Department of Industry, Technology and Commerce 1991).

Entrepreneurial women and nurses are a growing component of the workforce worldwide (Still et al. 1990). The Australian Bureau of Statistics estimated that in 1996-1997, health and community services represented 79.4% of small businesses (employing less than 100 people), and comprised 75.5% of all businesses (Australian Bureau of Statistics 1998). Micro businesses (employing less than 20 people) in 1996-7 represented 81% of all businesses, and non-employing micro businesses accounted for 44% of all businesses.

In a survey commissioned by the NSW Women's Advisory Council on self-employed women in Sydney, Still et al (1990) concluded various theoretical explanations for the trend of self-employment occurring amongst women. Such explanations included that female self-employment is a relatively recent development; entrepreneurship allows for women to accommodate work and child-rearing roles simultaneously; and self-employment brings a balance and flexibility to lives that a corporate environment does not allow.

The literature reveals that various personal characteristics such as age, family status, education and skills affect employment status or re-employment. A study by Monash University Faculty of Business and Economics (Gray 1998) found that age is not a handicap for self-employment and combined with experience, is in fact an advantage for the entrepreneur. Gray (1998) concluded that the family exerts influence by providing role models, support and resources to assist entrepreneurs to develop their business, although some husbands may be threatened by and resistant to their wives developing businesses.

High levels of education have also consistently been associated with receptivity to innovation (Still et al 1990). There could be an interesting link between this and the growth in private practice nursing which appears to have grown significantly in the last decade and since the move of nurse education to the tertiary sector. There is evidence (Gray 1998) that experience in the industry provided by the business entrepreneur has a positive effect on performance and on the individual's beliefs, skills and knowledge of their abilities.

Conclusions

As derived from the literature, evidence seems to suggest that with continued change in the health sector the trend to self-employment and the establishment of small businesses will continue to increase in all areas of the work force, including nursing. Self-employed persons as a group have many similarities irrespective of their discipline, background or the type of business they conduct. Recognising nurses as one sub-group within this group has interesting implications in terms of health policy development and in the provision of services and the nurturing of social change in nurses' employment opportunities. National nurses' associations have an important role to play in the ongoing evolution of nurse entrepreneurship and a responsibility to support as well as monitor and evaluate the results in terms of health outcomes and nurses' sense of professional wellbeing. The research reported on in this thesis will further explore the themes portrayed in the conceptual model, and generate a theory on nursing entrepreneurship that enhances understanding of this dynamic area of practice.

Summary

The conceptual model identified and related the aspects of being a self-employed nurse entrepreneur as experienced in nurses' everyday lives. The model provides insights into how nurses could be affected by environmental and psychosocial influences. This chapter

establishes the need for further research in this area of nursing practice. The study has been situated in a global body of literature explored in relation to the knowledge base of nursing. Entrepreneurship is of concern to nursing and of interest to nursing. Addressing this issue in this thesis will give voice to nurses in private practice.

In the next chapter, the philosophical orientation that guided the inquiry and the methodological approach taken will be explained.

STAGE TWO : PREPARATION FOR THE JOURNEY

CHAPTER FOUR ~ THEORETICAL FRAMEWORK

In order to enhance understanding of the methodology and methods chosen for this research study, namely Grounded Theory and Delphi technique, this chapter introduces Symbolic Interactionism as the theoretical orientation for the investigation. Grounded Theory and Symbolic Interactionism are purported to share similar basic tenets and so an understanding of Symbolic Interactionism enhances understanding of Grounded Theory (de Laine 1997). A branch of interpretive sociology, Symbolic Interactionism aims to explain the behaviour of individuals in relation to the interaction that occurs between them and their environment (Bowling 1997). In using Symbolic Interactionism as the theoretical framework underpinning Grounded Theory, the researcher hopes to identify with the ideas, values, interpretations, meanings and the social worlds of the individuals in the study. Understanding the social worlds of the individuals in the study will help to reveal the meanings inherent in their decisions, their experiences and their interactions. Taking this approach for the study allowed the researcher to begin with general ideas and develop a framework underpinned with inductive reasoning.

Symbolic Interactionism as a philosophical orientation

Developed by American George Herbert Mead (1863-1931) in the 1920s and 1930s, part of Symbolic Interactionism looks at peoples' concept of self (de Laine 1997). He believed that how people see themselves is constructed on how they perceive others seeing them. Another sociologist, Cooley (1964), termed this concept the 'looking glass self'. Herbert Blumer (1900-1987) took Mead's ideas and developed them into a more systematic sociological approach, coining the term Symbolic Interactionism in 1937. A branch of interpretive

sociology, the approach aims to explain social action by understanding the ideas, values, interpretations, meanings and the social world of individuals. Central to Symbolic Interactionism is the 'definition of the situation' the individual finds themselves to be in and the importance of the meaning of that definition for them (Harris 1996). In describing Symbolic Interactionism, Blumer explains:

The term "symbolic interaction" refers, of course, to the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response" is not made directly to the actions of one another but instead is based on the meaning, which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions. This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behaviour (Blumer 1969:180).

In this explanation, Blumer identified the main characteristics of the Symbolic Interactionist approach as: human interaction, interpretation or definition rather than reaction to the environment, response based on meaning, the use of symbols and interpretation of stimulus and response (Gingrich 2000). This interpretive process constructs the meaning of the social experience as it was lived in the environment.

Symbolic Interactionism is guided by assumptions that human behaviour is a reaction to external stimuli and is able to be systematically observed and measured (Benzies and Allen 2001). Adopting research methods that are appropriate to the topic of study, that are

rigorous, critical and objective, ensuring the systematic collection, analysis, and presentation of data increases the rigour of this type of social science research.

Bowling (1997) recommends that in contemporary social science, it is important that inductive approaches are applied so the researcher can begin with a topic and allow what is relevant to emerge from the analysis. Symbolic Interactionism is a theoretical orientation of social psychology and is an approach that has evolved principally from social behaviourism (Benzies and Allen 2001). It stresses the nature of human interaction which uses linguistic and gestured communication and in particular, language in the formation of mind, self and society (Benzies and Allen 2001). A pragmatic approach to the scientific study of human group life and human conduct, Symbolic Interactionism focuses on problems originating in daily life and the interpretation individuals derive from it. Originating amongst pragmatist philosophers such as George Herbert Mead, Charles Cooley and John Dewey, Symbolic Interactionism seeks to unify rational thought and logical processes with practical actions and appeals to experience (Harris 1996). Equally pragmatic, Grounded Theory is a process of discovering theory from data that have been systematically gathered and analysed. Theory is inductively derived during a process where data gathering, analysis and theory share a reciprocal relationship (Punch 1998).

Mead's Theory of Self

Mead's theory considered the self as the central component in the individual's life. The self arises from seeing things as others, both real and imagined, see them and taking their viewpoint (de Laine 1997). The self is designated as having an "I", an individual and personal dimension that is capable of performing behaviours and a "me" as a social dimension with an organised set of attitudes that are assumed as required (de Laine 1997). The self is an unfolding entity constituted out of the process of interaction between the "I"

and the "me". Self-identity emerges from the social interactions of humans and is modified as the self and the other adjusts to the changing situation. Drawing on the work of other pragmatists, Mead stressed the conscious mind, self-awareness and self-regulation of the social actors who are the individuals performing the action (Harris 1996). The interaction of an individual's self-conception ("I") and the generalised perceived view that others have of the individual ("me") is central to conceptualising Symbolic Interactionism (Harris 1996). As demonstrated in Figure 3, "me" is at the point of intersection between self and the other is being continually modified and is constituted in cultural roles, for example, those of nurse or mother. These elements are central to the concepts underlying Symbolic Interactionism.

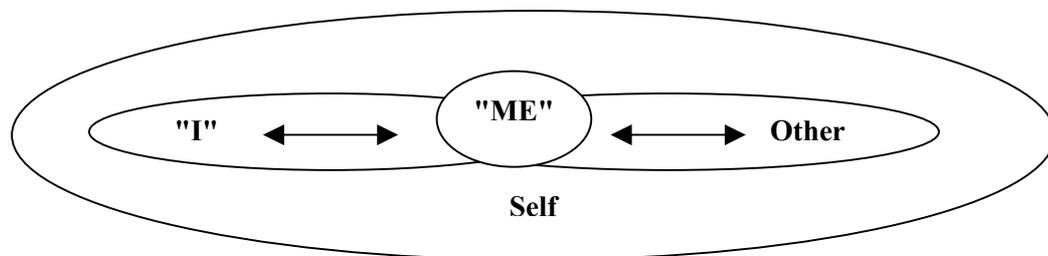


Figure 3: Mead's "I" - "Me" phases of the self (Adapted from: de Laine 1997)

Key ideas and concepts useful in guiding the inquiry

Three essential assumptions guide Symbolic Interactionism (Harris 1996). The first assumption considers that human beings act towards things based on the meanings those things have for them. Placed in this is the second assumption, that meanings arise from communications the individual has with others and through which the self is constructed. The third assumption asserts the person uses an interpretative process to deal with each instance in his [sic] environment (Harris 1996). The process and the environment are vital in the person's use of meaning and adjustment, allowing social activity to become possible through the role taking process. The greatest emphasis for Symbolic Interactionists is on the interactions among people (Gingrich 2000). With the use of thought, individuals modify

their interpretations of communications and different points of view eventuate to affect their behaviour (Nelson 1998).

Symbolic Interactionists believe the social world exists as a creation of human interactions and that society consists of individuals who are involved in interacting within larger networks. These social processes can be flexible and adjustable and may change depending on the interactions within. Reciprocal social interaction within these networks influences behaviour and the ensuing character of society (Benzies and Allen 2001). Symbols are used extensively and creatively in communication and interaction between human beings (Gingrich 2000). Therefore, Symbolic Interactionism provides a theoretical perspective for studying how individuals interpret objects and other people in their lives and how this process of interpretation directs their behaviour or actions in specific situations. The role of language and symbolic communication is important as an aspect of evolving human nature. 'Negotiation of the self' is considered the defining characteristic of Symbolic Interactionism (de Laine 1997). The self is formed through communication with others and develops over a lifetime. Its development is subject to the contingencies of everyday life and the variety of life-cycle alterations that affect health.

Symbols, in the form of words or actions, can be used to represent meanings associated with interpretation, action and interaction (Nelson 1998). At one level, symbols as the representation of one thing for another thing may appear fixed but the Symbolic Interactionist approach emphasises flexibility, variability and creativity in the use of symbols. The symbol may be significant in that it shares its meaning with another such as, for example, words often do. This process of adjustment and change underlies the process of analysis involved in all aspects for the use of symbols and communication (Gingrich 2000). The self is shaped through this process of change, adjustment and becoming and maintains flexibility allowing

for constant adjustment to others (Gingrich 2000). The process of change and adjustment is represented in many nursing situations, for example where a nurse may assist a morbidly injured person build a new sense of self and identity through interaction. Therefore, the self emerges from how the individual detects others see them and how the person responds to and develops responses to this (Gingrich 2000).

Implication for nursing theory development

Although a well known theoretical perspective for qualitative inquiry, Symbolic Interactionism also provides a structure for quantitative studies (Benzies and Allen 2001). Its assumptions are compatible with quantitative methods, allowing systematic, quantifiable measures to be applied. Combining methods within a single study to investigate the same phenomenon may serve to increase the depth and breadth of knowledge about human health by offsetting the biases inherent in each method (Polit and Hungler 1995). Associated with Grounded Theory for its focus on process analysis, it could be integrated with other theoretical frameworks in multiple method designs (Benzies and Allen 2001).

As, already asserted, underlying Symbolic Interactionism is the major assumption that individuals act because of the meaning that things have for them (Harris 1996). Importantly, the individual and the context in which that individual exists are inseparable. As an interpretive paradigm, it supports a holistic view of human health in nursing, defending beliefs that human beings are best understood in relation to their environment (Benzies and Allen 2001). As a theoretical perspective for multiple method research, it provides the means with which to systematically study human social behaviour with a distinct theoretical perspective (Benzies and Allen 2001). The understanding of covert human behaviour in terms of definition, interpretation and meaning differentiates the Symbolic Interactionist

perspective from that of behaviourists who focus on measurement of observable behaviours (Benzies and Allen 2001).

Within the Symbolic Interactionist perspective, nursing research is located in the natural world of human behaviour and social life (Benzies and Allen 2001). The individual and their environment have precedence to express what is important from their perspective, in order to understand the connection between the shared meanings and human behaviour. Research questions in Symbolic Interactionism emphasise process rather than structure and the need to understand the process and how meaning is attributed by the individual, hence the association with Grounded Theory (de Laine 1997). The history and past experiences of the group are also important as both locate the individual and the situation within time and past events. Data collection includes information about personal changes, including the family environment, and in behaviour over time.

An understanding of the research process is important for achieving a deeper understanding of the nurses' perspectives. Symbolic Interactionism asserts individuals interpret cultural values based on their goals and the perceptions of the consequences of their actions (Gingrich 2000). As in Grounded Theory, researchers need to examine the degree to which their conclusions are based on data volunteered by participants as in semi-structured interviews or on data directed by prior assumptions of the researcher.

Development of an interpretative framework

The concepts in the framework of Symbolic Interactionism have value in a study of people having difficulty establishing a reputation (de Laine 1997). This difficulty may be because of re-deployment, retrenchment, dissatisfaction or forced early retirement. The 'negotiation of

the self' as a defining characteristic of Symbolic Interactionism seeks to achieve a match between the subjective felt identity and public self-image (de Laine 1997).

The Symbolic Interactionist perspective emphasises the shifting, flexible, and creative manner in which humans use symbols as the representation of one thing or another. The processes of adjustment and change involve individual interactions and larger scale features such as norms and order. Plummer (2000: 224) notes how "habit, routine, and shared meanings occur, but how these are always open to reappraisal and further adjustment". The Symbolic Interactionist examines and analyses the processes involved in all aspects of the use of symbols and communication.

People constantly change, adjust and become in an active social world that experiences constant adjustment and organisation as essential features of social interaction (Gingrich 2000). The self is created through such interactions, but it is not necessarily fixed and inflexible, but one that is constantly adjusting to others and the environment. In research, the concern is with how the self develops, how individual lives develop, how social order is constantly adapted and how larger social forces emerge from these (Benzies and Allen 2001). For the Symbolic Interactionist, the world is an active one and society is this active social world.

Perhaps one of the main reasons that Symbolic Interaction has remained an important theoretical influence during most of the twentieth century is because of its attention to what actually occurs as humans interact. While the Symbolic Interaction perspective may seem to lack well developed concepts, logical models, or theoretical rigour, it makes up for this by studying the actual interaction of people in the social world (Benzies and Allen 2001).

The value of Symbolic Interactionism in the construction and conduct of questionnaires and interviews is stressed by de Laine (1997). As a theoretical framework for interviewing, the basic propositions of social interaction, role taking, interpreting and defining before responding are central to the model that might be used when constructing questionnaires. Empathising with the other and taking their perspective is essential for understanding social interaction in everyday life. In doing so, the researcher designing a questionnaire is provided with an insight into how the respondent may view the questions and context of the survey (de Laine 1997). This interactionist approach taken by the researcher towards understanding question-answer behaviour heightened the success of the questionnaires to which a high return rate and low drop-out rate was achieved.

Grounded Theory

Grounded Theory lies in the constructivist / interpretive paradigm and is underpinned by the theory of Symbolic Interactionism (Chenitz and Swanson 1986). Grounded Theory uses a Symbolic Interactionist perspective in its endeavour to understand human behaviour from the perspective of the people. It is a methodological approach entailing a cyclical process of induction, deduction and verification, and a set of strategies of data analysis to improve the reliability and theoretical depth of analysis (Green 1998).

Interested in exploring human behaviour that has been influenced by social forces or processes, Grounded Theory is oriented toward action or change from the perspective of human interactions. To discover theory about behavioural change, Grounded Theory asks about social process from within human interactions. By choosing this methodological design, the researcher hoped that nurses participating in the study would better understand their own theoretical interest in business development and self-employment through a process of participation, reflection and 'discussion' in iterative Delphi Technique rounds.

Grounded Theory and its relationship to Symbolic Interactionism

Similar to Symbolic Interactionism, the development of Grounded Theory was influenced by the sociological and philosophical traditions of sociology at the University of Chicago from the 1920s (de Laine 1997; Gingrich 2002). The Chicago School of Sociology emphasised the need to understand the actor's viewpoint in the process of interaction and social change. Contained in social processes are the person's experiences as they interact in an environment of social change. Anselm Strauss, a co-founder of Grounded Theory, spent time at the University of Chicago and was consequently influenced by interactionist and pragmatic writings, including those of George Mead, John Dewey and Herbert Blumer (de Laine 1997; Nelson 1998). Joining with Barney Glaser, who was trained in middle range theories and quantitative analysis, together they developed Grounded Theory, a qualitative approach to research (Green 1998).

As already stated, the tenets of Grounded Theory are based on those of Symbolic Interactionism. They emphasise the importance of theory grounded in reality, the continuing evolving nature of experience, the active role of persons in shaping the worlds they live in, an emphasis on change and process, and the inter-relationships among conditions, meaning and action (de Laine 1997; Nelson 1998).

Theory development involves exploration and formulation of propositions about the relationships among categories of data and building these propositions into theoretical schemes. Both Grounded Theory and Symbolic Interactionism focus on research interested in discovering regularities (de Laine 1997). They encourage processes of inductive reasoning from observations and build up general statements from them for testing. Both have theoretical perspectives that allow what is relevant to emerge. Both place social interaction and social processes at the centre of attention.

Grounded Theory entails a process of generating theory from data that have been systematically gathered and analysed. This allowed the investigator to start with general ideas and develop a framework for the study. Symbolic Interactionism stresses the need for the researcher to approach the topic without pre-conceived ideas (Bowling 1997).

Themes commonly addressed with Symbolic Interactionism are organisational communication, change, culture, power and institutional theory. Symbolic Interactionism sees culture as a result of the shared understandings people have of appropriate ways of behaving (Harris 1996). In keeping with this ideology, this research study investigated, a change in culture amongst a group of nurses, organisational change in the health sector and change in the way in which a group perceived their power.

Summary

This chapter has explained how the three key assumptions underlying Symbolic Interactionism focus on the meanings that events and things have for people, the language that arises in the process of interaction and the thought processes that modify the behaviours. Benzies and Allen (2001) assert that paying close attention to the assumptions will determine how clearly focused a study is. The use of Symbolic Interactionism as a theoretical perspective for multiple method designs in nursing research offers the hope of a richer, fuller, understanding of nursing and the individuals who are recipients of nursing services (Benzies and Allen 2001). The next chapter will discuss studies that have used Delphi Technique, postal surveys and Grounded Theory as methods of collecting information.

CHAPTER FIVE ~ OTHER DISCOURSES

This chapter examines some of the literature related to the research methods used in this inquiry. While these methods have been used in a variety of research studies, the concerns of this study are those factors which influence self-employed nurses and their experiences in private practice. Previous studies and literature have considered nurse practitioners and advanced nursing practice but have not addressed the issues central to this study.

Interpretation and foresight - Delphi technique

The RAND Corporation developed the Delphi technique in the 1960s as a methodology for forecasting future direction (Cline 1997). It was subsequently adapted as a group decision-making tool to maximise decision-making by informed panels whilst minimising the disadvantages of group interactions (Cline 1997; Pope and Mays 1999). The Delphi process takes its name from the oracle at Delphi whose skills of interpretation and foresight were legendary. The process proceeds in a series of rounds that measure a group's consensus on statements (Jones and Hunter 1995). Composed of three main characteristics: anonymity, statistical analysis and feedback to participants, the Delphi technique enables a researcher to obtain the opinion of experts without necessarily bringing them face to face (Armstrong 1989; Stuter 1996).

Delphi technique has been commonly adopted and used widely in medical, nursing and health services research (Jones and Hunter 1995). As a consensus research method Delphi technique aims to determine the extent to which people agree on a given issue. Given the flexibility of the technique, many forms of the Delphi exist and the original methodology has been modified to suit individual studies (Hasson, Keeney and McKenna 2000).

A search of the literature revealed an array of studies utilising Delphi technique in nursing and studies by researchers from other disciplines. Examples of the way in which the technique has been applied in nursing studies include: the clarification of nurses' roles (Peters, Hutchinson, MacKinnon, McIntosh, Cooke and Jones 2001; Roberts-Davis and Read 2001); for identifying educational needs of paediatric nurses (Twycross 2001); to identify factors influencing recruitment and retention (Huntley 1994); to identify nurses' research priorities (Annells, Averis, Brown, Gardner, Hockley, Surguy and Thornton 1997; Moreno-Casbas, Martín-Arribas, Orts-Cortés and Comet-Cortés 2001); to explore nurses perceptions of managed care (Harrison 1999); and to develop benchmarks (Crouch, Dale and Crow 2002). In medical research, Delphi technique has been used: to identify appropriate medical tasks; to identify general practitioners' information requirements; and to identify prescribing indicators (Green, Jones, Hughes and Williams 1999; Stewart et al. 1999; Campbell, Cantrill and Roberts 2000). In other health services research the Delphi technique has been the preferred method to investigate radiographers' supervision activities (Williams and Webb 1994) and the perceptions teachers, parents and health providers hold of quality of life in a public health study (Meuleners, Binns, Lee and Lower 2002).

Advantages of Delphi technique

Delphi technique assists with the management of decision making where there are problems making decisions arising from insufficient or conflicting information (Jones and Hunter 1995). A core advantage of the Delphi technique is that it is economical to conduct as participants are usually contacted by mail with a self-administered questionnaire, although computer communications can be used (Jones and Hunter 1995). Although only appropriate for investigating certain research problems, Delphi technique has been widely used in health service research (Jones and Hunter 1995). Hasson et al (2000) recommend careful consideration of the nature of the research problem when focusing on the suitability of this

method. Factors, which influence the decision, may include the resources available, the researcher's skills and issues surrounding communications between panel members (Hasson et al. 2000). Underpinning the method is a set of distinct features including group facilitation, participants who are knowledgeable of the particular area under investigation, iterative rounds of questionnaires and anonymity (Moore 1987). It is applied systematically through a multi-stage process designed to develop group consensus from opinion (Jones and Hunter 1995). The type of research objectives suited to the use of the Delphi technique are outlined by Green et al (1999:198):

- When the problem under study benefits from suggestive statements made on a collective basis;
- When more individuals are involved than can effectively interact in a face-to-face exchange;
- When disagreements are so severe or so politically unpalatable that the communication needs to be mediated by a third party, or anonymity preserved;
- When the researcher wishes to avoid a situation where strong or persuasive, personalities dominate the group.

Issues in using Delphi technique

A search of the literature that had utilised Delphi technique for a research based purpose produced nine articles that were analysed for dilemmas in its application, administration and reporting.

The major issues appeared to be in three distinct areas: sample size, criteria for defining consensus and reproducibility of the technique (Williams and Webb 1994). Sample sizes between the studies were vastly different, ranging from less than 20 to more than 450. Williams and Webb (1994) cautions researchers about too large a panel as this may yield an

extraordinary amount of data that is difficult to work with reliably. Crouch et al (2002), on the other hand, stresses the selection of the panel for their knowledge of the topic is essential for the success of the study and takes priority. Having peculiar knowledge of the subject matter may also indicate a higher level of interest and therefore a larger return rate of questionnaires.

There is not common agreement on the size of the panel in Delphi technique and neither are there recommendations concerning sampling techniques (Moreno-Casbas et al. 2001). Consequently, the size of the panel is left to the researcher to determine, depending upon the features of the research topic and study design. Conflicting opinions exist on the matter. For example, Meuleners et al (2002:342) recommended that a "Delphi sample size should be between 10 and 50 participants", whereas Duffield (1988) argued that the panel size is a matter of discretion for the researcher and should not be decided purely on statistical grounds.

Choosing respondents from a known cohort which firmly fits the criteria for inclusion enables the result to be considered representative of the whole population (Williams and Webb 1994). In that they were actively working as self-employed nurses, participants in this thesis were considered to be 'experts' of the subject under investigation and to be representative of that area of nursing.

The issue of determining when consensus is reached is an important consideration although not all studies examined reported on this. Williams and Webb (1994) argue that allowing the data to determine the level of consensus weakens the study and is best determined beforehand. In Williams' and Webb's (1994) study, consensus was determined at 100% when the pilot study was analysed as this gave a guide to how participants may score items. In contrast, Moreno-Casbas et al (2002) set a pre-established consensus level of 65% and

Loughlin and Moore (1979, as cited in Crouch et al 2000:28) suggest "consensus should be equated with 51% agreement".

Gathering information - Postal surveys

A major aspect of any research is the gathering of information. No matter what the basis of the study, McLennan (1999:1) believes it is essential to define the purposes of the study and to translate these into specific information requirements by asking four questions:

- What is the population being studied?
- What does the researcher want to know about this population?
- Is the information required to be collected more than once?
- Is a survey appropriate?

Choosing the most suitable and appropriate method for collecting data depends on a number of factors, such as the nature of the questions, resources available, time constraints and information on the sampling frame (McLennan 1999). The choice is then, McLennan (1999) asserts, whether to conduct personal interviews or a self-enumeration survey which is primarily postal. As the choice in this study was postal survey, that method of data collection will be discussed.

Advantages and disadvantages of postal surveys

Postal surveys can provide an effective and efficient method of data collection, particularly where a sample is widely spread geographically (McLennan 1999). They may also be the method of choice where names and addresses of the sample, as in this inquiry, are available (Duoba and Maindonald 1988). In addition, surveys are relatively inexpensive to conduct if

research monies are not available. The ability to establish and monitor a period for data collection is another advantage where there are time constraints.

The major disadvantage of postal surveys is that they usually have lower response rates and that has the potential to generate problems with data quality and reliability (McLennan 1999). Other issues to consider are the standard of written English that is easily understandable and keeping questions meaningful to respondents (Fink and Kosecoff 1985). Robertson (1994) recommends one way to address some of these concerns is to conduct a pilot study in the research setting. In doing so, the feasibility of the proposed survey is tested; problems in the survey design may be revealed; and the tool is tested for objectivity, validity, sensitivity and reliability (Dunning and Martin 1996).

Issues from other studies

Various topics were discovered in other studies when undertaking a review of the literature for this inquiry. As demonstrated by the many different studies uncovered, surveys are a popular method in both quantitative and qualitative research. They often allowed the researcher an interactive perspective by using open-ended questions (Britten 1995). Some of these studies will now be addressed and particular issues identified by the authors discussed.

Of the studies reviewed, the sample size and number of items surveyed in the studies varied widely, as did the topics covered. Etter and Pernegar (2000) applied a survey to smokers in the general population of Geneva, Switzerland. Although they used snowball technique to increase their sample, only one third of the people returned the questionnaires.

Sample sizes in the literature ranged from 30 to over 1100 participants and the number of items in the surveys varied from 18 to 60. The research study being reported on compares

favourably with these numbers. The sample sizes were 59 and 54 respectively for Questionnaires One and Two. In this inquiry, the first questionnaire contained 37 items, some with more than one statement. The second questionnaire contained 26 items.

Other studies applied surveys to gather information on nurses' concerns, roles and scope of practice (Dunt, Temple-Smith and Johnson 1990; Bonawit and Evans 1996; Bonawit and Watson 1996; McGee, Castledine and Brown 1996; Magennis et al. 1999); drug use amongst young people (Boys, Marsden and Strang 2001); individuals with diabetes (Dunning and Martin 1996); evaluations of nurses' and midwives' patients (Smith 1994; Paine, Lang, Strobino, Johnson, De Joseph, Declercq, Gagnon, Scupholme and Ross 1999); professional autonomy in nurses (Henry 1998); and the impact of graduate education on nurses' careers (Pelletier et al. 1998).

Three major issues raised by authors of the literature encompassed small sample numbers that led to problems of bias on the study, confusion with terminology resulting in inappropriate responses and the variables overlooked for inclusion. Etter and Perneger (2000) found their sample size doubled by allowing non-eligible persons to transmit the questionnaire to someone they knew to be eligible. Bonawit and Evans (1996) had trouble with common understanding of terms used and acknowledged pre-determined definitions would have been useful. Both of these issues are addressed in this inquiry through the application of the snowball technique to increase sample size from an invisible population, the conduct of a pilot study and the provision of definitions of terms in the surveys (Robertson 1994; Dunning and Martin 1996; Boys et al. 2001).

In summary, surveys are a generalised means of data collection using interviews or questionnaires (The Royal Windsor Society for Nursing Research 1999b). There are no

typical formats for a survey as they are designed to meet the needs of the researcher or fit the topic of research.

Discovering the voices - Grounded Theory

Grounded Theory has been described not so much as a specific method or technique but more as a style of doing qualitative analysis (Strauss 1987). The emphasis is on the discovery of theory from data collected from social research (Wimpenny and Gass 2000). Glaser and Strauss (1967) argue that data collected without having set about to do this from a prior basis of theoretical knowledge results in the development of a theory ill-suited to its anticipated uses. Therefore, it is understood that the principal aim to be achieved is the generation of theory from an inductive approach that allows whatever is theoretically relevant to the population of interest to emerge. Using this approach, Grounded Theory provides a means of studying human behaviour and interaction, creating a new perspective on and understanding of common behaviour (Sheldon 1998).

Grounded Theory, as an approach to inquiry was adapted beyond the field of social research where it began. Glaser (1978) points out that researchers in fields other than sociology have found Grounded Theory useful. Wimpenny and Gass (2000:148) suggest that "such utility supports the use of Grounded Theory in attempting to understand the complex social world of nurses". Gray and Pratt (1991) confirm that Grounded Theory is used to enhance nursing knowledge development, including the development of new roles for nurses in non-institutionalised settings.

The application of Grounded Theory by researchers who are investigating an area of inquiry in which they themselves are involved is supported by Glaser (1978). He recognises that researchers' own knowledge of the area is beneficial.

Grounded Theory is considered to be a useful method where little research has been done, in new domains or with small sample sizes (Borup 2002). Glaser and Strauss (1967) assert that it is important to gain a strong, broad base of information that helps to inform a general substantive theory on a topic from which other more focused studies arise. Grounded Theory emerged from the discipline of sociology and is based on Symbolic Interactionism (Beyea and Nicoll 1997). Similar to Symbolic Interactionism which was discussed in the previous chapter, Grounded Theory is about analysing social processes from within human behaviour and infers human behaviour is a product of processes influenced by social forces (Gray and Pratt 1991).

The issue of limited empirical literature being available to guide an inquiry is irrelevant in Grounded Theory. Strauss (1987) emphasises an extensive literature search is not undertaken as it may impede the process of allowing theory to emerge directly from the data and remain imbedded or 'grounded' in the data. Instead, review of the literature occurs continuously throughout data collection and analysis. Punch (1998) recommends the literature review is delayed or staggered until conceptual directions within the data have become clear. Initially, literature assists to guide the data collection process or to form initial research questions.

Similar to the Delphi technique, the sample in Grounded Theory includes people who are experiencing the social processes being investigated (The Royal Windsor Society for Nursing Research 1999a). Commonly, data are collected through unstructured questionnaires which allow the major concerns or point of views of the respondents to emerge (Wimpenny and Gass 2000). Continuous comparisons of these views with other data facilitates detection of emerging categories and concepts.

Critical challenges

Research studies utilising Grounded Theory in the nursing field appear to have focussed on either a specific population or a specific subject. A review of literature revealed a number of studies which primarily focussed on the experiences of the population under investigation and how these experiences influenced their behaviour (Williams and Webb 1994; Donovan 1995; Barclay, Donovan and Genovese 1996; Keddy, Sims and Stern 1996; Sheldon 1998; Ardern 1999; Chiang, Keatinge and Williams 2001; Kylmä, Vehviläinen-Julkunen and Lähdevirta 2001; Borup 2002).

The authors' experiences of using Grounded Theory as a method and their satisfaction with its outcome varied. Criticism focussed on its apparent lack of rigour, to its ability to fulfil the main aim of identifying and explaining the generalities that form substantive theory. In defence of the former criticism, Sheldon (1998:50) argues:

There has been a significant amount of criticism of the qualitative approach to research inquiry, particularly in relation to its lack of rigour. Grounded Theory, however, is sufficiently rigorous to interpret successfully patients' view of their experiences of hospitals. Fieldwork allows researchers to raise topics that otherwise would remain neglected.

In this quote, Sheldon is referring to 'patients' and 'hospitals'. Generalising this quote to 'participants' and 'in their contexts' is rational for its applicability across inquiries in different settings.

Keddy et al (1996:452) addresses the failure of Grounded Theory researchers to take the research conclusion to its finality by connecting the substantive theory to other social theories.

Researchers have left unaddressed the place of a given problem within the context of the larger social and political world. This would be easy to overcome as Grounded Theory methodology yields rich data that allows for strong political voices to be heard and reckoned with. By connecting a substantive theory with other well developed social theories and discovering where it goes beyond the latter, or refutes them, the research makes a contribution to knowledge that progresses beyond academic exercise to potential social action.

Summary

This chapter has discussed some of the literature that have used the research methods, Grounded Theory, postal surveys and Delphi technique and which have been chosen for this research. The methods were selected for their abilities to address the particular features inherent in the study. These are:

- To achieve agreement on issues experienced within the topic of inquiry
- To investigate an area of nursing where there has been little research, and
- To develop a substantive theory on private practice nursing.

The following chapter will discuss the methods as they applied for gathering information in this research in more detail.

STAGE THREE: SEARCHING

CHAPTER SIX ~ SEARCHING FOR INFORMATION

Selecting the research design for finding the answers to this inquiry's aims and objectives as provided in Chapter One is based on a considered, methodical plan. The methods for data collection through to the methods for data analysis were selected so that not only were the research aims addressed as validly, objectively and accurately as possible, but also so that the researcher controlled any error variances as the study progressed. The methods chosen to investigate this area of inquiry are detailed in this following chapter. These methods are both quantitative and qualitative in nature, namely, Grounded Theory, Delphi technique, and postal surveys including application of the Likert scale.

Choice of methods

The researcher's choice of research approach selected for this inquiry was done so based on the research aims and objectives. A qualitative approach was undertaken for identifying and describing matters such as behaviours, whereas a quantitative approach was taken for collecting demographic data and measuring responses to questions. It is apparent that each approach has a distinct purpose, using various methods to answer research objectives. The choice of Grounded Theory for this study is based on the writings of Glaser and Strauss (1967) to whom it is attributed.

In its quest to describe and explain phenomena, Grounded Theory is often considered more of a method and a way of thinking about, conceptualising and analysing data than a true methodology (Lye, Perer and Rahman 1997). In Grounded Theory, reality is socially and culturally based and the aim of using the approach is to understand the nature of human

behaviour by generating theories about social and psychological phenomena (Chenitz and Swanson 1986). With an emphasis on discovering what is taking place in the everyday environment for the participants, the researcher sought to obtain sensitively coded data to extract underlying reality (Glaser 1978). Semi-structured open-ended questions were selected as the most appropriate method to use as they allowed for a less restricted response, allowing participants to add comments and express their thoughts. The questions were asked via a self-enumerated questionnaire that was also designed to collect socio-demographic information about the nurse entrepreneurs who participated in this inquiry. Questions pertaining to the factors influencing the nurses were administered with a Likert scale and rated using Delphi technique. Each of these methods will be discussed in more detail.

Quantitative research

Quantitative research methods are based on the premise that the researchers and methods are objective and that variables can be measured precisely (Beyea and Nicoll 1997). Quantitative approaches to research inquiries have been successful in "measuring, analysing, replicating and applying knowledge gained from this method of inquiry" (Streubert and Carpenter 1995:1). The relationships between the variables are explored and the hypotheses tested in investigations that tend to be highly structured designs yielding numerical information (Polit and Hungler 1995). Surveys or questionnaires of the type conducted in this inquiry are typical non-experimental research designs that obtain data about the topic being studied (Polit and Hungler 1995). Data in this type of design are analysed with descriptive and inferential statistics (Beyea and Nicoll 1997).

Assessing rigour or quality in quantitative research involves the concepts of reliability and validity. The reliability of an instrument providing quantitative data is a major criterion for assessing consistency and adequacy in quantitative research (Polit and Hungler 1995). The

reliability of an instrument such as a survey is the degree of consistency with which it measures the attributes it is supposed to be measuring. Therefore, the less variation in repeated measurements of the same variable, the higher the reliability of the instrument and the stronger the stability, consistency or dependability of the tool (Polit and Hungler 1995).

Although reliability and validity are not totally independent qualities, a survey can be reliable without being valid. Validity, also an important criterion to evaluate an instrument's adequacy refers to the degree to which an instrument measures what it is meant to of the question (Punch 1998). According to Polit and Hungler (1995), validity is primarily concerned with the adequacy of the sample answering the questions being measured. Inadequate sampling may occur should the sample not represent the population of interest or if there is a significant number of non-responders to a question. Fortunately, neither of these issues were a concern in this research as the sample was specifically chosen to meet the criteria of being self-employed and, in this respect, was adequate to answer the research aim.

Qualitative research

In contrast to quantitative methods, qualitative methods focus on interpreting people's thoughts and behaviours, allowing them to influence the research process as needed (Ezzy 2001). The practice of using qualitative research arose from the social sciences because of a need to know about human phenomena that was not conducive to study by quantitative measurement (Streubert and Carpenter 1995). Concern for needing to understand more resulted in the utilisation of a group of methods in this thesis, including Grounded Theory and Delphi technique, that are diverse, complex and changing over time to suit differing research needs (Punch 1998).

Streubert and Carpenter (1995:10) emphasise six significant characteristics of qualitative research, which were adopted by the researcher in this inquiry:

- A belief that multiple realities exist that create meaning for the individuals being studied;
- Commitment to an inductive approach that focuses on discovery by allowing method and data collection strategies to change as needed;
- Commitment to reflecting the participants' points of view as with the use of unstructured or semi-structured questionnaires;
- Conduct of the inquiry in such a way that endeavours not to disturb the natural context of the phenomena;
- Participation of the researcher in the research as observer, interviewer or interpreter and therefore, the presence of subjective bias is acknowledged in methods such as Grounded Theory;
- The findings of the study are reported in a literary style containing participants' commentary and reflecting their experience.

The findings of qualitative research are the researcher's interpretations of participants' experiences; therefore, they provide an understanding of their social interaction and the social processes involved. To facilitate the discovery of information from the participants' perspective, approaches to method and data collection may change as the study progresses, should a need be identified (Streubert and Carpenter 1995).

Criticisms of qualitative research methods

There have been differences of opinions expressed as to the purposes of qualitative research. According to Pope and Mays (1995), the goal of qualitative research is:

The development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of all the participants.

Ezzy (2001) disagrees with Pope and Mays (1995) and argues that natural or untreated research settings do not adequately deal with concerns of subjectivity and relativity as a source of bias. He argues that just using the right methods does not remove bias and recommends an interpretative model of unbiased research. With this approach, the interpretations of participants' experiences are accurately described as well as the social processes underlying these interpretations. The researcher examined how particular social processes in this inquiry generate different understandings of the phenomena as "either a disaster or an opportunity to re-consider one's self" (Ezzy 2001:295). This last comment of Ezzy's was drawn upon by the researcher and seen to complement the methods for this inquiry as going into business and becoming an entrepreneur may be considered to result in disaster or an amendment to one's person or situation.

Mays and Pope (1995) observe that because of the strong tradition of biomedical research using conventional, quantitative methods, qualitative research is often criticised for lacking scientific rigour. Some common criticisms are that the results are an assembly of anecdote and personal impressions strongly subject to researcher bias and that qualitative research lacks reproducibility and generalisability as a large amount of information is general about a small number of respondents (Mays and Pope 1995). Mays and Pope (1995:109) refute these criticisms, pointing out, "the problem of the relation of a piece of research to some presumed underlying 'truth' applies to the conduct of any form of social research". Strategies they recommend to encourage rigour in qualitative research are systematic and self conscious research design, an account of the methods chosen and data collected and provision of a

plausible explanation of the matter under investigation. Green and Britten (1998) defend the use of the personal anecdote in research. They insist there are important differences between stories told for a dramatic effect and qualitative research where there is critical evaluation of their contribution to the area. Explicit sampling strategies, systematic analysis of data, examination of contradictory answers with openness about the methods used are all recommended to ensure validity and rigour (Green and Britten 1998).

Qualitative research can enrich our knowledge of aspects of health and health care and much has been written on the value of sociology for nursing (Bowling 1997). Qualitative research can contribute description and understanding to questions in a way that quantitative research cannot. However, as previously discussed, this does not imply quantitative research is redundant where qualitative research methods are used and the two methods are able to complement each other.

Combining qualitative and quantitative methods in one study

Combining qualitative with quantitative methods in research is a common strategy for enriching an area of inquiry (Bowling 1997). Combining qualitative and quantitative methods in one study can help to build a wider picture of the issues under investigation by illustrating the meaning of quantified descriptions or relationships. Polit and Hungler (1995) argue that an advantage of integrating different methods of research is to overcome or diminish the weaknesses in a single approach. For the researcher, the strength of precision and control in quantitative methods complemented the potential weaknesses of smaller sample and subjective data in qualitative research. Consequently, a combined methodological approach was undertaken in this inquiry through the utilisation of both questionnaires and Grounded Theory. By using both methods, the researcher allowed each

method to do what it does best, with the possibility of avoiding the limitations of a single method approach.

In using methods in combination, there appears a constructive and complementary, rather than an exclusive relationship between the methods. In using quantitative and qualitative methods, the two fundamental languages of human communication namely, words and numbers are used (Polit and Hungler 1995). Whilst quantitative methods often demonstrate that variables are systematically related to one another, they often fail to provide insights about why this is so. Integrated analyses interpret and give shape to relationships and causal processes. Glaser and Strauss (1967) favour the use of combining data in an attempt to enhance the meanings inherent in the information. Different types of data may be used to supplement each other as different forms of the same data from one or all participants in a study may facilitate the process of generating theory (Glaser and Strauss 1967).

Pope and Mays (1995) suggest combined methods can be applied before quantitative research to provide description and understanding of a situation or behaviour. In this inquiry, this strategy was used to establish themes from the literature for exploration by Delphi technique. Alternatively, quantitative data may provide demographic data on participants in a qualitative study as was done in this research. Combining methods allowed the exploration of complex aspects such as behaviours, attitudes and interactions through the application of Delphi technique and process analysis (Pope and Mays 1995).

Grounded Theory approach in this thesis

The use of Grounded Theory in the social sciences, including nursing, has been shown to increase understanding of experiences associated with life events (McCutcheon and Pincombe 2001). The objective of Grounded Theory is the development of theory that

explains basic patterns common in social life in order to understand the social construct, as in this case, of private practice nursing (Chenitz and Swanson 1986). In the present study, Grounded Theory helped to reveal nurses' perceptions of that which they experienced on a daily basis. This facilitated the emergence of a plausible substantive theory on the issue under investigation.

Since its development, Grounded Theory has traversed a rocky path with the separating of its originators when they developed contrasting views on the fundamental processes underlying the method. Strauss united with Corbin and they developed one coding paradigm, axial coding, in contrast to Glaser, who "set out a range of possibilities for integrating categories through theoretical coding " (Dey 1999:11). In addition, Strauss and Corbin (1990) proposed a matrix setting out a range of conditions or consequences which Glaser (1978) believed constrained the development of theory.

These dichotomous views to the application of Grounded Theory presented the researcher with a dilemma when preparing for this research. After reading widely on Grounded Theory, the decision was made to follow the style of the original, early explanations of the method by Glaser and Strauss (1967). In the researcher's opinion, their style offered a systematic set of procedures that best provided the means to form a true substantive theory. This was considered important to gain a strong, broad base of information from those experiencing the topic of investigation. It was anticipated this would form a general substantive theory on private practice nursing and provide a guide to other possibly more focused studies.

Characteristics of Grounded Theory

Grounded Theory aims to identify constructs, categories and relationships within the action of that which is occurring. Concepts as units of analysis generate the formation of categories

formed from the grouping of the concepts. This process of generating concepts enabled the researcher to make assumptions from the data that then guided theoretical sampling for the gathering of further information to answer the study's questions. The intent was to develop an account of the phenomena and through a systematic process, lead to identification of theory (de Laine 1997; Sheldon 1998). The findings of the study are described in descriptive language.

The potential for nursing lies in Grounded Theory's ability to allow new knowledge to be uncovered and articulated. One of Grounded Theory's major benefits is its flexibility through which it allows for change to occur over time, and allows participants of the study to tell their story as they perceive it (Sheldon 1998). This process was aided by five fundamental characteristics of Grounded Theory theoretical sensitivity, theoretical sampling, constant comparative analysis, use of the literature and memo writing.

Theoretical sensitivity

The researcher's experience of the problem was considered an asset which increased her theoretical sensitivity to develop theory (Glaser 1978). Possibly, the most important skill required of the researcher was that of sensitivity to the information rising from the data. Glaser (1992:27) aptly described theoretical sensitivity as:

The researcher's knowledge, understanding and skill, which fosters his [sic] generation of categories and properties and increase his ability to relate them into hypotheses and to further integrate the hypotheses, according to emergent theoretical codes.

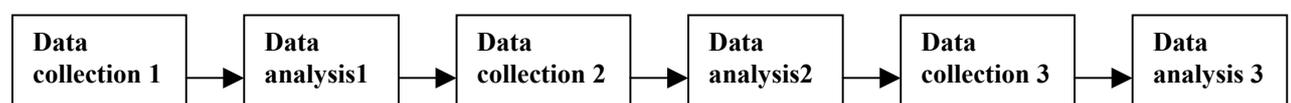
In short, theoretical sensitivity was the ability to generate concepts from data and relate them to the emerging theory. The researcher's professional experiences and in depth knowledge of the area helped in the generation of live (in-vivo) categories (Glaser 1992). Theoretical sensitivity guided on-going, appropriate theoretical sampling.

Theoretical sampling

Primary selection is the preferred strategy for theoretical sampling and is an integral part of maintaining rigour in Grounded Theory research (Glaser and Strauss 1967). Primary selection meant that the researcher recruited participants for the study and had control over the composition of the sample (Chiang et al. 2001). This level of control was important for theoretical sampling because it enhanced relevant data input for the constant comparative method which is integral to Grounded Theory (Glaser and Strauss 1967).

In the principle of theoretical sampling is contained the notion that data collection is guided by the development of concepts and categories as data are analysed (Punch 1998). In addition, determining who will next be sampled and why they are chosen is an integral part of theoretical sampling. In this study, theoretical sampling processes were modified in view of the limited population available and data were sourced from literature. The cycle of data collection and analysis (Figure 4) continued until theoretical saturation was reached.

Theoretical saturation was achieved when no new data or concepts pertaining to the study objectives emerged (Punch 1998). In some instances, data actually confirmed what had already been discovered.



Constant comparative analysis

The continual process of data collection and analysis guided the researcher's choice of data collection methods and definitive sample population. Being a convenience sample, the population did not change with data collection. Using this method, the researcher focused progressively on the data and emerging themes. The flexible approach of Grounded Theory allowed for sampling the views and behaviours of different groups of nurses in the literature, such as educators, managers and specialist nurses as the research process progressed. The quality of the developing theory was determined by the researcher's ability to explain new data and fulfil the major aim of theory generation (Gray and Pratt 1991). Using constant comparative analysis, the researcher anticipated the generation of a theory to describe the core category that characterises the behaviour of the study group (Chenitz and Swanson 1986). Analysis involved the comparison of data with data, data with literature and / or data with personal accounts. A variety of information sources was used to provide more in-depth knowledge about the core category by questioning the data in relation to the core category. One such question was, for example, "are there stages involved in developing private practice?"

During analysis, three processes occurred from which sampling procedures were derived.

These could overlap as need be:

- open coding, to break down data and extract concepts to form categories;
- the application of theoretical coding to identify connections between categories and their properties; and
- selective coding, where open coding ceases and the process to choose one category to be the core category to which all other categories relate begins (Glaser 1992).

During analysis, notes were made on the similarities with, or differences to, other data. Codes were used to develop categories from data with thematic analysis to make links between categories and develop theoretical propositions (de Laine 1997). Utilising this process led to the development of a single theme around which all other data related. Throughout the analysis process, memos and notes written by the researcher kept track of the developing theory.

Memo writing

During the research process memos written by the researcher, helped her to keep focussed on the emerging categories and to capture ideas as they came to mind (Lye et al. 1997). Memos varied widely in content and assisted the researcher to develop theoretical sensitivity. According to Glaser (1978:83):

Memos are the theorising write-up of ideas about codes and their relationships as they strike the analyst while coding. Memos lead, naturally, to abstraction or ideation. Memoing is a constant process that begins when first coding data, and continues through reading memos or literature, sorting and writing papers or monograph to the very end. Memo-writing continually captures the "frontier of the analyst's thinking" as he [sic] goes through his data, codes, sorts and writes.

By writing memos from the beginning of first data collection, a file of freely developed codes was built from ideas that came to mind as data were viewed. These in turn were sorted into categories.

Grounded Theory offered a systematic method of collecting and analysing data in order to develop theory about a little researched area of nursing practice. In this study, Grounded

Theory helped the researcher make comparisons among an array of practices to develop new hypotheses and categories within a theoretical framework pertaining to private practice nursing. Combining Grounded Theory with another data collection method, Delphi technique, was feasible as both seek to gather participants' points of view on a given subject.

Delphi technique in this thesis

A consensus method such as Delphi technique provided another way of synthesising statistical information. In particular, it is amenable to using a wider range of information than often used in statistical methods or where literature is inadequate or minimal (Jones and Hunter 1996). Primarily concerned with deriving quantitative estimates through qualitative approaches, Delphi technique provides a useful way of identifying and measuring opinion in health services research. Delphi technique has been used to clarify particular issues in areas of nursing services, organisation and, as used in this inquiry, to define professional roles and enable long term projections of need of a particular group of nurses.

Delphi technique was conceived as a way to obtain the opinion of 'experts' without necessarily bringing them face-to-face. It has been found particularly useful in business arenas and seeks to achieve consensus through a three-step process of thesis, antithesis and synthesis (Stuter 1996). The method has been used to both identify priorities and to achieve consensus (Moreno-Casbas et al. 2001). Recognised as a time consuming method for the researcher because of multi-cycle administration of questionnaires, the advantage for respondents is personal choice of time and place to complete it. For a national inquiry investigating nurses conducting a business, it was necessary to be aware of geographical restrictions and be sensitive to the subjects' time limitations and availability to attend face-to-face meetings. Feedback on results from each round and iteration of selected items provided participants with the opportunity to modify their opinion on selected issues.

The principal advantage of employing Delphi technique in this national study was that it allowed access to a large number of opinions from a group widely spread geographically without needing to try to bring them together. The anonymity provided through its design had the advantage of eliminating group influences, which can occur in face-to-face group meetings and in reducing influences that may occur should the researcher be known to the participants. The researcher was conscious of achieving adequate coverage so that all possible categories were uncovered, thereby not allowing the convenience of the method to prevent the application of a more suitable method (Denzin and Lincoln 1994; Kizzier 1999).

Iteration

The Delphi process generally proceeds in iterated rounds to provide the panel the maximum opportunity to consider the issues. Normally, to generate questions for the first round, either individuals are invited to provide information based on their knowledge and experience or the researcher expresses statements and selects a suitable panel to respond to them in questionnaire rounds (Jones and Hunter 1999).

Although up to six rounds of Delphi have been known, it is becoming frequently more common for two to three rounds to be the maximum application, depending on the preparation for the individual study (Kizzier 1999). Following the lead of Stewart et al (1999) and Twycross (2001) the initial statements were generated from the expert literature rather than from rounds of Delphi technique and in doing so, reduced the number required. Also, self-employed nurses who were eligible for inclusion in the study were recognised at the outset and then those within the eligible group who were willing to take part were identified by their compliance with the first questionnaire. Responses were summarised and re-circulated to all participants (Jones and Hunter 1996). New statements developed from feedback, additional annotations and statements where consensus had not been reached were

applied in a repeat questionnaire. Rounds ceased when consensus had been reached and no new information requiring consideration by participants was provided (Jones and Hunter 1996).

Issues of rigour, reliability and validity

Rigour in combined research methods

One of the benefits of combining both methods in a single study was to be able to address directly any discrepancies that emerged. By investigating incongruent data, the constructs under investigation or the research process could be re-considered.

Morse, Barrett, Mayan, Olson, and Spiers (2002), stress that without rigour, research is worthless and loses its utility. They insist that rigour in research is equally important in both quantitative and qualitative research. The difference lies with the strategies applied for demonstrating and confirming rigour. Different views exist on what terminology should be given to describe what is termed reliability and validity in quantitative research, to that used in qualitative research.

While quantitative studies rely on the reliability of instruments as well as internal and external validity criteria as measures of scientific rigour, qualitative studies require other means more appropriate to the research approach. The need to apply appropriate qualitative criteria to qualitative research respects the philosophical foundation upon which qualitative inquiry rests. Rigour in qualitative research is important for minimising errors and enhancing the accuracy of the research. According to Bowling (1997:121), rigour refers to several essential features of the research process and includes:

- The systematic approach to research design.

- The awareness of the importance of interpretation and perception or assumption.
- The systematic and thorough collection, analysis and interpretation of the data.
- The maintenance of meticulous and detailed records.

One strategy, by which a research study may be shown to be reliable and therefore dependable, is for its process to be documented. For Koch (1998) dependability means leaving a decision trail discussing explicit decisions taken about the theoretical, methodological and analytic choices throughout the study. This is one of the possibilities for enhancing the rigour of the research product (Koch 1998). Bowling (1997:121) explains that as a decision trail, an audit is:

Directed at the maintenance and achievement of quality and aims to improve outcomes. Central to an audit is evaluation of the scientific method. In health services research and audit, evaluation records the changes that occur and what led to those changes. The rigorous and systematic collection of research data assess the effectiveness.

A decision trail includes information on raw data, methods of recording, analysis, literature, reconstruction, synthesis, methodological notes and personal notes (de Laine 1997). In this research, the decision trail recorded information centred on memos about researcher and participant expectations, journal notes, and methodological information. Other information included how the researcher became interested in the topic, how and why participants were recruited, the strategies used to collect and record data and the contexts within which data has been collected. The trail also provided information on how the theoretical background had an impact on the development of categories and conceptual frameworks. A trail illustrated how conceptual categories developed, how they related to the concepts identified in the data and

to explain the steps used in analysing the data. By informing the reader of processes, auditability is enhanced (Koch and Harrington 1998). Reporting on the processes also ensures the findings remain connected to the data.

Verification with participants:

Verifying results with participants has been supported as a strategy for determining rigour (Streubert and Carpenter 1995). Glaser (2002) does not support verification with participants and argues they are unable to appreciate the analytic process and methodological meanings inherent in the research process. Whereas Guba and Lincoln (cited in Denzin and Lincoln 1994), recommend confirming results with participants, Morse et al (2002) disagree with the suggestion, warning it is often more of a threat to validity. Also Morse et al (2002) do not support verification with participants for establishing reliability and validity and warn it may cause more harm than good and threaten the validity of research. They argue reliability and validity is ensured through verification strategies that are applied to be consistent with the research methodology chosen and therefore occur all the way through the process and are not just something applied at the end.

Alternatively, for a Grounded Theory study, Streubert and Carpenter (1995:160) offers four criteria for judging the applicability of theory to a substantive area. They are the criteria of fit, understanding, generality and control. Theory should fit the substantive area if it has been faithfully and carefully induced from the data. If insufficient data were collected this could not occur. Representing the participants' reality as it does, the theory should be understandable to them and those practising in the area. To have generality, the theory should be abstract enough and include sufficient variation to apply to a variety of contexts in the substantive area. Lastly, the theory should provide firm direction for private practice nursing.

Investigator responsiveness

The responsiveness, receptivity and sensitivity of the researcher to gathering and analysing data played an important part in the research process so that participants' points of view were accurately reflected (Morse, Barrett, Mayan, Olson and Spiers 2002). The use of creativity and sensitivity with verification strategies determined the reliability and validity of the study (Morse et al. 2002). For example, in this study ongoing analysis with the constant comparative method formed questions that guided theoretical sampling for gathering more information. To assist responsiveness, the researcher remained flexible and willing to concede that those ideas poorly supported must be relinquished regardless of personal feeling. Morse et al (2002:6) argue:

The lack of responsiveness of the investigator at all stages of the research process is the greatest hidden threat to validity and one that is poorly detected using post hoc criteria of "trustworthiness".

Ensuring both reliability and validity required activities such as an audit trail that developed a process of checking and confirming that the methods used during the research process contributed to rigour (Kvale 1989). Strategies that helped to verify rigour were those such as ensuring congruence between research question and methods, an appropriate sample, collecting and analysing data concurrently and developing a valid theory through conceptual understanding.

Validity and reliability in Delphi technique

There has been active debate on the validity of the Delphi technique. Although a statistical technique for data measurement, it commands different criteria for its application and supporters of scientific methods may find this difficult to accept. Criticisms of the method

centre on poor questionnaire design, methods of defining and selecting consensus and of experts for the panel (Jones and Hunter 1995). These issues were confronted by disciplined questionnaire design piloted prior to application, pre-determined consensus level and a sample knowledgeable on the area of research. Response rates concern Williams and Webb (1994) more. Should the response rate decrease between rounds, which was not a concern in this study as the drop-out rate was very low, the validity of the result is subject to response bias. The reliability of the technique is also questioned, as there is no evidence that the same information given to another panel who had been selected using the same criteria would achieve the same result (Williams and Webb 1994). Constant comparison of the themes emerging from the data analysis with the expert literature, combined with responsiveness, sensitivity and strategies as discussed confirmed congruence, fit and reliability.

As Delphi technique is frequently applied as a postal questionnaire, discussion will now focus on that method of collecting data.

Postal surveys

In keeping with the other methods selected for collecting data in this inquiry, a postal questionnaire was deemed the most appropriate tool to gather information. Questionnaires, as a survey research method, rely on questioning participants about their knowledge, beliefs, attitudes and feelings (Beanland, Schneider, LoBiondo-Wood and Haber 1999). There are no typical formats for a questionnaire and they are designed to meet the needs of the researcher or fit the topic of inquiry (The Royal Windsor Society for Nursing Research 1999b). Items used in the questionnaires were closed-ended as in when collecting socio-demographic information or open-ended when respondents were required to respond in their own words. Three response formats were incorporated. Questionnaires were structured to provide a fixed response as with a Likert scale, unstructured with the use of open-ended questions or semi-

structured where there was a mix of the two (Beanland et al. 1999). Unstructured, open-ended response formats allowed for a greater range of responses but also required a qualitative technique such as process analysis in Grounded Theory to analyse the information.

Advantages and disadvantages

When mailed, questionnaires are considered to have some specific advantages:

- They are regarded as relatively inexpensive in comparison to interviews,
- A larger and more diverse sample can be accessed geographically,
- There is no interviewer bias, and
- The anonymity of participants is preserved should this be crucial to obtaining candid responses (Polit and Hungler 1995; Beanland et al. 1999).

The most significant problem identified with postal questionnaires was that of response rate, which is known to be lower, on average, than in face-to-face interviews (Polit and Hungler 1995). It was therefore difficult to assume that those who did respond were typical of the population. Design of the questionnaire was important to facilitate the best response rate.

Design

The response rate can be affected by the manner in which questionnaires are designed and mailed. When constructing a questionnaire, Polit and Hungler (1995) recommend the layout and physical appearance of the questionnaire should be considered to make it as appealing as possible. The questions should be numbered and ordered under topics (Bowling 1997). A covering letter about the study with details of who to contact for further information is provided with the questionnaire (Bowling 1997). In addition, stamped, addressed return envelopes are essential and the use of follow-up reminders to achieve higher response rates.

Follow-up letters are usually sent two to three weeks after the initial mailing and often include another copy of the questionnaire (Polit and Hungler 1995). Incoming returned questionnaires are logged as they are received to record the response rate. All of these recommendations were addressed in the design of the questionnaires.

One way of being confident of the clarity and specificity of the questions and that the length of the questionnaire was suitable, was to conduct a pilot study. Piloting acts as a check on potential errors in the design, structure and analysis of the questionnaire (Bowling 1997). The researcher was able to ascertain whether each question measured what was intended, that the wording was understood, whether any questions were frequently missed or whether responses suggested relevant issues had been excluded (Bowling 1997). Relevant adjustments could then be made to the questionnaire before it was posted to participants.

The provision of the Likert scale to assist in the statistical measurement of opinions and provide standardisation of responses in questionnaires is an acknowledged method which will now be discussed.

Likert scale

Attitude measurement scales usually evaluate people's beliefs, feelings and or actions in a particular way such as with a degree of positivity or negativity (Bowling 1997). One such scale applied in this research is the Likert scale, a popular scaling method commonly used by sociologists (Bowling 1997). The scale assessed attitudes by presenting respondents with stated beliefs about the attitude being measured. Respondents were asked to indicate their degree of agreement or disagreement to the statements provided (Polit and Hungler 1995). The Likert scale was relatively quick for participants to respond to and this made it an attractive inclusion, for both participants and researcher, in the questionnaires.

Attitudes are underlying constructs, which, as one of the unifying principles of the personality influence behaviour (Magennis et al. 1999). They are perceptions formed on previous emotional and perceptual evaluation and may be positive or negative toward a situation, person or thing (Magennis et al. 1999). It was hoped that identification of perceptions such as attitudes may give some indication of how nurses perceive their needs and role in relation to private practice nursing.

When developing a scale, Polit and Hungler (1995) recommend developing a large pool of statements that clearly state different positions and then choose ten to fifteen for inclusion in the Likert scale. They also recommend including statements that are worded both negatively and positively. Likert scales commonly, but not always use a five-point scale to measure response but are often constructed as four, seven or ten-point scales to measure categories from agreement to disagreement (Beanland et al. 1999). In the current study a four-point scale was used to overcome problems of central tendency where participants commonly indicate the central value as the easiest option.

Summary

This chapter has outlined the fundamental characteristics and application of the methods utilised in this research. Combining qualitative and quantitative methods, using Grounded Theory, applying Delphi technique, Likert scales, postal surveys and issues of rigour were discussed. The choice of methods for this study was considered appropriate to enable nurse entrepreneurs to express their knowledge and experience about private practice nursing so that the researcher may form a substantive theory. How these methods were applied in this research inquiry will now be explained in the following chapter.

CHAPTER SEVEN ~ PATH OF THE SEARCH

As already discussed in the previous chapters, the choice of methodology for this study was Grounded Theory. The method of applying Grounded Theory research procedures complemented by Delphi technique to this investigation involved several processes which will be elucidated in this chapter. A discussion regarding the development and refinement of the research question, sampling, literature review and role of the researcher in this investigation is followed by a dissemination of data generation, treatment and analysis.

Refining the research question

The nature of the Grounded Theory methodology requires that the research question be refined as data are generated and analysed in the study (Streubert and Carpenter 1995). The research question at the start of this inquiry gave focus and helped clarify that which was to be studied as the research progressed. As preparation for the study progressed and various theoretical and philosophical underpinnings were considered, it was increasingly evident that a Grounded Theory methodology would be appropriate. The research question was subsequently refined in two ways – to identify social processes and to develop theory on private practice nursing.

Sample

The requirement of the Delphi technique to have an ‘expert panel’ of informed participants in the area of inquiry was one of the main criteria for selection of the sample. Volunteers for this study were sought from the membership of the only known group of self-employed nurses, *Nurses and Midwives in Private Practice, Australia (NAMIPPA)*, which is now named *Nurses in Business (NIB)*. Members of the group included nurses and midwives who

held roles as clinicians, researchers, educators or consultants. A criterion for inclusion in the study was defined as ‘nurses or midwives who receive at least some of their income by being self-employed in private practice’. As this research related to a specific area of practice, it was determined that members of the expert panel needed to be working in private practice and not only to hold an interest, as did some members of *NAMIPPA*.

Permission was sought from the Royal College of Nursing, Australia to access the database and approach the members of *NAMIPPA* to participate in the study (Appendix 7). At the time, the group was newly formed and membership numbers were low. Membership numbers increased considerably over the next twelve months but unfortunately second access to the membership was denied as access had only been approved for a ‘one-off’ occurrence. Snowball sampling, as a strategy for locating a sample difficult to locate in other ways, was used (Beanland et al. 1999). Participants were asked to suggest others whom they knew who would be interested in participating in the study and who fitted the criteria. In addition, advertisements calling for volunteers were placed in two monthly nursing periodicals. Fortunately, snowball sampling was successful in increasing sample numbers.

Sample sizes in qualitative research are determined by several factors. Factors to consider included the type of research design, heterogeneity of attributes under investigation and the degree of precision required (Beanland et al. 1999). Sample sizes in qualitative research tend to be smaller because of the volume of non-numerical data but also because of sampling strategies inherent in the methods, as in Grounded Theory. Nevertheless, it was desirable to ensure that the sample was representative of the population. In this inquiry, 54 self-employed nurse entrepreneurs participated in the first questionnaire with 51 in the second questionnaire. Initially 106 nurses were approached to participate, with the letter detailed in Appendix 8. The large drop in numbers was attributed to the actuality that members of *NAMIPPA* were

not required to be in private practice to hold membership of the group. The criteria for inclusion in this inquiry confined the sample to a homogeneous group whose attributes met the criteria required. Therefore, the number of participants in the study was not considered to be of concern to the validity of the study.

Theoretical sampling

Choosing the participants for research utilising Grounded Theory was guided by the principles of theoretical sampling, which Glaser (1978:36) explains as:

The process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is *controlled* by the emerging theory, whether substantive or formal.

Wishing to develop a substantive theory about a particular group within nursing, self-employed nurses, the researcher considered the basic question in theoretical sampling "what groups or sub-groups does one turn to next in data collection?" (Glaser 1978:42). This prompted the second criterion for selection of the sample in this inquiry. The logical answer was to choose the group most needed to answer the research questions. Although the sample was identified from an existing professional group for nurses and midwives in business, data collection throughout the study continued to be guided by theoretical sampling which in turn was controlled by the emerging theory (Chenitz and Swanson 1986).

To help develop concepts proving to hold theoretical relevance to the evolving theory, theoretical sampling guided the sampling process once data collection and analysis was underway. Although Grounded Theory is an inductive method, developing hypotheses after

data collection starts, deductive thinking guided the researcher in assessing the match between the category emerging from the analysis and the data.

Ethical considerations

Ethical clearance to undertake this inquiry was granted by the Research and Higher Degree Committee of the Department of Clinical Nursing, The University of Adelaide and the Royal Adelaide Hospital Research Ethics Committee (Appendix 6).

Participation in the study was voluntary. Volunteers received an information sheet detailing the investigation and any potential harm or benefit was explained (Appendix 9). A separate consent form was not deemed necessary as consent was implied with the return of the completed questionnaire. Confidentiality was assured so that participants had the ability to expand their information in the comments section. Information collected was kept secured and no personal details revealed outside of the project with only the researcher knowing the identity of the participants. Data were not used for any other purpose than that consented to. Each participant was assigned a coding number so that anonymity was ensured.

Role of the researcher

In Chapter One, the researcher explained how she came to be interested in this area of research. Her personal knowledge and experience of the area of inquiry was an advantage to the study. This view is supported by Streubert and Carpenter (1995:152), who acknowledge the presence of the researcher in qualitative research and state, "the investigator brings personal experience to the study to enhance understanding of the problem".

Glaser (1992:11) identified there are certain skills needed for Grounded Theory research and in particular, "the ability to step back or distance oneself from it, and then to abstractly

conceptualise the data". This was done while drawing on theoretical knowledge and using theoretical and social sensitivity to the sample's shared community. The researcher in this inquiry recognised she was an integral part of the investigation and sought to heed Glaser's advice by distancing herself in order to avoid bias and obtain valid and reliable data.

Data generation

Data for a Grounded Theory study may be collected by various methods including interview, survey questionnaires, observation, documents, daily journals, informal interviews or a combination of these sources (Glaser and Strauss 1967; Streubert and Carpenter 1995). Data for this study were generated from literature, self-administered postal surveys applying Delphi technique in semi-structured questionnaires and from qualitative analysis of extensive additional notes provided by the majority of participants. In addition, a spontaneous discussion was held with a group of employed community health nurses to gather their views on private practice nursing.

Literature review and the expert panel

Initially, the literature was searched for personal accounts and reports of being in private practice as a nurse entrepreneur and used to inform the conceptual model (Figure 2). In keeping with the Grounded Theory approach, a more extensive literature search was not done at commencement, but reviewed continuously throughout data collection and analysis. Reviewing the literature extensively before a study's commencement may lead to pre-judgements and be detrimental to the study (Streubert and Carpenter 1995). A more extensive literature review on extended and expanded areas of nursing practice occurred as theory started to develop to assist with conceptualisation.

When deciding how to apply the methods of data collection chosen for this study, care was taken not to dilute the sample by using them as both an expert panel and respondents to the questionnaires. For this reason, it was decided to employ personal accounts of being in private practice taken from the literature search, to form the 'expert panel' (Stewart et al 1999; Twycross 2001). In doing so, the nurses who gave personal accounts of establishing their own business in the literature served as an informed panel of experts which assisted with the composition of the themes for the Delphi technique statements in the questionnaires. The key concepts extracted from the literature on the experiences of being in private practice formed the items for investigation in the first questionnaire. The notion of 'expert' is not specifically defined in Delphi technique. In general terms, members of an informed or 'expert' panel preferably have some knowledge of the area of inquiry but this is not mandatory (Williams and Webb 1994). Accordingly, the use of literature as an expert panel is supported in various studies including those of (Crouch et al. 2002) and Green et al (1999). According to Glaser (1992) descriptive literature from biographies, diaries, comments and reports are material that should be related to the substantive area being studied in Grounded Theory. This type of literature provides more data to compare with new or emerging data for generating categories and properties. Glaser (1992) stresses that this literature may be read at any stage of the research as data and is supplemental to a survey.

Issues of consensus

Defining consensus

The aim of Delphi technique as a consensus method was to determine the extent to which informed persons agreed about a given issue. A universally agreed level of consensus does not exist for the Delphi Technique and may be determined by the researcher. Jones and Hunter (1996:47) distinguish between two parts of agreement which both apply to defining consensus:

Firstly, the extent to which each respondent agrees with the issue under consideration and, secondly, the extent to which respondents agree with each other.

So not to weaken the study with researcher bias, Williams and Webb (1994) suggest agreement levels should be pre-determined and if necessary, the decision assisted with a pilot study.

Determining consensus

A universally agreed level of consensus does not exist for the Delphi technique and may be determined by the researcher. In this inquiry, the researcher considered the resources available, sample numbers, results of the pilot study and aim of the research and pre-determined the consensus level for agreement at 51% (Hasson et al. 2000). This level was also considered appropriate for a little researched area, as it was necessary to be flexible and to allow as many views as possible to emerge with minimal reduction.

Data were analysed by calculating the percentage measure of agreement to each statement. Standard deviation was used to measure the stability of consensus and convergence of agreement between rounds on items where opinion changed (Greatorex and Dexter 2000). As a "measure of spread", it represented the amount of disagreement within the panel (Greatorex and Dexter 2000:1018). The mode represented the score most frequently chosen by the majority of respondents and the mean represented the group opinion of the participants.

Development of the questionnaire

The first questionnaire (Appendix 10) was designed with three sections. The purpose of the first section was to collect socio-demographic data on each participant. There were eighteen

items developed by the researcher. Questions 1-4 related to the sample group's age, gender, postcodes for place of abode and place of business. Questions for 4-7 referred to employment and training history. Questions 8-18 referred to participants' business and professional profile.

The literature on self-employed nurses' experiences was reviewed for common themes that the researcher developed into categories reflecting business, personal and professional features. The practice of obtaining data from qualitative sources as the basis for generating items for quantitative instruments is common (Polit and Hungler 1995). In section two of the questionnaire, the categories developed for exploration were divided into five statements. The statements were directed at those personal, internal or external factors that influenced participants' decisions to become self-employed. Of the five questions, all but one contained several items for rating. Respondents indicated their agreement or disagreement to each question on a four-point Likert scale - one indicating 'strongly agree' and four indicating 'strongly disagree' with each statement. As previously discussed the number of points in a Likert scale may vary. The researcher decided on a four-point scale in order to address the disadvantage of five-point scales where respondents may be tempted to choose the central point (Bowling 1997). Both positive and negative statements were included to avoid bias (Polit and Hungler 1995).

Questions 19 to 23 were designed to measure whether respondents' opinions of the advantages, disadvantages, barriers and reasons for going into private practice supported those in the literature. The results, provided in chapter eight, indicated close agreement with several items.

The third section of the questionnaire sought information that would illustrate the nurses' range and extent of practice. Understanding this aspect of the participants' experiences would increase the depth and breadth of knowledge about private practice nursing. Participants were asked to "please complete those areas that are relevant to you", as questions were divided under headings of 'clinical', 'educational', consultancy' and 'research'. The researcher acknowledged that some participants would provide services from more than one of these domains.

Questions 26 to 31 were designed to collect information of a clinical nature. Nurses were asked to provide a description of their services and to whom they were provided. Data on the type of clinical problems presented, charges and remuneration and length of consultations were sought.

Questions 32 to 34 enquired of the charges, remuneration, and number of sessions for services of an educational, consultancy or research nature. Nurses providing these types of services were then asked to describe their service in questions 35 to 37.

To enrich the data obtained and provide participants with as much opportunity as possible to express their thoughts, each question invited participants to add additional comments. In addition, a blank page was inserted at the end of the questionnaire and comments encouraged. The overwhelming majority (89%) of participants added comments at the questions and / or on the blank page. Comments ranged from being two or three sentences to a whole page.

To gain the consent of respondents to approach them for further participation in the study, an 'expression of interest' was inserted at the end of the questionnaire. In addition, respondents were asked if they knew of any other nurse who would be interested in participating.

Pilot questionnaire

A pilot study was administered to 10 nurses chosen at random from the sample. All were required to fulfil the requirement of earning some or all of their income from self-employed means. Seven responses were received. Apart from completing the questionnaire, respondents were asked to comment on the ease or difficulty of answering the questionnaire and to annotate anything that was not clear or understood.

The prime objective of the pilot was to determine participants' understanding and acceptance of the questionnaire and to ensure that it provided the information that was required. There were some minor modifications to the questions and clarification of instructions to participants based on this feedback. The pilot questionnaire was mailed complete with letter of invitation; information sheet and reply paid envelope. No deadline date was given to encourage maximum response. Seven of the ten questionnaires were returned within one month.

Round one

Following minor alterations, the modified questionnaires (n=106) were mailed with attachments and inclusions as with the pilot questionnaire. Again, the researcher decided not to implement a deadline date for returns but sent a reminder letter two weeks later.

Analysis

Responses provided by participants in the first round were analysed with the Statistical Package for Social Sciences (SPSS), with which frequencies and descriptive (mean, median, mode, percent, and standard deviation) statistics were calculated. Details of these responses are provided in chapter eight. These rankings were summarised and fed back to participants for further ranking in a second questionnaire (Appendix 11) along with new items developed from annotations written by the participants in the first round.

Round two

Using the categories developed from round one, a second questionnaire was developed and sent out to all those who participated in round one (n=54). Respondents were asked to rate their opinion to 26 statements. The aim of the second round was to establish the areas generally agreed to be priorities for consideration when establishing a private practice. Once again a four point Likert scale from strongly agree to strongly disagree was used. Participants wrote few comments, which did not generate any new information leading to the development of new categories for further exploration in a subsequent round. Consequently, this was considered an appropriate time to cease Delphi rounds (Hasson et al. 2000). Following round two, a report summarising the results was distributed to respondents. Figure 6 shows the summary flow diagram of two rounds of questionnaires and analysis.

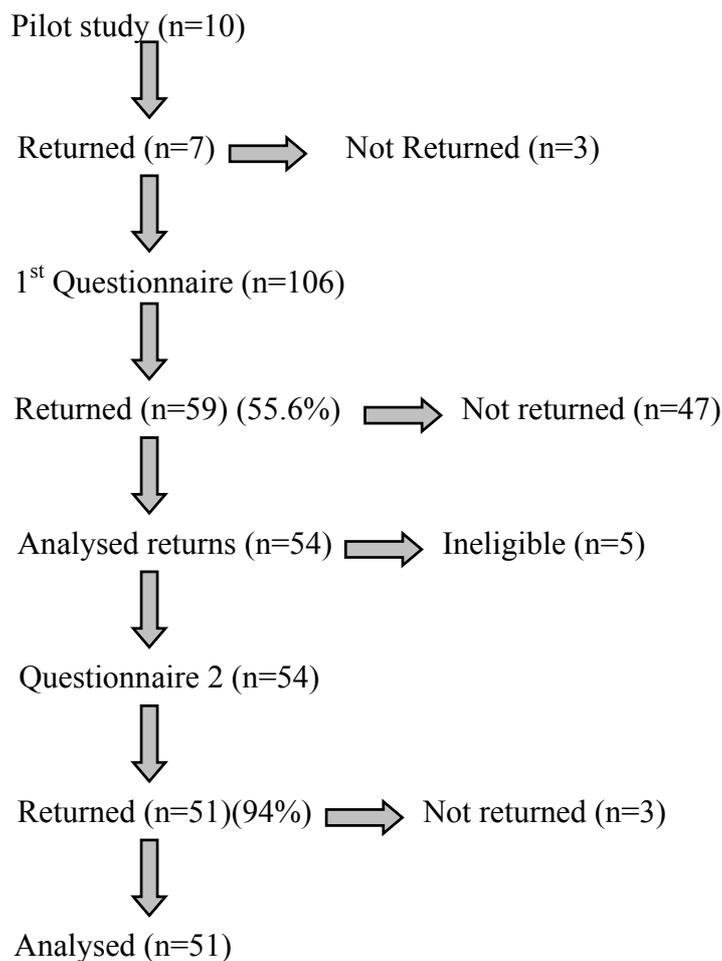


Figure 6: Summary flow diagram of questionnaire rounds

Data management and analysis - generating theory

As completed questionnaires were received, the simultaneous process of data collection, coding and analysis began. Quantitative data were entered into the Statistical Package for the Social Sciences (SPSS).

Data management files were established to keep a systematic, accurate record of qualitative data and the memos written as analysis proceeded. Qualitative data in the form of annotations written by the large majority of participants were coded for emerging categories. The quality of the developing theory was contingent upon the quality of the analysis and the recording of data and notes on the research process (Browne and Sullivan 1999). Initially, these files were developed manually in MSWord, but when the files became large and unmanageable, the data set was transferred to a computerised qualitative data management program NVivo (QSR International Pty Ltd 2002).

A transcript file recorded participants' annotations and the codes assigned by the researcher. Spaces for making notes about the process, the annotations, or codes were added to the side column. Records of the analytical notes made about category labels emerging from the data were recorded in an 'analytical file'. This file included information on the meaning and definitions of codes. A methodological file documented notes about the research process with cross-referencing into the transcript file when data related to both. As reflective thoughts occurred, comments on validity considerations, the researcher's role, aspects of data collection and interpretation were noted. In this way, the file doubled as a personal journal of the research process.

Categories were defined as they were developed with properties assigned and notes made on their relationships to other codes or categories. A bibliographic file kept notes and records of

particularly relevant references with hyperlinks into bibliographic software for easy retrieval. Notes were made on the relationship within the literature and other information and comparisons made with other literature. The data files helped the researcher work actively with the data and become very familiar with it. In addition, creating these files provided an audit trail of the events, influences and actions of the research during the inquiry and therefore enhanced rigour in the study (Koch and Harrington 1998).

Computer management of data

There came a stage during data analysis when the amount of data being generated became difficult to manage. At this point, the researcher decided to instigate NVivo (QSR International Pty Ltd 2002) computer software for qualitative data management. The advantages were being able to create and edit documents from within one file and annotate and code continuously in one document. NVivo (QSR International Pty Ltd 2002) became an adjunct to the other files that had been devised. They had allowed the researcher to become well acquainted with the data, whereas NVivo (QSR International Pty Ltd) assisted the researcher to order the data more efficiently and effectively (Beanland et al. 1999).

Coding

In keeping with the Grounded Theory approach data were collected, analysed and coded simultaneously from the beginning of the study (Streubert and Carpenter 1995). As qualitative data were collected from the returned questionnaires, it was entered into a transcript file and open coding commenced. Line by line *in-vivo* (live) coding identified key words and key phrases to capture the essence of the respondent's comments. Gradually a listing of all *in-vivo* codes as 'free nodes' was developed.

As repetition of the codes occurred in the data, grouping similar codes together collapsed the 'free nodes'. Similar code phrases were also grouped to form sets or clusters. These were assigned properties and renamed categories. Constant comparison of the codes and categories to identify similar properties and relationships continued to fit the data under constantly modified categories. As part of the process, the emerging categories were compared with those in the literature and if verified, their meanings expanded with new data. Once a category was labelled, other codes could be identified as properties of the category and integrated as concepts.

Selective sampling

The focus was now to find the central theme or story line of the data, around which all the other categories could be subsumed. The researcher became intent on seeking data that would saturate the central issues that were emerging (Glaser 1978). Through this process, the basic social process (BSP) which represents a problem shared by participants would be revealed. To find the core category the researcher compared the properties of the substantive categories and selectively sampled from the literature to fill the missing pieces in the emerging theory. The role of the literature, in this situation was to add completeness to the theoretical description of the theory (Streubert and Carpenter 1995). Alternatively, new data extended the research beyond what already existed in the literature.

Continually, as data were received from the first and second rounds of questionnaires, new information was coded and compared to existing data. To continue to saturate the data and develop further concepts, data from the second questionnaire were selectively sampled to compare with existing concepts. This helped the researcher to determine the conditions under which the concepts occurred and if they were central to the emerging theory. This data helped identify relationships in the data, identify properties and saturate categories (Streubert

and Carpenter 1995). Asking questions about relationships in the data allowed links between the categories to be established and a degree of conceptual order to be implemented. Three of the questions asked were "what is this data a study of?", "what category does this incident indicate?", "what is actually happening in the data?" (Glaser 1978). The categories strengthened as their number reduced but the concepts within each increased. It was possible to begin to identify an emerging story line about the process of going into business. Out of 171 'free nodes' (initial codes), 23 categories were developed, each with several concepts. Comparing the categories with one another to discover the core category was time consuming and, at times frustrating. After a period of extensive coding the researcher returned to the Grounded Theory literature (Glaser and Strauss 1967; Glaser 1978; Chenitz and Swanson 1986) to refresh herself about basic social processes. Using the constant comparative method (Glaser and Strauss 1967), the number of categories were gradually collapsed to 24, then 12 and then to the final five. At this point, the researcher felt close to describing a basic social process that accounted for the social processes inherent in being in private practice. Emergent categories were compared with the literature and with the coding families recommended by Glaser (1978). To prevent losing her thoughts on the analysis process, the researcher recorded them in her journal.

These strategies were found useful and the process of theoretical sorting of memos by their similarities, connections and conceptual orderings to identify patterns in the data began. This stimulated the emergence of the final five categories. The interpretation of these categories is described in detail in chapter nine.

Theoretical coding

After emergence of the core category, the researcher began to modify and integrate the concepts. Through the application of theoretical codes, the conceptual framework moved

from a descriptive to a theoretical level (Streubert and Carpenter 1995). Theoretical codes conceptualised how the substantive categories related to each other as mini-theories to be integrated into the theory (Glaser 1978). To assist researchers examine the data theoretically; Glaser (1978) provides a list of coding families with which the analyst can enhance the meanings of the categories and concepts. Using this list the researcher applied theoretical codes to the categories by examining all the codes and concepts that emerged during data analysis. The theoretical codes assigned to the categories are further explained in chapter eight with interpretation of the categories.

Memo writing

Throughout the entire process of data analysis, memos were written to interpret *in-vivo* material, articulate and explore ideas, define codes and categories, examine relationships among codes and finally, to generate theory. Much reflection and questioning followed the emergence of the core category and these thoughts were recorded. Memo writing was particularly helpful in finalising data analysis and developing a synthesised account of the process to core category.

Theoretical sorting

Memos written during the research process were sorted into groups pertaining to the concepts they related. Sorting memos helped the researcher to develop a theoretical outline of the emerging theory. Memos that did not fit into a concept were set aside for consideration later such as during write up of this study. Sorted memos became the basis for the outline by "putting the fractured data back together" (Glaser 1978:116).

Validity concerns

To be credible a grounded, substantive theory must fit the phenomena being studied (Glaser and Strauss 1967). To fit, the categories developed must be indicated by the data and be able to be applied to the data, as the researcher believes they do in this study. She believes the analysis has captured that which is relevant to the participants in the study and to others in that setting, making it broadly applicable to the population under investigation. Initially the researcher had concerns about being able to step back adequately and not bias the study with personal experience. The researcher has achieved this by being theoretically and conceptually grounded throughout the process of data generation. This has also resulted in pleasant surprises sometimes when data has shown an unexpected event that the researcher had not personally experienced or had assumed otherwise, such as some of the reasons for nurses going into business.

Green (1998) believes that the key to developing rigorous and valid theory using the constant comparative method is the search for deviant cases. These may be found in the research data which were searched for exceptions to the emerging relations between codes. This strategy added to that of theoretical sampling as the study progressed. Concepts found to be different to the main themes expressed by participants are highlighted in the qualitative analysis.

Summary

This chapter has provided a description of the research process utilised in this inquiry. Grounded Theory plays a significant role in the conduct of qualitative research. Discussion has included refinement of the research question, sampling, data generation, data treatment and analysis.

This research study utilised Delphi technique by means of questionnaires to provide participants with the opportunity to interact through successive rounds in order to establish agreed meanings to things in their environment. The meanings were modified using the Delphi technique and further interpreted through the process of Grounded Theory to define and locate their meanings in the participants' environments. Importantly, the study design did not separate the individual participants and the contexts in which they acted. The methods used captured participants' transitional phases as they metamorphosed to adjust to the transition into private practice.

In the next chapter, the researcher will provide the findings and interpretations of the data generated by the methods reported on in this chapter.

CHAPTER EIGHT ~ UNDER SCRUTINY - ANALYSIS AND INTERPRETATION I

This study seeks to develop a theory on private practice nursing and in doing so identify the personal and professional characteristics of the self-employed nurse. As such, it is necessary to understand the personal, professional and contextual perspectives of the nurse. Results of the research are presented in two chapters. The findings from the survey data on socio-demographic features, influencing factors, entrepreneurial qualities and scope of practice are presented in this chapter. The following chapter will present the results from the Grounded Theory process of analysis. Findings are presented in both figures and text. Figures (graphs, tables and diagrams) present the complete findings in numerical terms, while the accompanying text focuses on and interprets the most important aspects of the results.

The mode, median and mean as measures of central tendency were drawn upon to summarise certain aspects of the results. The mode as “the value most frequently occurring in a set of scores” was chosen to represent the score chosen by the majority of respondents (Robson 1995:42). The mean is “the average of a set of scores, obtained by adding all scores together and dividing by the number of scores” (Robson 1995:40). The median is the central value in a list of scores placed in order of size. In being so it “... is a value chosen so that it has as many scores above it as it has below it” (Robson 1995:41).

The spread of responses on the Likert scales are measured in terms of the inter-quartile range, which describes the range of that half of the data that falls in the middle of the distribution. Twenty-five percent of the data lies below this interval and 25% of the data lies above this interval. The semi-interquartile range measures the variability of responses and is computed

as one half of the difference between the 75th percentile and the 25th percentile (Robson 1995).

QUESTIONNAIRE ONE

Socio-demographic profile of the participants

Descriptive analysis of questions 1 – 18

A total of 54 questionnaires were examined for participants' responses to questions in the first section of the first questionnaire (Appendix 10) that sought to gather socio-demographic data from the participants in order to determine whether the respondents were a heterogeneous or homogenous group in respect to several factors and therefore increase our understanding of this population. These factors were age, gender, places of living and work, year of commencing business, year of registration, practice configuration, years in business, initial nurse training, qualifications, employment prior to private practice, hours worked, areas of practice, type of clients and preparation to go into business. Of a total 106 questionnaires posted to self-employed nurses in all states of Australia a response rate of 55.6% (n=59) was achieved. Five respondents did not meet the eligibility criteria resulting in a total sample of 54 participants for round one. The geographical spread of participants is shown in Figure 7.

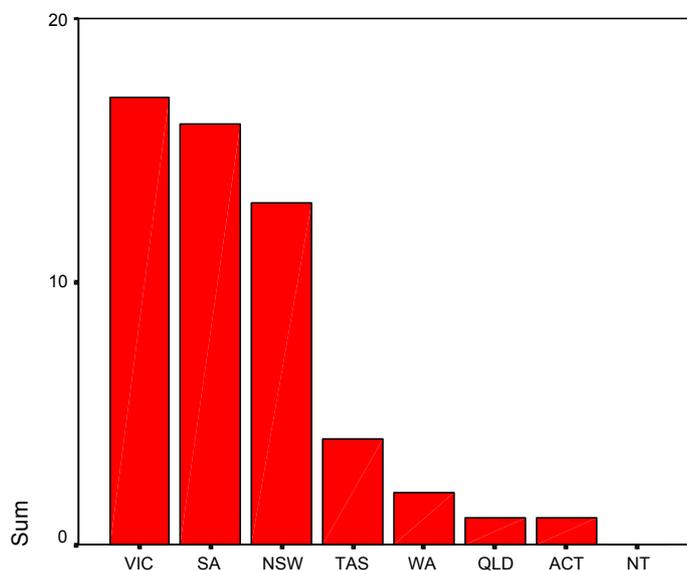


Figure 7: Responses from each state to questionnaire one.

Question one asked respondents for their *age and gender*. One response was invalid. Ages ranged from 25 to 69 years. The age most frequently stated was 46 years as indicated by the mode. The median was 48 years and the mean 50 years (Figure 8). One male nurse participated in the study although seven had been part of the initial 106 nurses invited to take part.

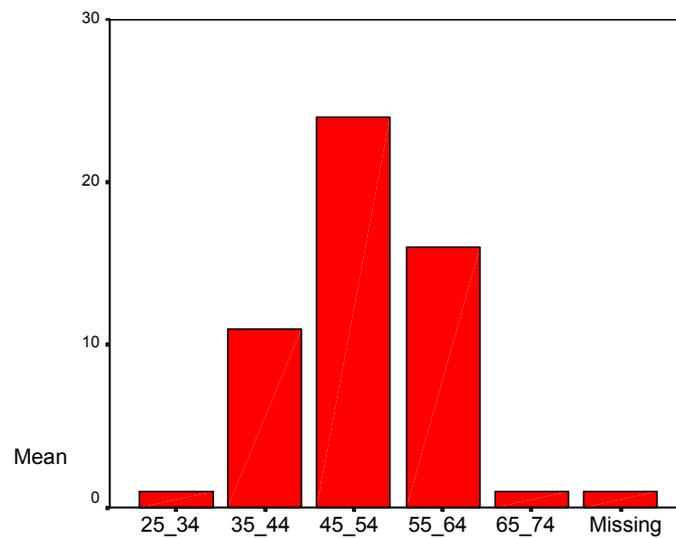


Figure 8: Age spread of participants in years

Questions two and three asked respondents for the postcode *where they lived and conducted their business*. Figure 9 indicates the residential spread of participants across Australia. The largest responses were from Victoria (31.48%), South Australia (29.6%) and New South Wales (25.93%). There were none from the Northern Territory. Of the responses, 25% of respondents had two or more places of business and 29.6% did not work at the same postcode as they resided, leaving 70.4% who lived and worked in the same district.

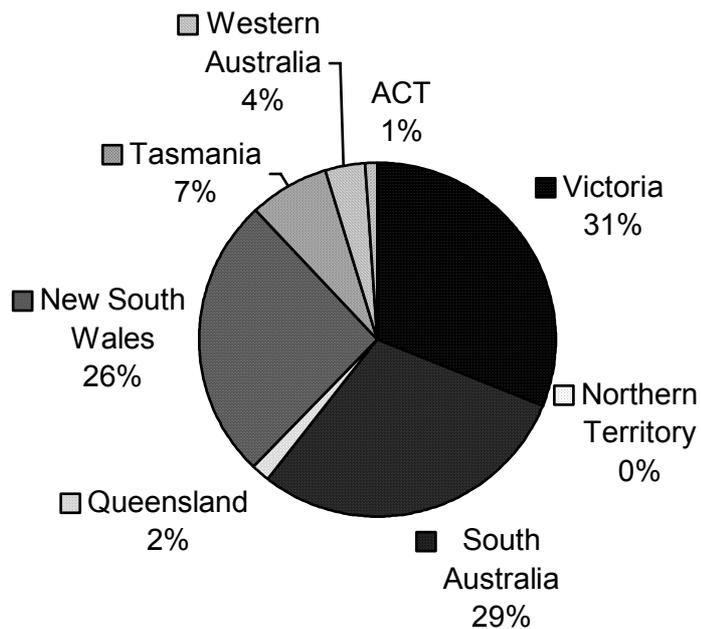


Figure 9: Participants state of residence

In response to **question four**, *where did you do your initial nurse training?* 96% percent indicated they trained in a hospital and 3.7% at a university or college. Of those who answered the question, 11.1% trained overseas in either the United Kingdom or South Africa, 33.3% in South Australia, 22.2% in New South Wales, 20% in Victoria, 8.9% in Tasmania, and 2.2% in each of Australian Capital Territory and Queensland.

In reply to **question five** which asked *were you unemployed at the time of going into private practice? If no, where were you working?* the majority, 70.4% indicated ‘no’, and 29.6% indicated ‘yes’. At the time of going into private practice, 23.1% of those who responded worked in public hospitals, 20.5% in private hospitals, 25.6% in community locations and 30.8% in a diversity of situations including the university sector, medical practice, aged care, private nursing service, professional association or unpaid maternity leave.

Question six asked participants *what proportion of time do you work for yourself?* Approximately half (51.9%) responded ‘full-time’, meaning thirty-eight or more hours per week, 3.7% worked 30-38 hours per week, 13% worked 20-30 hours, 22% worked up to twenty hours and 9.3% percent worked irregularly or occasionally for themselves.

Asked, *other than being self-employed are you employed by some-one else?* in **question seven**, the majority, 60.4%, responded ‘no’, and 39.6% ‘yes’. Of those who were also employed, approximately a third (34.8%) were employed for thirty to thirty-eight hours per week, 21.7% ten to twenty hours per week, and 17.4% for twenty to thirty hours per week.

Participants’ response to **question eight** *how long have you been in private practice?* varied from one year to twenty years across participants. The most common response given as demonstrated by the mode was five years (13%), with the median at six years and the mean at 7.6 years.

Participants’ answers to **question nine**, *what year did you first start in private practice?* revealed a twenty year range. The mode was 1995 (14.8%), the median 1994 (11.1%), and mean 1992 (2.8%). Peak years were 1994, 1995, and 1999.

In **question ten**, participants were asked *What year did you first become a registered nurse?* The responses varied widely from 1952 to 1995. When compared to the scores of question nine, a mean of twenty-one years experience prior to commencing private practice was revealed.

Table 1 summarises the main statistics from the last few points and highlights the high number of years experience within the sample:

Table 1: Descriptive Statistics: age, years in private practice and experience

	n	MINIMUM	MAXIMUM	MEAN	STD. DEVIATION
Age	53	25	69	50.21	8.59
Length of time in private practice	54	1.00	20.00	7.611	4.79
Years between registration & private practice = experience	54	4	42	20.93	8.66

Question eleven asked participants to *please indicate the configuration/s you practice in*. From the three choices given of, solo, partnership and company, 63% indicated they were sole traders, 14.8% indicated they were in partnership, 20.4% indicated a company formation and 1.9% indicated more than one practice configuration.

In response to **question twelve** that asked *do you employ staff?* a slim majority (54%) responded ‘yes’ and 46% answered no. The type of staff employed were described as being clerical, registered nurses, enrolled nurses, carers, research assistants, subcontractors, locums, and office support.

Question thirteen asked participants: *do you work from....?* More than one choice could be selected. The largest response, 77.8%, indicated working from a home office or consulting rooms, with 22% working in clients’ homes, 13% in institutions, 9% from rented rooms, 7% from both shared premises with other professionals and doctors’ rooms, and 3.7% percent in group practices with other nurses.

When asked *what are your current qualifications* in **question fourteen**, 96.3% of participants were registered nurses. There was one enrolled nurse and a midwife who did not indicate she was also a registered nurse. In addition, a large number of nurses held additional qualifications (Figure 10). It was noted that 16.7% of participants did not hold any post-registration qualifications.

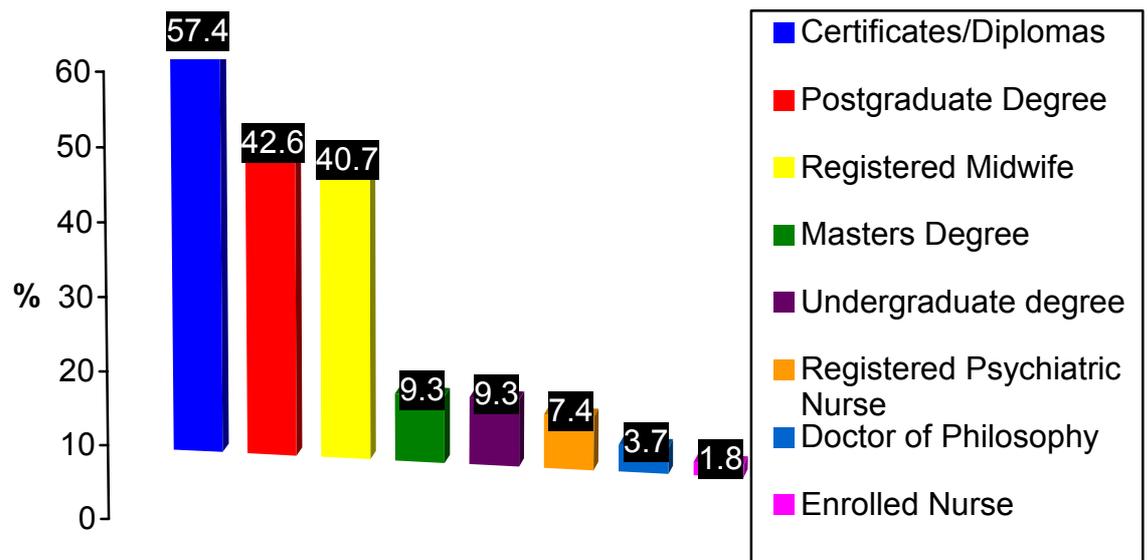


Figure 10:Qualifications of participants

Question fifteen asked participants to *please indicate your membership/s of professional organisations (nursing & non-nursing)*. More than one response could be made. The high response rate for the Royal College of Nursing Australia is anticipated to be due to the high percentage of participants originating from the College’s database (Figure 11). A number of participants (63%) indicated membership of a wide range of other professional organisations such as those relative to their specialty area, complementary health groups, counselling groups, business and management organisations.

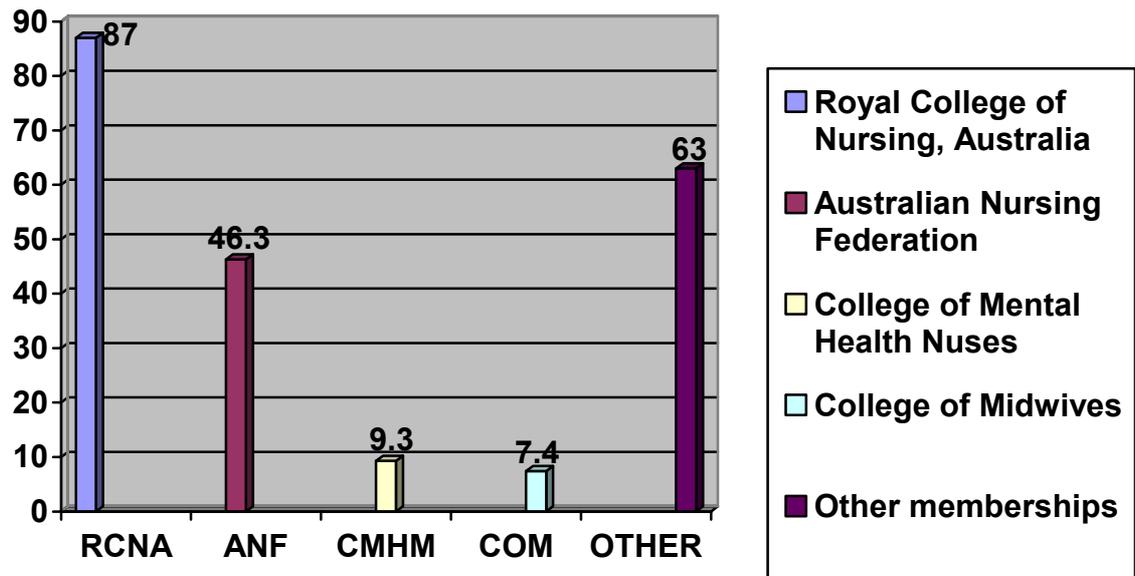


Figure 11: Membership of professional organisations

Question sixteen asked participants to *please rank the areas of practice you have worked in during the last 12 months (1=most time worked)*. Just over a half (53.7%) ranked the clinical area as the most time worked, 37% ranked consultancy as the area in which they spent most time, 22% indicated they worked mostly in the area of education, and 1.9% ranked research as the area they worked in the most.

In response to **question seventeen** which asked participants to *please rank the type of clients you work with in order of amount of time worked in the last 12 months (1=most time worked)*, 68.5% reported working mostly with individual clients, 25.9% worked mostly with institutions or organisations and 18.5% worked mostly with groups of clients.

Question eighteen was an unstructured question which asked participants *what preparation did you need to undertake to be in business?* This information would help the researcher understand what was involved in establishing a business. The responses were analysed and grouped under representative headings. The result shows that there are extensive activities to undertake when establishing business to ensure a successful and smooth operation. Table 2

demonstrates some of those activities assembled from participants' responses within the areas of business management, industrial affairs, professional activities, education, personal affairs and experience. It is apparent from viewing the listings that many activities are not part of nurse education curricula and are extra knowledge or skills that need to be acquired.

Table 2: Preparation for business

<p>Business Management</p> <ul style="list-style-type: none"> ◆ Market research ◆ Marketing ◆ Advertising ◆ Start-up grant ◆ Graphic artist ◆ Small business course ◆ Business plan ◆ Business forms and practices ◆ Set fees ◆ Book keeping & accounting ◆ Update CV ◆ Buy office hardware ◆ Upgrade computing skills 	<p>Industrial Affairs</p> <ul style="list-style-type: none"> ◆ Insurance – public liability, professional indemnity, product liability, loss of income, accident ◆ Legal advice ◆ Health fund negotiations ◆ Register with service providers – DVA, HACC ◆ Liaison with LMOs, hospitals, visiting rights ◆ Pathology providers – liase
<p>Professional activities</p> <ul style="list-style-type: none"> ◆ Nurses Board – registration ◆ Colleagues – advice, information, partners ◆ Networking – information, referrals, know-how ◆ Memberships – professional associations 	<p>Education</p> <ul style="list-style-type: none"> ◆ Seminars ◆ Reading – business knowledge ◆ Specific studies – area of practice ◆ Continuing education ◆ Additional qualifications ◆ Masters degree ◆ Office practices
<p>Experience</p> <ul style="list-style-type: none"> ◆ In a nursing product 	<p>Personal Affairs</p> <ul style="list-style-type: none"> ◆ Family support ◆ Second income ◆ Psychological preparation ◆ Financial assessment

Summary of the demographic data

The data demonstrates that the demographic profile of a self-employed nurse is a registered nurse aged between 45-57 years with 14-27 years experience before private practice. She holds more than one post-registration qualification and has been in private practice for 4-11 years. When she decided to undertake private practice she was not unemployed and has

maintained some part-time employment. She mainly works from a home office or consulting rooms as a sole practitioner.

Influencing Factors

Descriptive analysis of the Delphi statements 19 – 23 in the first questionnaire.

Questions 19-25 required participants to respond to a series of Delphi statements in relation to the personal, internal or external factors that influenced their decision to become self-employed. The items included the advantages, disadvantages and barriers to private practice nursing. Participants were asked to respond to each question on a four point Likert Scale where 'strongly agree' was coded as a one, 'agree' as a two, 'disagree' as a three and 'strongly disagree' as a four. Results were analysed using SPSS statistical software. Consensus was pre-determined and equated with 51% agreement amongst respondents (Loughlin and Moore 1979 as cited in Hasson et al 2000) on any single issue.

The responses elicited were codes 1-2-3-4 on a Likert scale, which yields ordinal data with an inherent sequence. Responses were summarised using the mode, which represents the score most frequently chosen by the majority of respondents. Variability in responses is expressed in terms of the inter-quartile range (IQR).

Question nineteen asked respondents to consider a choice of items in response to the statement *your decision to move to private practice was influenced by* and resulted in the highest ranked reasons being because of need for the service and the participant's wish for a new challenge. Since 87.8% of participants were not influenced by redeployment and 87.5% had not been unable to find work, it is evident that private practice was a choice. Dissatisfaction at work and the wish to use other skills and / or knowledge also played a significant role in decisions making. Results are presented in Table 3.

Table 3: Factors influencing nurses to become self-employed

ITEM	NO. OF SCORES 1-2 ON THE LIKERT SCALE	NO. OF SCORES 3-4 ON THE LIKERT SCALE	MODE*	INTER-QUARTILE RANGE
Redundancy	8 (19%)	34 (81%)	4	3.75-4
Redeployment	5 (12.2%)	36 (87.8%)	4	4
Unable to find work	5 (12.5%)	35 (87.5%)	4	4
New Challenge	40 (85.1%)	7 (14.9%)	1	1-2
Dissatisfied	37 (74%)	13 (26%)	1	1-3
To use other skills	42 (82.4%)	9 (17.7%)	1	1-2
Existing need	41 (89.1%)	5 (10.8%)	1	1-2
Anticipated need	38 (86.4%)	6 (13.6%)	1	1-2

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

Even though the mode and IQR were positive on all accounts, the wider IQR for *dissatisfied* shows there was some disagreement and not all the nurses had been dissatisfied at work.

Question twenty asked respondents to consider whether *post-graduate qualifications are essential for developing, managing and running a private practice*. The mode was one and the IQR 1-3, which indicated some nurses disagreed post-graduate qualifications are necessary in business.

For **question twenty-one**, respondents were asked to consider a choice of items in response to the statement *the following are advantages of being in private practice*. High levels of agreement were found on most items although there were differing opinions on whether an increased income was achieved in private practice (Table 4). Accordingly, this question was reapplied in the second Delphi survey. The response showed a stable opinion (mean 2.4) with increasing agreement (Standard Deviation 1.14/.80) resulting in a 55.8% agreement that “potentially, increased income is an advantage of self-employment”.

Table 4: Advantages of being in private practice

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	MODE*	INTER- QUARTILE RANGE
Autonomy	54 (100%)	0 (0%)	1	1
Flexible hours	49 (92.5%)	4 (7.5%)	1	1-2
Increased work satisfaction	53 (98.1%)	1 (1.9%)	1	1
Own boss	51 (94.4%)	3 (5.6%)	1	1-2
Able to use talents/skills	54 (100%)	0 (0%)	1	1-1.25
Control decision making	52 (98.1%)	1 (1.9%)	1	1.2
Variety of functions	49 (94.2%)	3 (5.8%)	1	1-2
Making a difference	49 (96.1%)	2 (3.9%)	1	1-2
Quality Care	49 (96.1%)	2 (3.9%)	1	1-2
Enhanced image	50 (96.2%)	2 (3.8%)	1	1-2
Increased income	25 (49%)	26 (51%)	1	1-3

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

Even though the mode and IQR were positive for most items, the wider IQR for *increased income* shows there was some disagreement and not all the nurses found increased income to be an advantage.

Question twenty-two asked participants to respond to four items (see Table 5) in relation to the statement *the following are disadvantages of being in private practice*. The items that indicated most variance in opinion were 'lack of team support' and 'unspecified work hours', both items which some nurses would have been used to in employed practice settings and which, it is conjectured, vary depending upon the practice setting.

Table 5: Disadvantages of being in private practice

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	*MODE	INTER- QUARTILE RANGE
Reduced or variable income	40 (76.9%)	12 (23.1%)	1	1-2
24 hour responsibility	37 (71.1%)	15 (28.9%)	1	1-3
Lack of 'team' support	35 (66%)	18 (34%)	2	1.5-3
Unspecified work hours	31 (59.6%)	21 (40.4%)	2	1.25-3

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

As can be seen, the IQR is wide for *24 hour responsibility*, which is not surprising as not all participants would have this requirement, depending on the area they worked in. The IQR for *lack of 'team' support* and *unspecified hours* shows there was some disagreement and not all the nurses found these factors to be a disadvantage.

Question twenty-three asked respondents to consider nine items in response to the statement *the following are barriers to conducting a private nursing practice*. There were high levels of agreement to most items as indicated in Table 6. The largest difference of opinion occurred with the item, *lack of acceptance of the changed nursing role*.

Table 6: Barriers to private practice nursing

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	*MODE	INTER-QUARTILE RANGE
Lack of acceptance of changed nursing role	31 (60.8%)	20 (39.2%)	3	1-3
Lack of knowledge about nursing	43 (81.1%)	10 (18.9%)	1	1-2
Lack of reimbursement private	48 (96%)	2 (4%)	1	1-2
Lack of reimbursement public	48 (96%)	2 (4%)	1	1-2
Attitudes other professionals	47 (92.2%)	4 (7.8%)	1	1-2
Attitudes other nurses	47 (92.2%)	4 (7.8%)	1	1-2
Lack of industrial support	48 (94.1%)	3 (5.9%)	1	1-2
Difficulties with referrals	48 (96%)	2 (4%)	1	1-2
Lack of collegial / professional support	48 (94.1%)	3 (5.9%)	1	1-2

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

Even though the mode and IQR is positive for all items, the IQR is wide with some nurses not agreeing that lack of acceptance for a *changed nursing role* is a barrier to private practice.

Summary of influencing factors

The data presented has shown that there is a large range of factors influencing nurses in private practice. Agreement between respondents was high to the majority of items presented in each section with some variable levels of opinion in a minority of cases. Each of these have been commented on beneath the relevant table. The results of this section show that the average nurse in private practice was looking for a new challenge in which she could use other skills and address a need in the health sector. From this new venture, the nurse has found increased work satisfaction with increased autonomy, although the disadvantage is a reduced and variable income. There are several large barriers, which are associated with endorsement of the role.

Entrepreneurial Qualities

Descriptive analysis of the Delphi statement 24 and 25 in the first questionnaire.

Descriptive analysis is presented of the participants' responses to questions 24 and 25, which required participants to respond to a series of statements in relation to those personal and professional characteristics that enable a person to undertake challenges and step outside the traditional nursing framework. Participants were again asked to respond to each question on a four point Likert scale as in the previous questions.

The responses elicited were codes 1-2-3-4 on a Likert scale, which yields ordinal data with an inherent sequence. Responses were summarised using the mode, which represents the score most frequently chosen by the majority of respondents. Variability in responses is expressed in terms of the inter-quartile range (IQR).

Question twenty-four asked respondents to consider 13 items in response to the statement *the following characteristics are required to be a nurse entrepreneur*. Results are presented in Table 7.

Table 7: Nurse entrepreneur characteristics

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	*MODE	INTER-QUARTILE RANGE
Motivation	52 (98.1%)	1 (1.9%)	1	1
Flexibility	51 (98.1%)	1 (1.9%)	1	1
Ambition	49 (94.2%)	3 (5.8%)	1	1-2
Assertion	52 (100%)	0 (0)	1	1-2
Accountability	52 (100%)	0 (0)	1	1
Commitment	52 (100%)	0 (0)	1	1
Self-discipline	52 (98.1%)	1 (1.9%)	1	1
Independent nature	47 (90.4%)	5 (7.6%)	1	1-2
Good listener	48 (92.3%)	4 (7.7%)	1	1-2
Desire to work alone	30 (57.7%)	22 (42.3%)	3	1-3
Creative	50 (96.2%)	2 (3.8%)	1	1-2
Incentive	50 (96.2%)	2 (3.8%)	1	1-2
Good imagination	48 (92.3%)	4 (7.7%)	1	1-1.75
Willing to take a risk	50 (96.2%)	2 (3.8%)	1	1-2

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

The mode and IQR are positive for all items. The wider IQR for *a desire to work alone* indicates that not all nurses agreed this is a required entrepreneurial characteristic.

Question twenty-five asked respondents to consider six items (Table 8) in response to the statement *the following skills and/or knowledge are required for being in private practice*. The item of the highest disagreement was with regard to the need for a nurse to have previous business experience before establishing a business.

Table 8: Skills and / or knowledge required for private practice

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	*MODE	INTER-QUARTILE RANGE
Business know-how	50 (92.6%)	4 (7.4%)	1	1-2
Management skills	51 (96.2%)	2 (3.8%)	1	1-2
Planning skills	53 (100%)	0 (0)	1	1-2
Need to be multi-skilled	52 (98.1%)	1 (1.9%)	1	1-2
Customer service focus	52 (100%)	1 (0)	1	1
Previous business experience	18 (34.6%)	34 (65.4%)	3	2-3

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

The mode and IQR are positive for all items with small ranges. Only one item, *previous business experience*, did not have any respondent strongly agree with it.

Summary of entrepreneurial qualities

The results in this section have focussed on determining the characteristics, skills and knowledge respondents consider necessary for being a self-employed nurse entrepreneur. The most desirable characteristics are: assertion, accountability and commitment, planning skills, a focus on customer service, self-discipline, a range of skills, motivation and flexibility.

Scope of Practice

Descriptive analysis of questions 26 to 37 in the first questionnaire:

This section provides descriptive analysis of the participants' responses to questions 26 to 37, which required participants to complete those areas that were relevant to them. Quantitative data were analysed using SPSS statistical software to produce frequencies and descriptive

statistics. The questions covering respondents' scope of practice were divided into four domains, clinical, education, consultancy and research and which were defined, as they related to the research, for participants.

Questions 26 to 31 referred only to clinical practice.

Clinical: Practice involving the direct or indirect provision of care to individuals or groups. Includes counselling, and 1:1 teaching where health status and clinical improvement can be attributed to the outcomes of teaching / counselling processes.

Question twenty-six asked respondents to *please describe the type of services you provide and to whom*. The results demonstrate a wide assortment of nursing services (Table 9). The recipients of the services were individuals, both adults and children, health agencies and hospitals.

Table 9: Type of services provided

<u>Type of Services</u>	
Case management	Health education
Clinical management systems	Health promotion & prevention services
Complementary Therapies	Maternal & childhealth nursing
Continence Management	Medical / Surgical nursing
Continuous quality improvement activities	Midwifery – lactation, childbirth education
Counselling	Nutrition
Dermatology / cosmetic	Palliative care
Diabetes education & management	Peri-operative
Disability nursing	Primary health nursing
Domicillary & community nursing	Rehabilitation
Early discharge service / post-hospital care	Respite care
Gerontic nursing	Stomal therapy & wound management
Health assessment & screening	Women's health

In **question twenty-seven**, respondents were asked *how many clients/patients do you see on average per week*. Approximately half (53.8%) reported they saw up to 10 clients/patients per week, 15.4% saw 11-20 per week and 15.5% saw over 50 clients/patients per week. The remainder of respondents (15.4% in total) indicated their client/patient numbers were

scattered between 21-50 per week. The clinical problems reported on **question twenty-eight** which asked respondents *what type of clinical problems do clients present with*, are presented in Table 10.

Table 10: Type of clinical problems presented

Type of Clinical Problem	
Ageing & increased frailty	Suicide
Cancer	Physiological dysfunction
Cardio-respiratory dysfunction	Administration and monitoring of medication
Cognitive and physical disabilities or impairments	Violence
Cognitive impairments	Reproductive / endocrine disorders
Dysfunction of the nervous system	Wounds and stomas
Enuresis and continence	Terminal illness
General nursing care / personal care	Relationship issues
Health education	Midwifery / post natal problems
Rehabilitation	Stress
Social, emotional and psychological difficulties	Assessment and screening
Substance abuse	Post-operative care

Question twenty-nine asked respondents *how are you remunerated for your services?* More than one option could be indicated. Results illustrated 55% received remuneration directly from the client or patient; 17.5% received payment through a third party for example, insurance company or organisation; 12.5% indicated they were reimbursed by both clients and a third party; 10% by all means and 2.5% each for remuneration by Workcover and Workcover plus a third party.

In **question thirty** respondents were asked to indicate *how much do you charge for your clinical services per hour?* Responses were divided into the “*first consult*” and “*follow-up*” consult in “*your clinic*” and “*their home*”. Respondents were asked to indicate their charges within seven choices ranging from free to \$140. The results are presented in the following table.

Table 11: Fees for clinical services

	First Service at the Clinic	Follow-up Service at the Clinic	First Consult at their home	Follow-up Consult at their home
Free	4.3%		3.8%	
\$1-20	4.3%	8.3%	7.7%	14.3%
\$21-40	21.7%	41.7%	42.3%	42.9%
\$41-60	34.8%	29.2%	23.1%	28.6%
\$61-80	30.4%	20.8%	15.4%	14.3%
\$81-100	4.3%		3.8%	
\$121-140			3.8%	

It is evident from these results that 85-90% of pricing for services is between \$21-\$80, a fairly broad range. The most common charges for services lie in the \$21-40 range.

In **question thirty-one**, respondents answered the question *approximately how long (hours/minutes) do you spend with each client?* for both initial and follow-up consults. The results demonstrate that initial consultations are of the longest duration with one hour being typical of follow-up consultations.

Table 12: Time spent with clients

	Initial Consult	Follow-up Consult
30 minutes	26.5%	23.5%
60 minutes	20.6%	35.3%
90 minutes	38.2%	17.6%

Questions 32 to 37 referred to questions on education, consultancy and research.

Education: Where the aim is that nursing knowledge is transmitted rather than a change in health status of the people being taught. Usually a course/session guide or curriculum is involved.

Consultancy: The provision of skills and resources to solve problems and issues of consumer clients such as businesses, industry, hospitals, universities, nursing homes etc. Teaching may

be involved but less formally than with education. The general intent is active problem solving and framing rather than direct action to affect health status.

Research: Fee for service scientific, social or market research of a quantitative and/or qualitative nature. You may be the chief investigator or an assistant involved in your own or another’s research program.

Question thirty-two asked the respondents *how much do you charge for educational, consultancy or research services per hour?* The results are provided in the following Table 13.

Table 13: Charges for education, research, consultancy services

Service		FREE	\$1-20	\$21-40	\$41-60	\$61-80	\$81-\$100	\$101-\$120	\$121-\$140	\$141+
One session	Education	11.1%	8.3%		27.8%	22.2%	13.9%	11.1%		5.6%
	Research	18.8%		6.3%	12.5%	25%	25%			12.5%
	Consultancy	14.7%	5.9%	5.9%	11.8%	17.6%	20.6%	14.7%		8.8%
Group sessions	Education	6.3%	6.3%	9.4%	25%	15.6	18.8%	6.3%		12.5%
	Research	4.2%	4.2%	8.3%	29.2%	20.8%	16.7%	8.3%		8.3%
	Consultancy	9.1%	9.1%	9.1%	18.2%	18.2%	18.2%			18.2%
Preparation	Education	40.9%	13.6%	4.5%	18.2%	13.6%		4.5%		4.5%
	Research	45.5%			27.3%	18.2%				9.1%
	Consultancy	40%		5%	15%	15%	15%	5%		5%

These responses show that fees for education, research and consultancy services vary broadly, but the greatest percentage of fees charges lie in the \$41-\$100 bracket for both single and a group of sessions. Preparation time appears built into the fee and not charged separately in the majority of instances.

Question thirty-three asked, *on average, how many educational/consultancy/research courses or sessions do you provide per week ?* The results summarised in Table 14 show that up to ten sessions per week are common except in the research area.

Table 14: Number of education, consultancy, research sessions per week

	Number of Sessions				
	0	1-10	11-20	21-30	>30
Education	10.8%	73%	10.8%	2.7%	2.7%
Consultancy	15.6%	65%	12.5%	3.1%	3.1%
Research	55.6%	44.4%			

In **question thirty-four** respondents were asked, *how are you remunerated for your educational, consultancy or research services?* to which 16.3% indicated they were remunerated directly by the client or individual, 30.2% by organisations and 53.5% indicated remuneration was from both sources.

Question thirty-five asked respondents to *please describe the type of educational services you provide and to whom.* The collated results are presented in Tables 15 and 16. They show that nurses in business provide a wide range of services to a range of recipients.

Table 15: Type of educational services

Type of education services	
<ul style="list-style-type: none"> • Aged Care Training • Anatomy & Physiology + general medicine • Behavioural problems • Business - private practice • Cardiac/Trauma nursing • Clinical pathways/issues • Communication Skills • Community education • Complementary Therapy • Conflict management • Continence • Continuing Education - staff • Diabetes • Disability • Documentation • Drug &/or Alcohol • Group facilitation • Health Education & health management • High Dependency 	<ul style="list-style-type: none"> • Infection Control • Infectious Diseases • Leadership • Lecturing/speaking engagement • Life Support • Management • Manual Handling • Mental Health • Midwifery/Lactation education • Nutrition • OHS&W • Palliative care • Parenting • Psychological aspects of care • Senior 1st Aid & Resuscitation • Stress Management • Tutoring • Workshops/Seminars • Wound/Stoma management • Writing Educational materials

Table 16: Recipients of educational services

<u>To Whom</u>	
<ul style="list-style-type: none">• Aged care• Assistants In Nursing /carers• Allied health workers• Community Health workers• Consumers/clients/public• Country Hospitals• Doctors• Enrolled nurses• Family & Child Health Nurses• General Practice staff• Groups & individuals• Health & service Agencies• Health Professionals	<ul style="list-style-type: none">• Metropolitan Hospitals• Midwives• New mothers• Nurses• Organisations• Parent groups• Pharmacy• Physiotherapists• Retirement Village staff• Speech Therapists• Student Nurses• TAFE• University• Youth

Question thirty-six asked, *please describe the type of consultancy services you provide and to whom.* Once again a wide range of services and recipients shown in the results (Tables 17 and 18).

Table 17: Type of consultancy services

<u>Service Type</u>	
<ul style="list-style-type: none">• Accreditation• Aged care• Assessment of client needs• Career transition counselling• Change management• Conference design and management• Conflict management• Continence management• Curriculum development• Diabetes care• Disability• Education / programs / staff training	<ul style="list-style-type: none">• Emergency equipment and procedures and related activities• Grief and loss• Group discussions-general health• Human Resource Management• Infection control• Management matters• Management of performance• Maternal & Child Health issues• OHS&W• Policies / procedures• Resume preparation• Reviews• Stress management

Table 18: Recipients of consultancy services

To Whom	
<ul style="list-style-type: none">• Aged Care Institutions• Ancillary services• Camp Breakaway• Carers/family• Consumers• Doctors• DVA• Forensic Health• Government dept.• HACC• Health care agencies	<ul style="list-style-type: none">• Hospitals and service providers• International Organisations• Legal companies• Midwives• National nursing organisations• Nurses/Nursing sector• Organisations - corporate• Other professional health workers• Pharmacies• Retirement Villages• University/TAFE

Question thirty-seven asked respondents to *please describe the type of research projects you are involved in and for or with whom* (Tables 19 and 20). In the responses, it was interesting to note that there were participants who responded to this question who had indicated research as an area they practised in. It is unknown whether this is because the nurses conducted informal research activities such as *collecting data from own work* and *questionnaire to clients* and were not promoting themselves as researchers, or for another reason.

Table 19: Research projects

Type
<ul style="list-style-type: none">• Advisor to research groups
<ul style="list-style-type: none">• Aged Care
<ul style="list-style-type: none">• Carer input and support
<ul style="list-style-type: none">• Community Nursing - Health Outcomes for DVA
<ul style="list-style-type: none">• Conduct of research
<ul style="list-style-type: none">• Data from own work
<ul style="list-style-type: none">• Forensic psychiatric patients-exploring the experience of families
<ul style="list-style-type: none">• Market Research
<ul style="list-style-type: none">• Midwifery and Obstetrics
<ul style="list-style-type: none">• Models of practice
<ul style="list-style-type: none">• Palliative Care
<ul style="list-style-type: none">• Preparation of proposal
<ul style="list-style-type: none">• Questionnaire to clients

Table 20: Recipients of research projects

To Whom
• Clients
• Colleagues-research grant
• Educational program
• General Practitioners
• Hospitals
• Individuals
• Management consultancy
• Organisations
• RDNS
• Research groups

Summary of scope of practice

Self-employed nurses provide a wide range of services to a variety of recipients. Recipients are diverse and can be persons of any age or health organisations. The average number of clients seen in a week appear to be on the low side (less than 20) with income variable depending on the type of work. The fee range for services is very broad and at times appears very low for the time spent. Research services appear to be the least utilised area of all work domains and some respondents mentioned quality assurance mechanisms which may not be considered as research, when addressing questions to this area.

Summary

Analysis of the data from the first questionnaire has described the demographic features of nurse entrepreneurs and the different settings in which they work. The data increases knowledge about the persona of nurses in private practice and the type of work they do. It also provides an account of their client profiles and service fee structures. An important aspect of the data analysis is the section presenting results from the application of Delphi technique. This data presents information that helps to increase understanding of many of the issues experienced by nurse entrepreneurs.

QUESTIONNAIRE TWO

Descriptive analysis of Delphi statements 1 – 26 in the second Delphi survey.

Following is a descriptive analysis of the participants' responses to the second Delphi survey which sought to gather consensus on issues identified in the first Delphi survey. The statements for the second round were developed from those statements in the first round where consensus had not been achieved, where there was dissension and from new information provided in respondents' written comments. The issues focused on the need for maintaining employment while establishing business, the skills required in business, professional activities undertaken to promote success or maintain collegial support, qualifications for success, financial considerations and attitudes of others.

All the respondents (n=54) who participated in round one were posted a questionnaire for round two. A response rate of 94% (n=51) was achieved (Figure 12). Three respondents from the first survey expressed their unavailability due to other commitments. The consistent participation rate was pleasing as it increased the validity and reliability of the results. The questionnaire contained 43 items, which endeavoured to elicit consensus on the issues raised. Reasonably high consensus was evident with 16% of responses having 100% level of agreement, 65% of responses having overall levels of agreement $\geq 80\%$ and 93% of responses with overall levels of agreement $\geq 51\%$. The levels of weakest agreement were seen in those factors that had related, in the first round, to qualifications and support. Participants wrote few comments and did not generate any new information leading to the development of new categories. Consequently, this was considered an appropriate time to cease Delphi rounds as discussed by Hasson et al. (2000).

The responses elicited were codes 1-2-3-4 on a Likert scale, which yields ordinal data with an inherent sequence. Responses were summarised using the mode, which represents the score

most frequently chosen by the majority of respondents. Variability in responses is expressed in terms of the inter-quartile range (IQR).

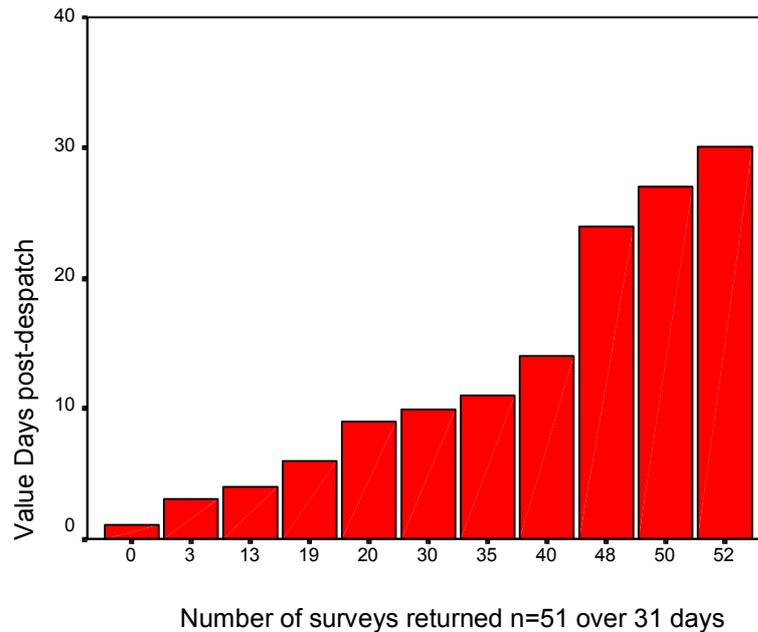


Figure 12: Return rate of questionnaire two

Question one stated: *when starting in private practice it is preferable to combine private and employed work.* Agreement with this statement was 81.3% (n=39) of respondents who were almost equally divided between strongly agree and agree. Of the remainder, 14.6% (n=7) disagreed and 4.2% (n=2) strongly disagreed that it was not preferable. The mode was one and the IQR 1-2 indicating a positive result.

Question two stated: *when preparing for business the following are necessary,* and proceeded to list five items for ranking (Table 21).

Table 21: Preparing for business

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	*MODE	INTER-QUARTILE RANGE
Business management skills are necessary	48 (98%)	1 (2%)	1	1-2
Professional activities are necessary	46 (93.9%)	3 (6.1%)	1	1-2
Networking abilities	51 (100%)	0 (0%)	1	1-2
Education in the specialty area	51 (100%)	0 (0%)	1	1-2
Experience in the product offered is necessary	50 (98%)	1 (2%)	1	1

* 1=strongly agree; 2=agree; 3=disagree; 4=strongly disagree

Even though the mode and IQR is positive for all items, strong agreement is shown for experience in the product that is offered.

Question three stated: *nursing is not just a job, it's a vocation* and 82.4% of participants gave a ranking of 1-2 with the statement and 17.6% ranked 3. The overall IQR was 1-2 and the mode 1 indicating general agreement with the statement. Some participants expressed their disagreement to this question stating it was an "outmoded term" or indicating it was irrelevant.

In **question four**, the statement *family commitments influenced my decision to go into private practice* resulted in an overall ranking of 2-3 with the mode 3. This indicates that the majority n=32 (62.7%) of participants disagreed with the statement and n=19 (37.3%) agreed.

Question five asked participants to rate their opinion to the statement *wanting to make a difference in health outcomes influenced my decision to go into private practice*. A

significant number of participants, 80.4% (n=44) positively ranked 1-2 and 19.6% (n=10) ranked 3-4 with the statement. The mode was 2 and the IQR 1-2.

In response to the statement: *potentially, increased income is an advantage of self-employment* in **question six**, 54.9% (n=28) ranked 1-2 and 45.1% (n=23) ranked 3-4 with the mode 2 and overall IQR 2-3.

Question seven stated: *private practice is a roller coaster - what is an advantage one day may be a "downer" the next*. This statement attained a mode of 2 and IQR 1-2 indicating general agreement with the statement.

Question eight stated: *increased professional recognition is an advantage of self-employment*. The responses showed that there was a degree of disagreement with this question. The mode was 2 and IQR 2-3. Comment was passed to the effect that some participants had more recognition before they embarked on private practice.

Question nine asked participants to respond to five different items under the statement *to be self-employed, qualifications are necessary in the following areas*. The results in Figure 13 show that participants consider it more important to obtain practical qualifications that may assist them in their day to day work than academic qualifications.

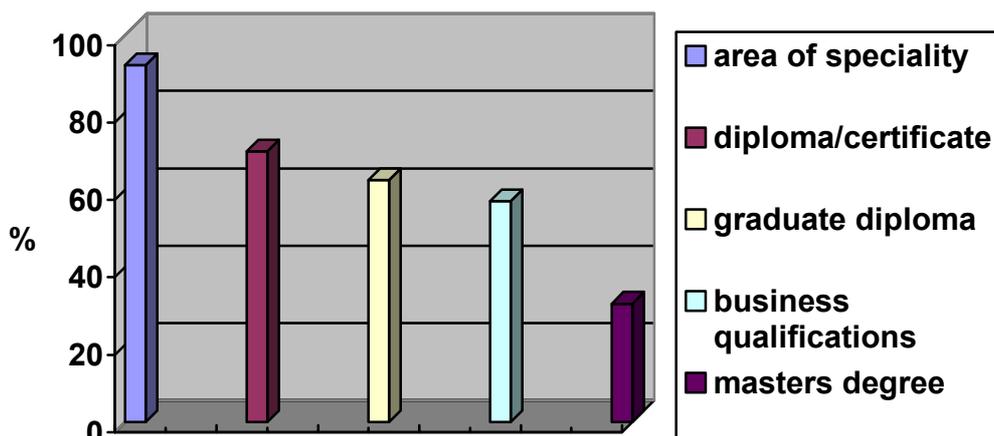


Figure 13: Qualifications considered necessary

A statistical comparison of responses to items in questions two and nine about education, experience and qualifications was conducted. The results of the correlation (Table 22) demonstrate that there is a medium relationship between education leading to qualification in the area of speciality and experience in the nursing product or service offered.

Table 22: Correlations: education, experience and qualifications

(A) Descriptive Statistics

	Mean	Std. Deviation	N
Education in the area of specialty is necessary	1.27	.45	51
Experience in the product offered is necessary	1.14	.40	51
qualification in area of specialty necessary	1.47	.64	51
Graduate diplomas are necessary	2.33	.75	48
diplomas/ certificates necessary	2.04	.60	50

(B) Correlations

		Education in the area of specialty is necessary	Experience in the product offered is necessary	Qualification in area of specialty necessary	Graduate diplomas are necessary	Diplomas/ certificates necessary
Education in the area of specialty is necessary	Pearson Correlation		.451** MEDIUM	.442** MEDIUM	.194 SMALL	.037 NONE
	Sig. (2-tailed)		.001	.001	.187	.801
	N	51	51	51	48	50
Experience in	Pearson	.451**		.365**	.000	.060

the product offered is necessary	Correlation	MEDIUM		MEDIUM	NONE	NONE
	Sig. (2-tailed)	.001	.	.008	1.000	.679
	N	51	51	51	48	50
Qualification in area of specialty necessary	Pearson Correlation	.442** MEDIUM	.365** MEDIUM		.289* SMALL	.370* MEDIUM
	Sig. (2-tailed)	.001	.008	.	.046	.008
	N	51	51	51	48	50
Graduate diplomas are necessary	Pearson Correlation	.194 SMALL	.000 NONE	.289* SMALL		.661* LARGE
	Sig. (2-tailed)	.187		.046	.	.000
	N	48	48	48	48	48
Diplomas/certificates necessary	Pearson Correlation	.037 NONE	.060 NONE	.370** MEDIUM	.661** LARGE	
	Sig. (2-tailed)	.801	.679	.008	.000	.
	N	50	50	50	48	50

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

In question ten, participants were asked to rate their opinion to the statement *lack of professional supervision is a concern in private practice / business*. The mode was 3 and IQR 2-3, indicating a moderate agreement with the statement. It is assumed that responses to this question reflect needs that are dependent on the areas participants worked in.

Question eleven stated, *professional image is downgraded in private practice*. The mode was 3 with IQR 2-3 indicating overall disagreement. When the scores are reversed and compared with the result of question 8, which is positively worded the mean of both scores showed agreement at 71.55%. Interpretation indicates that self-employed nurses consider increased recognition is an advantage and professional image is lower in private practice/business. Statistical correlation of the variables image and recognition showed a very weak relationship (Table 23).

Table 23: Correlation: image and recognition (image reverse scored)

		PROFESSIONAL IMAGE IS LOWER IN PP/BUSINESS
increased recognition is an advantage	Pearson Correlation	-.275
	Sig. (2 tailed)	.051
	N	51

In response to **question twelve**, *continuing professional education is necessary in business/private practice*. The mode was 1 and the range 1-1.25 indicating strong agreement.

A majority of participants disagreed that a *lack of industrial support is a concern* in **question thirteen** with the mode 3 and IQR of 1-3 showing a large variation of opinion.

The response to **question fourteen**, which stated: *the attitudes of other nurses are a barrier/drawback*, drew a mode of 3 and IQR of 2-3 showing that not all nurses agreed with the statement.

Participants' response to **question fifteen**, *nursing is not viewed as a professional business or enterprise as other health professions are*, was agreed with as demonstrated by a mode of 1 and IQR of 1-2.

To **question sixteen** which stated: *generally, it is not realised nurses' roles have changed*, the mode of 2 and IQR of 1-2 showed the majority of participants agreed with the statement.

Question seventeen stated: *to be able to work alone is a necessary pre-requisite*, to which the mode was one and the IQR was 1-2, indicating agreement.

In **question eighteen**, participants were asked to rate their opinion of the statement, *the low status of nurses & nursing contributed to my decision to consider private practice or*

business. The majority scored 3 on the IQR and the mode of 3 indicated disagreement with the statement.

Question nineteen stated: *self-employment gave me increased flexibility in my life*. A mode of 2 and IQR of 1-2 indicated most respondents agreed.

Question twenty, stated that *private practice is a way of staying in the workforce*. A mode of 2 and IQR of 2-3 showed most respondents agreed but some did not. Underlying this response were factors effecting some participants ability to work in tertiary nursing setting for personal or physiological reasons. It is probable that not all respondents are aware of this issue in nursing and how private practice may offer an alternative to mainstream work.

In response to **question twenty-one**, *financial support is necessary for success during establishment of the business*, the mode was one and IQR 1-2, representing support for the statement.

The statement *a supportive family is essential for success* in **question twenty-two**, received a mode of 1 and IQR of 1-2, indicating a positive score.

Question twenty-three stated: *putting a monetary value on my service is difficult*, to which 78% of participants agreed and 22% disagreed.

Participants' response to **question twenty-four**, stating *private health funds do not recognise nurses' services to the same degree as to other health professionals*, gave a mode of 1 with IQR 1-2 indicating strong agreement.

Question twenty-five stated: *in business skills are sometimes learnt on the job* to which the mode of 1 and IQR of 1-2 represented agreement.

Question twenty-six provided participants with ten items (Table 24) under the broad heading *to be a successful business person / entrepreneur you need to be able to:*

Table 24: Entrepreneurial abilities

ITEM	NO. OF SCORES 1-2 ON LIKERT SCALE	NO. OF SCORES 3-4 ON LIKERT SCALE	*MODE	INTER- QUARTILE RANGE
persevere and be hardy	50 (100%)	0 (0)	1	1
have personal stress management techniques	50 (100%)	0 (0)	2	1-2
be determined	50 (100%)	0 (0)	1	1-2
need to have focus and vision	49 (98%)	1 (2%)	1	1
to network effectively	50 (100%)	0 (0)	1	1-2
have good self esteem	50 (100%)	0 (0)	1	1-2
to have a 'pro-active' mindset.	49 (98%)	1 (2%)	1	1-2
need to be patient	49 (98%)	1 (2%)	1	1-2
to be a lateral thinker	48 (96%)	2 (4%)	1	1-2
to ignore instilled nurse 'programming'	47 (95.9%)	2 (4.1%)	1	1-2

The characteristics mentioned in the above table represent those considered to be the most important as a nurse entrepreneur. The IQR of '1' prioritises the top two entrepreneurial characteristics which are *persevere and be hardy*, and *need to have focus and vision*.

Standard deviation was used to measure the stability of consensus and convergence of agreement between rounds on items where opinion changed. The mode symbolises the score most frequently chosen by the majority of respondents, the mean represents the group opinion

of the participants, whilst the standard deviation, "as a measure of spread, represents the amount of disagreement within the panel" (Greatorex and Dexter 2000:1018). The lower the level of standard deviation, the higher is the level of agreement within the panel. Consistency in the mean between rounds demonstrates stability of opinion within the panel. The changes demonstrated in the table show how the Delphi technique worked between rounds and any change in conformity that occurred in the group opinion. Using standard deviation to measure the amount of agreement between rounds shows whether the consensus agreement occurred from the beginning or was due to the Delphi technique process. Such information reassured the researcher of the quality and reliability of the final decision and guides the conclusions that may be determined from the result. Table 25 shows the change in respondents' opinions either between each other or with questions between rounds.

Table 25: Change in consensus level between rounds

QUESTION	Agreement	Mode	Mean	Standard Deviation	Result
Increased income is an advantage of private practice					
Round 1	51%	1	2.43	1.14	
Round 2	58%	2	2.45	.81	The panel was of reasonably stable opinion across rounds but the amount of group opinion increased. This is a classic Delphi item (Greatorex and Dexter 2000)
QUESTION					
A desire to work alone is a characteristic of a nurse entrepreneur					
Round 1	57.7%	3	2.10	.87	
Round 2	98%	1	1.45	.61	increasing agreement with large change in group
To be able to work					

alone is a necessary pre-requisite					opinion, questioning the trustworthiness of the final opinion. Another round may not give a reliable result.
QUESTION Increased professional recognition is an advantage					
Round 1	96.2%	1	1.52	.58	
Round 2	68.6%	2	2.12	.82	Fairly stable group opinion but with variable agreement.
QUESTION The attitudes of other nurses are a barrier					
Round 1	92.2%	1	1.55	.76	
Round 2	54.9%	3	2.31	.86	Unstable group opinion with consistent agreement with the consensus. This doesn't give confidence in the decision or that a repeat round would provide a stable opinion.
	Agreement	Mode	Mean	Standard Deviation	Result
QUESTION Business know-how is needed.					
Round 1	92.6%	1	1.57	.63	
Round 2 Business management skills are needed.	98%	1a	1.53	.54	Reasonably stable opinion across rounds with increasing group opinion.

The greatest levels of agreement between participants were seen in those factors that were identified as activities or personal qualities needed to ensure successful and viable private practice. The nurses agreed unanimously that networking, and being able to do this effectively was highly desirable. Similarly, personal qualities of good self-esteem, perseverance and determination to succeed are required for successful enterprise.

Comparison with other nurses

Data for Grounded Theory research may be obtained from a range of sources (Glaser and Strauss 1967). During the course of the research, a spontaneous discussion was held with a group of employed community health nurses. The six nurses had been involved in a meeting with the researcher and enquired about the research. The nurses were asked for permission to seek their views on private practice and to take notes of the discussion.

In general terms, the nurses believed private practice was a trend across all professions. One nurse remarked "private practice is in the culture of our society, seeing if you can do it". Their opinion was that private practice is an opportunity to extend yourself but also to have more control over personal life, for example, family. They also felt nurses have 'come of age' and believe they are professionals with skills equal to other health care providers. They also acknowledged that the status of nurses and their self-esteem are different to other professionals, probably due to the history of nursing. They emphasised that private practice was a chance for nurses to be seen separately to another profession such as doctors, and therefore not be subordinate or complimentary to doctors. Financial matters were not thought to be influential. The group also thought that private practice gave an experienced nurse opportunity later in life when a change in direction and /or escape from authority, oppression and frustration were desirable. To go into private practice, the nurses felt there were three

factors they needed to consider. They needed to (1) gather confidence in setting up business, (2) develop confidence in their skills for doing it, and (3) gain confidence in charging fees.

When considering the issues raised by the community health nurses, there was congruence with research data. The majority of participants were experienced nurses looking for a change in direction and, for some increased control over personal life. They were seeking to achieve similar recognition status to other health professionals and work more autonomously. Financial rewards were not an influence but the opportunity to extend their skills was. Like the community health nurses, confidence and charging fees are two of the largest issues faced when establishing a business.

Comparisons with other studies

In an attempt to assess the similarities and differences between nurses in business with other small business operators in Australia, findings were compared with data from a survey conducted by the Australian Bureau of Statistics (Australian Bureau of Statistics 2000a). It was anticipated this would provide an interesting comparison of demographic data even though the numbers for the ABS study are so much larger.

The Australian Bureau of Statistics (2000a) surveyed 1,397,900 business operators of 990,100 small businesses in Australia. The definition of a small business was a business employing less than 20 persons. The ABS data included all private sector non-agricultural small businesses and reported that health and community services small business were 43.3% of all small businesses. Also, a narrow majority (55%) of persons working in their own health and community services businesses were female. The ABS also reported the average annual rate of growth in health and community services businesses between 1984 to 2000 was six percent. As was anticipated in this thesis, the majority of participants were female

(98%), as there remains a significantly higher proportion (88%) of females to males entering nursing (Australian Bureau of Statistics 1999).

In the ABS survey (2000a) and this research, the majority of participants were aged between 30 to 50 years, indicating that it is probable that decisions to enter business are mostly made after first gaining experience in a product to be offered.

Comparisons of the data on qualifications of those surveyed illustrate that nurses are well qualified academically. The ABS data revealed that at the end of 1999, the most common qualification held by small business operators was the completion of secondary school without gaining a degree. In addition, four percent had not completed the highest available year of secondary school. Apart from holding a basic vocational qualification, 83% of nurses also held qualifications at degree or diploma level.

Proportionally, more nurses were both part-time in business and operating a home based business than what was demonstrated in the ABS survey. Home-based businesses are those where most of the work of the business is carried out at the home of the operator (Australian Bureau of Statistics 2000a). The high proportion of part-time nurse operators could be linked to the somewhat higher proportion of home-based businesses and female participants. The ABS survey revealed that home based businesses make up a very large proportion of the total small business picture in Australia (62%), and are increasing. Home based operators are more likely to be working part time with 34% usually working less than 35 hours per week and female home based operators in particular more likely to work part time in their business.

The number of business operators reporting employing staff was almost equal (54% vs. 55%), in both surveys. ABS reported that of 2.5 million people in 527,000 small employing

businesses, there was an average of four employees per business. Both surveys reported similar results for the number of years businesses had been operating, except for in the one to less than five-year bracket, which was double in the ABS survey. The figures suggest that approximately one in four businesses continue to operate after ten years.

As the information in this inquiry is based on data obtained from nurses primarily accessed through one database, the results may differ from those that would have been produced if all self-employed nurses in Australia had participated in the study. The size of the two surveys discussed was also vastly different, with the sample size of the nurses' survey being 54, and the number in the ABS survey 1,397,900. With these limitations considered and as a purposive sample, the nurses were considered to be representative of the population of self-employed nurses.

Contrary to Schön's study (1992) which found that nurses' attitudes to control over nursing practice and receptivity to change were negatively influenced by the length of time since initial registration, this thesis did not support these findings. In her survey of all nurses registered in a certain district, Schön (1992) found 27.4% did not favour independent nurse practitioners. Other results referring to those in independent private practice agree substantially with those of this thesis. She found that the large majority (98.5%) was female and older with a mean age of 41 years. Two thirds of the nurses in her study held qualifications at diploma level and a minority favoured a masters degree. These results suggest that most nurses believe nursing practice is based on experience, not education. It can be assumed from the profile of the participants that age and years of experience did not effect their ability to embrace challenge and change.

Similarities between the study by Bonawit and Evans (1996) and this thesis are also of particular note. The findings of this study are consistent with the diversity of practices and the statistics for nurses' diploma qualifications, numbers of clients and location of business premises reported on in that study.

Other reports concentrate on the clinical roles of advanced practice nurses and frequently fail to mention the diversity of roles undertaken in private practice nursing. These roles include education activities, research projects and private consultations. While some of the comparative data used from the literature is several years old, they represent one of the few times there is data available to perform a comparison with data from this study.

Summary

This chapter provides an account of the data generated from the 54 nurse entrepreneurs who participated in this study and compares it with similar studies. Important aspects of the data analysis are the results from the application of Delphi technique. The factors in which participants showed lowest agreement in their opinions were the type of post-graduate qualifications and support infrastructure needed in private practice. There was strong agreement in support of nurses holding qualifications in their particular area of speciality as the product offered in their business. Only a third of participants considered a master's degree a necessity, whereas the majority of nurses supported post-graduate diplomas or certificates, probably because this would support their practise. Business qualifications per se were not strongly supported, although there was strong support for acquiring skills in planning, management and business issues.

The results of this study provide a consensus between participants on the influences on and experiences of private practice nurses with issues prioritised. This data helps us to

understand many of the issues experienced by nurse entrepreneurs. It also contributes to providing a deeper understanding of the results of the qualitative data that will be presented in the next chapter.

CHAPTER NINE ~ UNDER SCRUTINY - ANALYSIS AND INTERPRETATION II

This chapter provides the second part of the analysis and interpretation of data gathered in this thesis. Guided by the philosophical and methodological approaches chosen for this study the qualitative data generated from the comments provided by participants after each question were analysed to describe the experiences of nurses in private practice and expand on meanings in the quantitative data. From this process, five major categories and one core category were discovered. The process of how 171 codes formed these five categories is presented in diagrammatic format. The chapter concludes with a descriptive narrative of the five theoretical categories. Considerable discussion of the finding occurs during the description.

Analysis of the qualitative data to develop the core category

The option to comment and expand on questions was built into the questionnaires. Many respondents chose to include additional comments. The purpose of gathering responses to semi-structured questions was to enable the researcher to better understand and capture the points of view of the participants. A Grounded Theory method of analysis (Figure 14) was applied to the comments provided by 89% of participants in the first questionnaire and 26% in the second. The reduced number of additional responses indicated theoretical saturation and contributed to the decision to cease rounds. The process of using the Delphi Technique for data collection with the Grounded Theory approach to data analysis is depicted in Figure 14. The quantitative and qualitative data were analysed using the constant comparative method, whereby a continual and systematic process incorporating data collection, coding and analysis was applied.

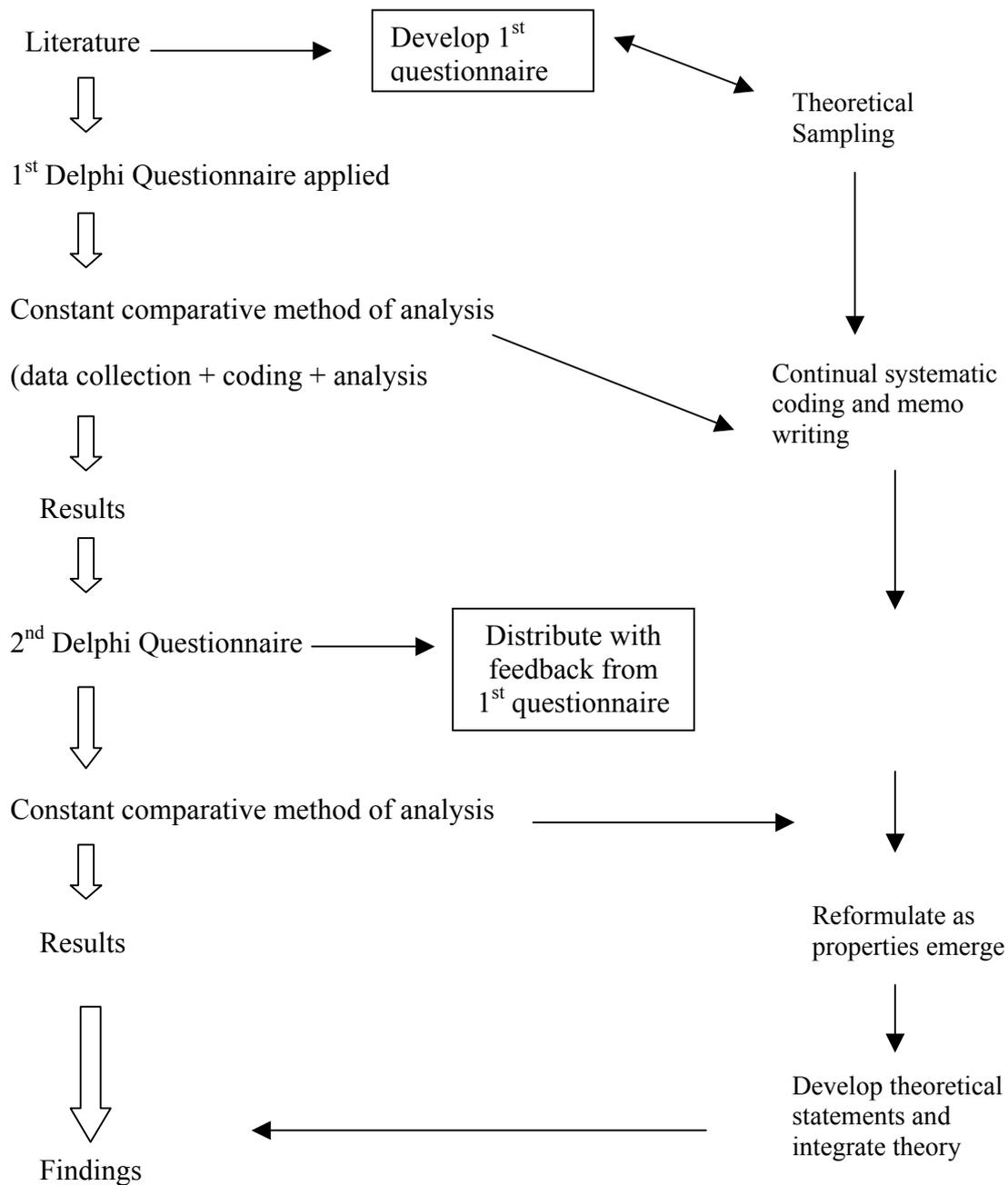


Figure 14: Process of analysis using Delphi Technique and Grounded Theory

As the data were collected, each word and line was examined to label the participants' meaning. Codes were developed through a process of open coding and entered into the NVivo (QSR International Pty Ltd 2002) computer program, a software system for managing, organising and supporting research in qualitative data analysis. Sometimes, the actual words used by the participants were assigned. This helped to maintain the participants' own meanings of the concepts rather than the researcher's meanings. However, where this was not possible, the researcher assigned a label for the concept. One hundred and seventy-one free

nodes were created initially. The descriptive codes evolved further as analysis progressed and were clustered into categories representing themes emerging from the data. The data were coded and re-coded, with logical groups of concepts classified as categories. Re-coding and forming categories brought the number of *in-vivo* nodes to 55 tree nodes. The categories were theoretically coded to conceptualise how they related to each other and to reveal the underlying patterns within them. Using the constant comparison method, the major themes that emerged from the preliminary analysis of questionnaire one were verified with the literature and the quantitative data and are displayed in Table 26.

Table 26: Major themes from initial analysis

Major themes	
▪ Being professional	▪ Getting paid
▪ Business management	▪ Job satisfaction
▪ Business success	▪ Knowledge
▪ Change	▪ Personal characteristics
▪ Clients	▪ Professional image
▪ Collaboration	▪ Qualifications
▪ Demand for services	▪ Recognition and acceptance
▪ Education	▪ Reimbursement
▪ Equality	▪ Skills
▪ Fees	▪ Support
▪ Future options	▪ Time

The researcher worked extensively with the properties and the dimensions of those properties within each category. Questions were asked of the data as the researcher regrouped and integrated categories. Questions strove to identify the contexts, conditions and variances under which the categories existed. During this process, theoretical codes were assigned to the preliminary concepts to conceptualise how they related to each other and to reveal the underlying patterns within them. Additional data were added from the questionnaire and incorporated into the results and emerging story line where appropriate, in the final stages of

the analysis. Further examination of the categories by assigning properties, using constant comparison technique, and theoretical coding resulted in the final five theoretical categories.

Linking the categories through their theoretical codes enabled further reduction toward the identification of the core category. The resultant categories, their properties and the theoretical codes that were assigned to them are detailed in Table 27. Theoretical saturation of the data was achieved through comparison with relevant literature and the quantitative data obtained in the study.

Table 27: Core and theoretical categories

CORE CATEGORY	CONCEPTS	THEORETICAL CODE
Development <ul style="list-style-type: none"> - Advancement - Expansion - Growth - Moving forward 	Support Being professional Business success Facing challenge Future opportunities	Interactive Family <ul style="list-style-type: none"> - mutual effects - interdependence - mutual dependency
THEORETICAL CATEGORIES		
Support <ul style="list-style-type: none"> - Infrastructure components that provide assistance, information, moral courage, guidance, the people, provision of resources, help, overt acceptance, overt verbal acknowledgement, visible, felt, seen, known about, active. To prop, to provide for, to maintain. 	Peers Isolation Reimbursement Industrial Professional	Context <ul style="list-style-type: none"> - environmental background - settings - conditions
Being Professional <ul style="list-style-type: none"> - forming - maintaining - professional persona 	Competent Qualified Experienced Accountable Autonomous Knowledgeable Learning on the job Taking responsibility Continuing education	Process Family <ul style="list-style-type: none"> - stages - phases - steps
Business Success <ul style="list-style-type: none"> - achievement - accomplishment 	Identify service need / gap Providing quality service Form affiliations Personal Characteristics	Dimension Family <ul style="list-style-type: none"> - elements

	Personal abilities & skill Take risks Seize opportunities Combine skills Satisfaction / Fulfilment	<ul style="list-style-type: none"> - divisions - pieces of - parts
Facing challenge <ul style="list-style-type: none"> - confront - face up to 	Time for change Income considerations Self-management Coping with uncertainty Breaking through glass ceilings Wearing all hats Administration	Cutting edge family <ul style="list-style-type: none"> - critical junctures - turning point - break point
Future opportunities <ul style="list-style-type: none"> - chance - opening - break - prospect 	Advanced practice option Retention Recruitment Training	Strategy Family <ul style="list-style-type: none"> - tactics - strategies - dealing with

The final round of the study generated 10 main issues for self-employed nurses. Listed in order of priority the 10 issues identified as very important for nurses establishing a business were:

- Time to change career direction; time to spend with clients; time to promote oneself and the business.
- Getting value for your service; charging and setting fees.
- Having or being able to access the right qualifications.
- Having good professional image both within and outside of nursing.
- Achievement in job satisfaction and personal fulfilment.
- Dealing with having an unstable income
- Provision to and access to appropriate continuing professional development
- Having a demand for services
- Equity of fee reimbursement for clients.
- Being able to use personal skills

Related issues raised in the literature include subordinate nursing roles, lack of flexibility in personal life and inability to control personal circumstances (Shaver, Gartner, Crosby, Bakalarova and Gatewood 2001).

To demonstrate the conceptualisation of each category, five diagrams showing the linkage of concepts or codes that created each category are provided with brief comment on the following pages. As concepts are not exclusive to a single category, some may be repeated. Figure 15 presents a simplified audit trail of the concepts to the core category of *development*, which is fully described in chapter ten. Development was chosen as the title for the core category because of its properties and therefore its relationship to the substantive categories. Reflected in *development* are the properties of advancement, progress, creation, growth, forming, striving, moving forward and expansion. These properties symbolise opportunity for change and the development of the self, as the individual nurse and for the profession in expanding and extending the role of nurses.

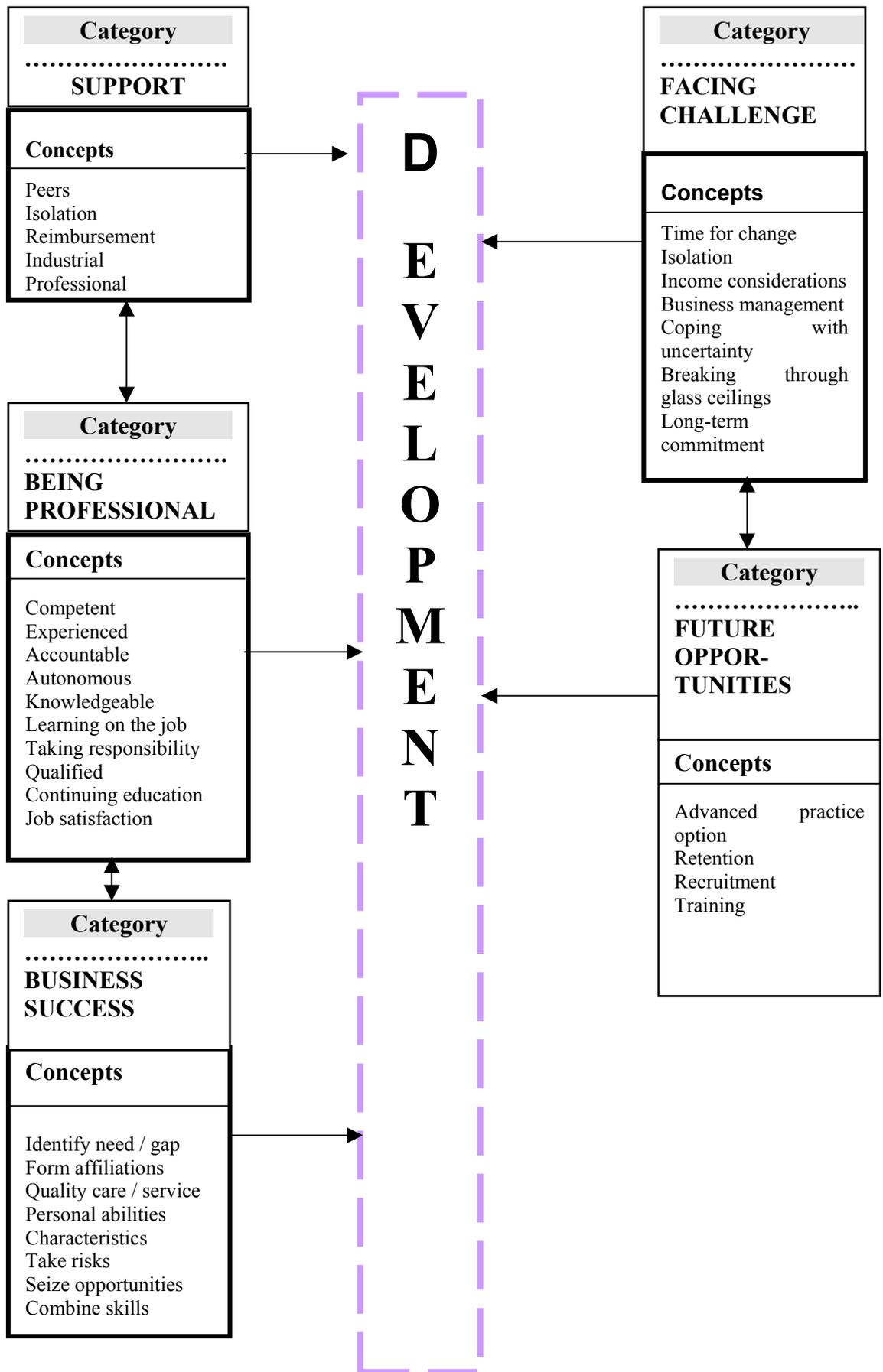


Figure 15: Audit trail to core category 'development'

Description of the five theoretical categories

Continued constant comparative analysis of the data generated the theoretical categories *support, being professional, business success, facing challenge* and *future opportunities*. In this section of the analysis and interpretation of the data, findings are reported in a narrative style that draws on direct quotations from the participants' transcripts in an endeavour to draw on multiple realities that create meanings for individuals (Streubert and Carpenter 1995). Participants' data sets were compiled into one transcript and tracked with line numbers as indicated by the letter 'L' alongside the quotations. Participants' codes were assigned the letters 'NO' if they were accessed from *Nurses and Midwives in Private Practice, Australia*, and 'SO' to indicate they were part of the snowball sample. Quotations that appeared to represent the main opinion were chosen, as written by the participant, as typical of the perceptions and experiences recorded. They are not, however, statistically representative of a larger population.

Following the Grounded Theory method of data analysis, concepts and categories were moved, integrated and refined as coding developed. Different colours in the following figures indicate some of this movement. Much more change occurred than is depicted in these charts and examples only are provided. Yellow signified that the category and properties were moved to another category or became that category; aqua signified a concept that was a category but was moved to merge with the current category; mauve indicated the concept was moved from another category and pink indicated a concept that had shown up at different levels within categories.

Figure 16 shows the five main categories that evolved from the constant comparative process and led to forming a higher order category, the core category, 'development' that interacts with each category and represents moving forward through growth and expansion.



Figure 16: Core category and theoretical categories

The model in Figure 17 shows how the category 'support' emerged from an initial categorisation as 'lack of support' that was drawn from the concepts 'peers', 'isolation', 'reimbursement', 'unreliable staff', 'industrial concerns', 'professional matters', 'amalgamation' and 'administration'. How other constructs, 'facing challenge', 'administration' and 'business success' linked to the model are depicted.

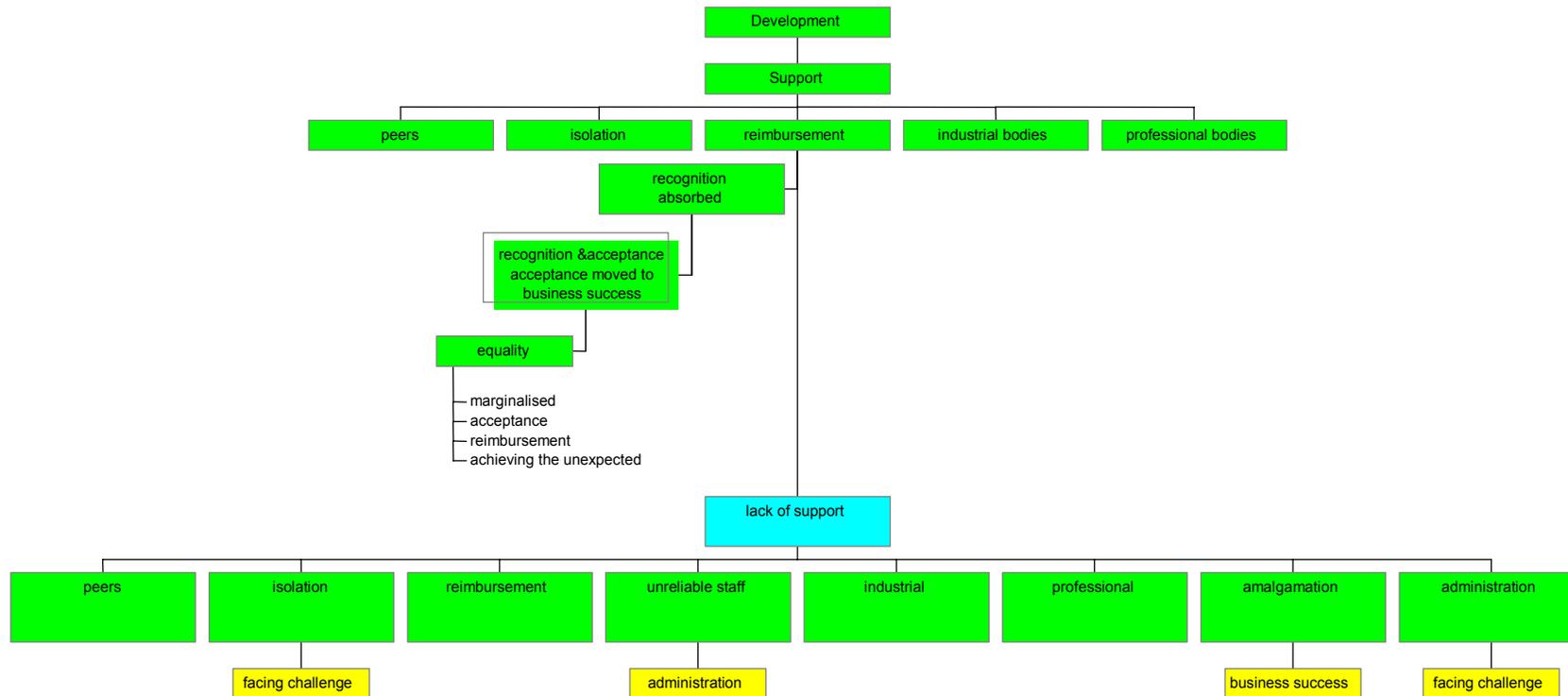


Figure 17: Audit trail to category 'support'.

Category 'Support'

Going into business for yourself, becoming an entrepreneur, is the modern day equivalent of pioneering on the old frontier.

- Paula Nelson -

Support is a category that describes the components of the infrastructure around nurses in business, the level of support received from a range of professional and industrial bodies and the effect insufficient support has on restricting business development and initiatives. *Support* conceptualises the nurses' environmental background, highlighting some of the differences in conditions between settings. Prominent concepts include the need for comparable reimbursement with other health service providers for nurses' services by private and public health insurance and support from peak nursing bodies.

Reimbursement

Support also conceptualises the difference between nurse entrepreneurs working in different domains, as to the type and amount of support that is required. For example, for clinicians, reimbursement for their consultancy services to clients is considered paramount, whereas for non-clinicians it is not an issue. The following quotes highlight this difference:

NO42, L196: [Lack of reimbursement] but not for me.

SO25, L189: Lack of reimbursement a barrier for nurse practitioners; does not affect nurse consultants.

SO32, L192: I think these barriers may be more relevant for those in clinical roles in private practice.

Third-party reimbursement for nursing services is a structural issue affecting control over nursing practice. The nurses expressed strong feelings about the inequity afforded their services as compared to other health professionals.

NO40, L318: This stinks! (Private Health not recognising nurses to the same level as other professionals).

NO13, L39: Many nurses don't view private nursing as a professional business - capable of making money, whereas they view, say Podiatrists or Occupational Therapists as "professional".

The literature on third party reimbursement has largely focused on the desirability of such payment and the difficulty in getting it (Smith 1996). Unlike medical practitioners, nurses do not have the right of private practice in the public setting, which would strengthen the financial aspect of their practice. In the private sector, clinical private practice nurses bill the client directly, and some, not all, private health insurers reimburse for these services depending upon their nature.

NO62, L214: Some clients are reimbursed a very small amount under Home Nursing on Private Health Insurance - requires top cover and is about \$10 an hour!!!

NO57, L150: some clients don't have the money to pay.

Determination

Participants almost unanimously identified the need for guts and determination to develop a successful practice. In the quantitative analysis these characteristics were ranked as one of

the top six required. The following quote shows the determination nurses felt in not allowing the barrier of reimbursement to hold them back, but to try to use it to be more successful.

SO22, L230: Determination to succeed

NO46, L236: Madness, a lot of guts and determination!

NO14, L43: Preparation - a lot of guts. Strength & determination

Industrial and professional support

Study participants considered that the support offered from industrial and professional nursing bodies was inadequate in some instances and expressed hope that this would improve so that creative advancement within the profession with increased role opportunities could be achieved.

NO49, L337: In any event, the assumed minuscule numbers of nurses in private practice will ensure we remain on the margin to some extent. When (with the help of key organizations working determinedly with NAMIPPA) rebate justice is achieved for clients of nurse practitioners, then we can celebrate professional recognition.

NO39, L75: I fortunately have received total support from professional / industrial areas. In some cases not from other RNs. (Educator).

NO50, L344: Unions are of little help. Support from the 'profession' is more important.

Isolated

Being isolated as a sole provider was accepted as a point of reality but not considered a problem from a professional position. It was acknowledged that it was easy to become isolated if working as a sole provider from a home based business.

NO31, L50: Easy to become isolated, especially if working alone and at home

NO08, L251: Never really professionally alone.

NO55, L143: Ability to continually inform people of the work I am doing. Working alone means there is no peer support of my skills.

Peer acceptance

Participants acknowledged that how they were perceived by peers had changed over time, with attitudes now being more accepting of private practice even though many still found this to be an issue of concern.

NO39, L301: A major drawback, particularly in the earlier years was not being accepted as a consultant in nurse education by the mainstream RNs and a number of Directors of Nursing - (not like the Nurses Board of South Australia staff or the staff at the Australian Nurses Federation). Since these earlier 12 months though, due probably to my perseverance and determination, I have mostly received acceptance and now, since my announcement of retirement many attempts have been made for me to continue offering the program here in SA and NT.

NO40, L310: In some quarters it seems less professional recognition actually within nursing field.

The nurses also expressed their disappointment at colleagues attitudes to private practice, which they felt expressed misunderstanding of the private practitioners' intentions, that were primarily to provide quality health services that would make a difference to health outcomes.

NO49, L332: While a tangible professional recognition is not important, in my view, it is crucial for the viability of private practice that the key leaders + nursing organisations, e.g. Australian Nurses Federation + Nurses Boards + Royal College of Nursing Australia, accept, support, encourage + praise the private practice movement, rather than put barriers and negative influences in place.

NO40, L416: Professional recognition is improving, however colleagues still see private practice in nursing as a "money grabbing exercise".

Schöen (1992) identified support for nurses in private practice as one of the basic issues involved in control over nursing practice. Schöen's study (1992) found favourable attitudes toward independent practice were associated with a more college-based initial nurse training program, more recent initial registration, a greater attachment to the labour force and a stronger commitment to a nursing career. As in this study, Schöen (1992) also found that variables related to education such as the amount of education after registration have a significant effect on attitudes toward independent practice. The results of her study are relevant for an additional reason. They provide insight into divisions amongst nurses that are related to nurse characteristics that are found in this study.

NO68, L388: Attitudes of other nurses - Agree it is a problem from the perspective of one living in an isolated rural area. It also depends on the level of education of

fellow colleagues. The lower education they have the more opposition there seems to be.

NO08, L254: ANF has not been supportive in the past.

The effects that divisions within the profession have on practice development are well articulated in the literature by Schöen (1992). The attitudes of nurses toward private practice needs to be acknowledged as the history of nursing is replete with instances where internal divisions have prevented the attainment of common goals. For nurses to succeed in private practice, many of the barriers they encounter, such as lack of support will need to be overcome. In her study on nurses' attitudes of extended practice, Schöen (1992) found a nurse who belonged to at least one nursing organisation had a more supportive attitude than one who did not. Support for autonomous practice was significantly predicted by membership in a professional organisation.

Support relates to the concept of context and describes the over-arching operational environment in which the nurse practises. Such an environment has boundaries and structures that together shape the environment for practice (McCormack, Kitson, Harvey, Rycroft-Malone, Titchen, Seers 2002). The components of this structure include nursing peers, health insurance providers, industrial bodies and professional groups. Environment indicates the culture and organisational structure of the workplace that values entrepreneurship as much as mainstream traditional nursing. To be effective, nurse entrepreneurs need to be where major strategic and tactical decisions are made. Acceptance of the private practice role facilitates this occurring.

McCormack et al (2002), consider that little research has been undertaken to explore the impact of the context of the practice environment on practice outcomes, including quality of care and user outcomes. Environments that provide appropriate resources, information, feedback systems and clearly defined boundaries enabling and empowering relationships are more probable to lead to positive outcomes. A structure that assists nurses to expand their entrepreneurial role would help the health industry adapt to the rapidly changing look of health care (Parker 1998).

Summary of Category 'Support'

Creating the correct environment to enable the entrepreneur to thrive while at the same time safeguarding principles of quality care in the sector would be developing new ways to care for the health of the community with fewer resources.

The theoretical construct *being professional* will be presented in the next section.

The theoretical construct, 'being professional' emerged from the concepts and categories shown in the diagram in Figure 18. The constructs of the category 'education' are detailed. The concepts 'time with clients', 'credible', quality service' and 'flexible' are clustered in the initial category 'being professional'.

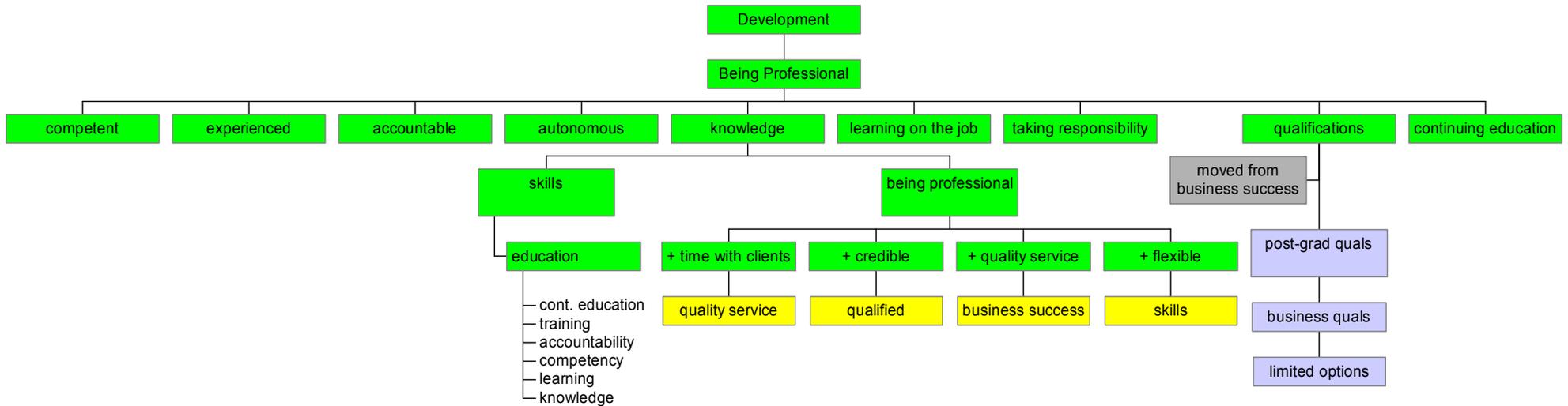


Figure 18: Audit trail to category 'being professional'

Category 'Being Professional'

Success is not a matter of chance, but a matter of choice.

- President William Jefferson Clinton 2000 -

Being Professional incorporates key concepts considered part of the persona of the professional nurse. Obtaining and maintaining qualifications, skills and knowledge for competent practice are concepts considered important in this category. Other parallel concepts are education and experience. This category also addresses job satisfaction and the self-fulfilment experienced from being in private practice, which was considered highly essential in the quantitative data. *Being professional* overlaps with another category, *business success*, in that it contains the personal requirements to achieve success in business.

This category conceptualises the process of becoming a nurse entrepreneur in private practice. Three stages are identified; one of obtaining the qualifications necessary pertaining to the nurses' product, a second of developing experience and a third of maintaining those skills and qualifications.

Education

Continuing professional education that is specific to the area of practice and in matters relevant to setting up business was considered highly desirable. Respondents felt they had lost access to this and stated a wish for its return.

NO04, L11: It was a great pity that the Australian Visiting Nurses Association was swallowed up by the Royal College of Nursing Australia - the Australian Visiting Nurses Association lectures were regular and directed towards our work and expertise.

NO40, L78: I think ongoing professional development in areas covered in my practice is essential. I think also that business management skills are essential to get it up and running initially.

Education was considered vital to developing the nurses' broad view of business and for demonstrating credibility. Overall, nurses in the study demonstrated a strong positive attitude to acquiring education, as was demonstrated by the range of post-registration qualifications indicated.

NO417, L418: Tertiary education qualifications such as masters degrees and diplomas enhance practice and credibility.

NO08, L252 Ongoing education is preferred or you won't be in business for long!

NO71, L232: Common and business sense are essential, education helps.

As reported in the analysis of the quantitative data, although several participants did not hold tertiary qualifications they did hold certificates or diplomas relevant to their area/s of practice. The consensus was that these types of qualifications were more relevant to their practice than were tertiary qualifications. Both the knowledge gained from experience and the gaining of educational qualifications were considered crucial to running a successful business.

NO39, L72: It would be extremely difficult without the practical experience and the necessary knowledge.

NO69, L158: Not just the quals but the experience getting them & the experience in practice. Different experiences.

Participants also considered that qualification in tertiary education enhanced practice and credibility. The following quote is typical of the opinions expressed.

NO35, L57: For marketing, credibility and knowledge base reasons but obviously the subject matter must be relevant to the product you're selling.

The data in this study concurs with Schöen (1992) who found in her study that graduates of baccalaureate programs who had a broader educational base, were more likely to hold a more professional perspective with a greater range of work options and favour autonomy in nursing.

NO68, L390: The lower education they have the more opposition there seems to be.

NO62, L370: Increased prof. recognition - it's a great advantage if it occurs - I feel I have met with a great deal of suspicion an lack of recognition, especially by peers and some of the medical profession.

SO16, L407: Prof. recognition - it's a long time coming - had a high profile to start with.

Personal characteristics

The personal characteristics of the nurse as entrepreneur were considered to influence the type of education that needed to be undertaken.

NO31, L51: Depends a great deal on the entrepreneurialship of the individual and business sense / skills.

NO47, L92: Depends on the qualifications. In my case my MEd provided a lot of background for my practice. Over all I think they are valuable in terms of developing ability and thinking/plan also confidence in self.

NO53, L117: Postgraduate qualifications - Depends on the experience & characteristics of the individual and area of practice - a RN who maintains up to date practice and self-directed learning could be competent and accountable.

The importance and value of experience for those who graduated before nurse education was established in the tertiary education sector is indicated in the following quote.

NO55, L358: Prior learning and years of experience are of immense importance to someone of my age (I graduated in 1966). There are no tertiary qualifications available for my area of expertise. Neuro-linguistic Practitioner..... Practitioner qualification is the level of qualification.

Some respondents held a different view of the need for post-graduate qualifications, or were cautious in rating their level of importance. Two of the views expressed were:

NO08, L22: Useful but not essential

NO04, L246: PG & business quals - preferred maybe, not necessary.

Expertise and accountability

Many nurses considered developing expertise on the job to be the norm but required one to be adaptable and flexible to change and be able to adopt opportunities as they arose.

NO62, L374: Can learn a lot on the job - some things cannot be taught..

NO40, L311: Life experience is very important, I think too!

Holding professional accountability was considered a bonus of being self-employed from the aspect of being recognised for success and seeing outcomes.

NO45, L106: When things go wrong there's no committee to blame. When things go right I don't have to share the glory.

NO53, L120: "An RN can hang out the plaque".

NO55, L142: Having the responsibility is part of the advantage.

Qualifications

Business qualifications were considered an advantage but not essential to running a business.

NO31, L51: depends a great deal on the entrepreneurialship of the individual and business sense / skills.

NO35, L57: PG quals in business would be very helpful when it comes to funding proposals!

The lack of qualifications were perceived to limit the scope of business practice by restricting opportunities to become a proprietor of a business rather than a contractor undertaking work for some one else.

NO04, L9: have no post-graduate [qualifications] so that's why I am a 'contractor', not an employer.

Job satisfaction and autonomy

Many nurses expressed the importance of enjoying their jobs, which in turn improved self-image and confidence and influenced success.

NO50, L113: Increased sense of personal and professional well-being.

NO69, L155: Job satisfaction overall.

For 74% of respondents in the study, work satisfaction was of high personal necessity. This assumes that nurses act rationally to develop their interests as they see appropriate. Nurses starting a business are seen to be controlling their practice as determined by their attempt to maximise their utilities. Influences that encourage nurses to consider developing a business enterprise included background factors that influence their perception of their profession, career factors that relate to their present and desired future and other uncontrollable factors such as workplace changes.

A number of studies have found a positive relationship between job satisfaction and autonomy of nurses (Schöen 1992). This is enhanced with the satisfaction of administering personalised care with acknowledged health outcomes.

NO14, L275: It doesn't make you a fortune due to the fee structure and limitations by Dept. of Veterans Affairs - however it beats working in the Public Hospital Sector.

NO55, L142: Apart from small client base, I mostly find only advantages in my practice.

The notion that autonomy gives total self-control over work was exposed as a myth when the nurses explained that different bodies applied influence and control on their practice. Organisations such as the Department of Veterans Affairs (DVA) and the Australian Taxation Office (ATO) were mentioned. Being required to work within the bounds of an organisation's business plan constrained development of the nurses' businesses. It also influenced the nurses' ability to stay focussed on their own business goals.

NO30, L46: As a self-employed nurse everyone is your boss i.e. Health funds, Department of Veteran Affairs, Australian Taxation Office.

NO14, L258: It is very hard to have focus & vision for building up a business when government changes e.g. Department of Veteran Affairs are constantly changing all areas of client classification, monetary rates, clinical pathways, guidelines etc.

Autonomy is promoted as a characteristic of the independent consultant and as an advantage of the role. It results from the nature of being self-governing in that one becomes a freelance operator when self-employed. Braddock and Sawyer (1985) and Crowley (1989, in Berragan 1998) warn that the notion of autonomy in independent practice may be constrained by a greater number of forces in the external environment that impose control over their work and thus stifle their autonomy.

Autonomy is considered an essential ingredient in professionalism and confers independent function at the individual practice. The principle of autonomy refers to the individual's capacity to make independent decisions based on the assumption that he or she possesses the cognitive, psychological and emotional faculties to make rational decisions. Aprile (1998) explains that three criteria of professionalism are autonomy, competence and dedication for social good, all of which nursing has. Independent nursing practice implies that nursing decision-making is autonomous. Implicit in this statement is that nurses who practise independently have direct responsibility and accountability for their actions (Smith 1996).

Blanchfield and Birodi (1996) also lend their support to the concept of autonomy in practice. For nurses to be effective, they are empowered with sanctioned authority and autonomy to manage relevant aspects of health care and deliver patient care. Authority is discussed as sanctioned or legitimate power delegated to an individual and which allows the individual to make decisions and perform related functions. Autonomy on the other hand is an individual's ability to independently carry out responsibilities of the position without close supervision. Blanchfield and Biordi (1996) stress that autonomy is consistently rated as a very important factor for both job satisfaction and effective health care. Participants rated the importance of job satisfaction very strongly, as was expressed in their previous comments.

Maintaining professional development is an issue that brings the nurse in business both opportunity and challenge. Smith (2002) supports the notion that more than ever professionals must keep up to date with changes and be open to developing new knowledge and skills for career development. For the business nurse this may create a choice of accepting work to earn income or attending professional development, which is paid for out of their income. Smith (2002) stresses that the use of common sense and judgement must prevail as the opportunity in attending professional development is to network and find out what is happening in the market place with the possibility of self-advertising.

Summary of Category 'being professional'

The value of education was considered from more than one perspective. In holding credentials, it was considered necessary that they be of sufficient status so not to be a limiting consideration. Porter-O'Grady's (1998) view that education prepares one for broader areas of responsibility and for a wider variety of functions that assist to make a difference in work outcomes and impact on the health care system is supported by the participants. In addition, education strengthens commitment to create or facilitate meaningful change in the profession and health system. The role of education in expanding understanding of the impact of nurses on the health of the community and the variety of non-hospital roles for nurses is vital. Combining nursing with business insights and skills may help to understand the dynamics of the health system and the operational realities that influenced it. The theoretical category *business success* will be presented in the following section.

The categories of 'personal abilities and characteristics', 'identify gap', 'take risks', and 'seize opportunities' were drawn from the concepts 'qualification', 'entrepreneurial' and 'form affiliations' and the theoretical construct 'business success' was formulated as displayed in Figure 19.

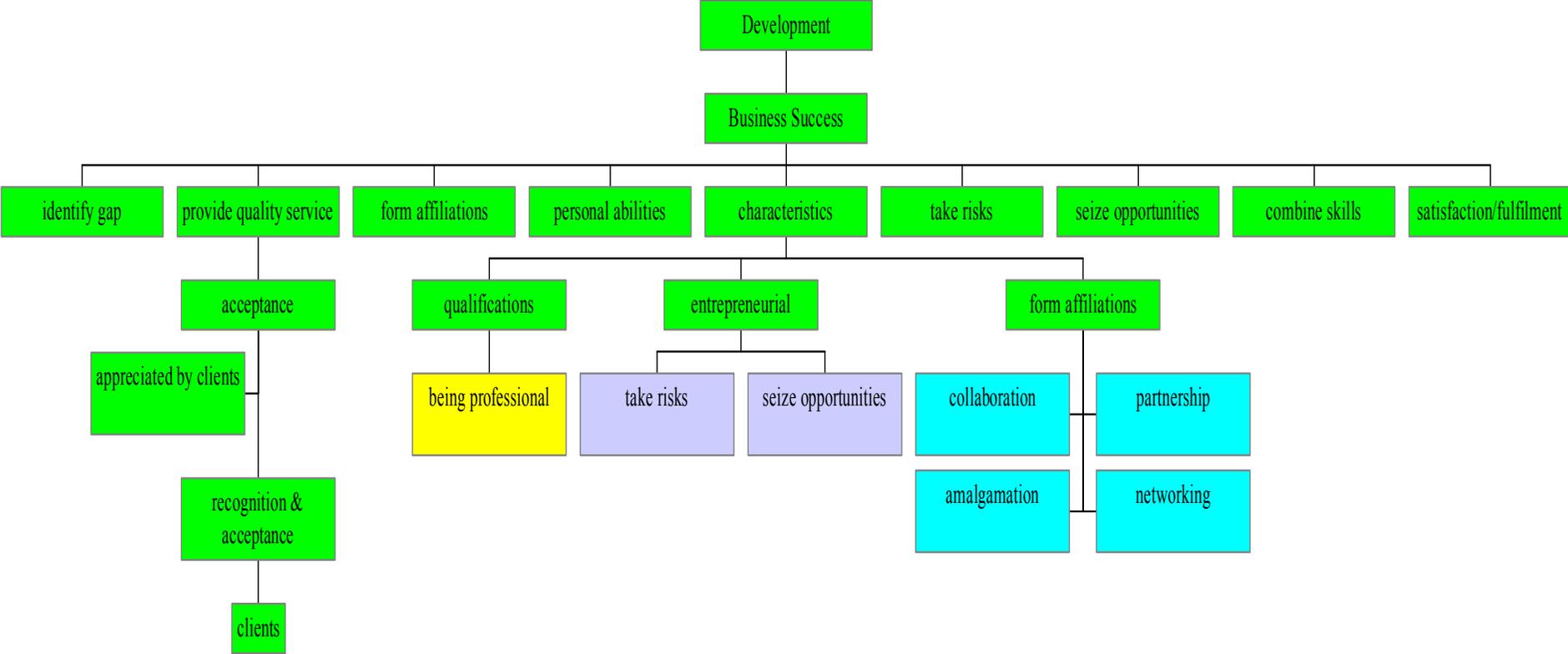


Figure 19: Audit trail to category 'business success'

Category 'Business Success'

*Success to me is having ten honey-dew melons
and eating only the top half of each one*

- Barbara Streisand -

The category *business success* describes the activities participants considered the most constructive in achieving success in business. The concepts in this category illustrate dimensions of establishing a business and the personal characteristics required for being entrepreneurial. The category intersects with at least one other category *facing challenge*, as both categories conceptualise risk, opportunity and challenge.

The concepts in *business success* may be divided into resources (collaboration with others or partnership; personal abilities), actions (risk-taking, seizing opportunities) and rationale (need in the community or service gap; job fulfilment). These concepts play a variable role in the development of a business, changing their prominence as the entrepreneur's needs and situation change. The concepts illustrate that success is influenced by the activities undertaken by the nurse and the personal and professional features of the nurse.

Partnership

To address some of the issues of isolation, cost-effectiveness, lack of peer supervision and access to support, some respondents considered it desirable to join in partnership with others or to combine different services or providers in one office. The ideal successful business practice was considered by some to be a group of nurses who would share the burdens and costs involved in administration.

NO62, L382: The ideal would be a group of nurses - with one person to take on some of this for all of us. That requires sufficient income to pay rent and that requires enough clients which requires all the hats for a period - it's a bit of a catch 22! All the best with all your hats!

NO55, L379: One of my biggest problems is being "IT" - wearing all hats - clinician, booking clerk, accountant, debt collector, advertising agent etc not forgetting THE COMPUTER!! entries. It's difficult to balance it all.

NO13, L261: ... feel without amalgamation or less pressure for data and increased paperwork, we will be working very long hours for the dollar.

Finding a niche

Without a need for the nursing product being offered it would be hard to build a business. Finding a niche or gap in health service provision lends itself to the development of a health service or business. Determination to succeed is necessary to overcome some of the barriers and to develop a vision that leads to success.

NO08, L265: However, in Newcastle, patients attend doctors practices to have dressings changed, rather than paying private nurses. Compared to Sydney, when I worked for an agency, the majority of clients were private.

NO, L33: Doctors phone me to nurse their clients, the work just kept coming.

Recognition, funding, credibility and professionalism

The link between recognition, funding, credibility and professionalism was expressed passionately. The belief that these concepts were important to ensure business success was very strong.

NO35, L63: Recognition, funding, credibility and professionalism - hand in hand - are the cornerstones of a successful practice. You can't do without any of them and they feed off each other.

Success was also seen to depend on the qualifications held by the individual, as these provided credibility and knowledge and enhanced practise.

NO47, L92: Depends on the qualifications. In my case my MEd provided a lot of background for my practice. Over all I think they are valuable in terms of developing ability and thinking/plan also confidence in self.

NO07, L16: Continuing education is necessary - and new challenges.

Personal skills and abilities

Business success was also considered dependent upon certain personal skills and abilities.

NO62, L211: Be able to think laterally and see different opportunities.

NO71, L238: Management & practical skills, self confidence and expertise

NO46, L237: Guts and determination.

Recognising personal abilities and making the most of them by combining skills broadens the range of services the nurse can offer and expands her opportunities.

NO54, L130: In business as well as nursing.

NO71, L405: Although a nurse, I am also a qualified accountant. I do not only work as a nurse practitioner in private practice. I work on projects and offer financial education for nurses.

NO55L136: Having had personal experience of the efficacy of NLP for health and healing and positive change, I believed this combined with years of nursing experience would be a wonderful way to work on an individual basis.

The data highlighted that contributing to health outcomes was important to nurses. Nurses revealed they felt dissatisfied with their work as an employee and this contributed to their decision to enter business.

SO25, L188: Dissatisfaction in the work place was a primary reason, however more time with family was another (this turned out to be less time as business grew).

The properties and dimensions of *business success* are closely related to those of *being professional*, for example continuing professional education is a characteristic component of business success. Many of the nurses believed that continuing professional education as well as formal qualifications was essential although needed to be relevant to the area of practice.

NO55, L139: Not necessarily tertiary but study in area of practice.

NO66, L154: Staying abreast of current trends in nursing.

Taking risks

Nurses in this study described being entrepreneurial as taking risks, having imagination, being creative, being determined and having courage and energy. Parker (1998) considers a rich source of imagination to be an integral component of entrepreneurship and supports many of the characteristics the nurses considered necessary for being entrepreneurial. In addition, she acknowledges the demands of the environment upon a nurse entrepreneur to have knowledge, mental toughness, energy and courage. Being entrepreneurial is required to achieve business success.

NO57, L203: As the business does not produce much profit I am still on disability pension. I draw some for extras but put most profit back into the business.

NO08, L 252: Some may wish to have employment when starting for weekly income - others feel you can't do all the PR necessary if not available all of the time.

NO56, L223: The consultant needs to assist themselves prepare for what is a challenging life.

NO50, L345: Finance and cash flow are necessary when getting started.

Clients

Both negative and positive aspects of dealing with clients were raised in the data. Some nurses commented on how they were valued by their clients.

NO13, L33: My elderly clients are so grateful to be able to stay at home - many fear institutions.

For all the hindrances or barriers often encountered in business, it appears that the satisfaction felt with the type of work undertaken overcame the frustrations felt.

NO46, L322: 10 years down the track I still take "Stars for Money" but at least I enjoy my work and my patients appreciate having the same person to care for them on a long term basis!

NO39, L298: I plan to retire at the end of this year. I have thoroughly enjoyed being self-employed over the past 9 years, although I must admit, at times I have worked longer and harder than ever before.

Quality service

Quality in service delivery has the potential to result in a practice "being more business like, more consumer focused and ultimately more fulfilling" (Phelps 2001:119). In achieving this the nursing practice, like any other business, increases its potential to remain viable. Ultimately, all nurses in private practice are business people and good business practice is reflected in good service delivery. The need for quality, effective services that meet the needs of customers are essential for success (Storfjell and Smith 2000). Respondents pointed out the expectations of clients and the professional responsibilities they had to meet those expectations.

SO32, L193: Private practice is no different than any other type of practice. It is the professional behaviour and level of skill the patient pays for.

NO55, L364: It would be difficult to remain in private practice if you were not sure that the service you provide was of great value and effective.

Summary of Category 'Business Success'

Starting a business can be exciting and full of risk. Success needs the personal characteristics of creativity and innovation but also involves hard work. Creating a niche starts with developing ideas and determining what product to sell. Storfjell and Smith (2000) agree with the participants that success requires drive, energy and commitment. In addition nurse entrepreneurs are driven from an internal desire to maintain control. Shaver et al (2001) believe the locus of causality rests within either the person or external to the person. Personal abilities and skills are causes located within the person, whereas service need or gap are situated external to the person. The causal factor may also be described as being stable or variable, depending on its characteristics. Demand for the product, service need and personal abilities are stable causes as they are enduring properties of either the person or environment and are unlikely to be changed in the short term (Shaver et al 2001). In contrast, being entrepreneurial, which involves taking risks, making effort, following personal desires, attempting to increase personal income and being creative is a variable because it can be changed at any moment due to a person's whim and if involved in partnership, relies on the actions of other people.

The theoretical construct *facing challenge* will now be discussed.

Figure 20 shows the constructs that emerged to form the theoretical category 'facing challenge'. Of prominence are the concepts of 'time', 'administration' and 'income'. The representation of codes relating to 'time' demonstrates the movement of concepts within the categories.

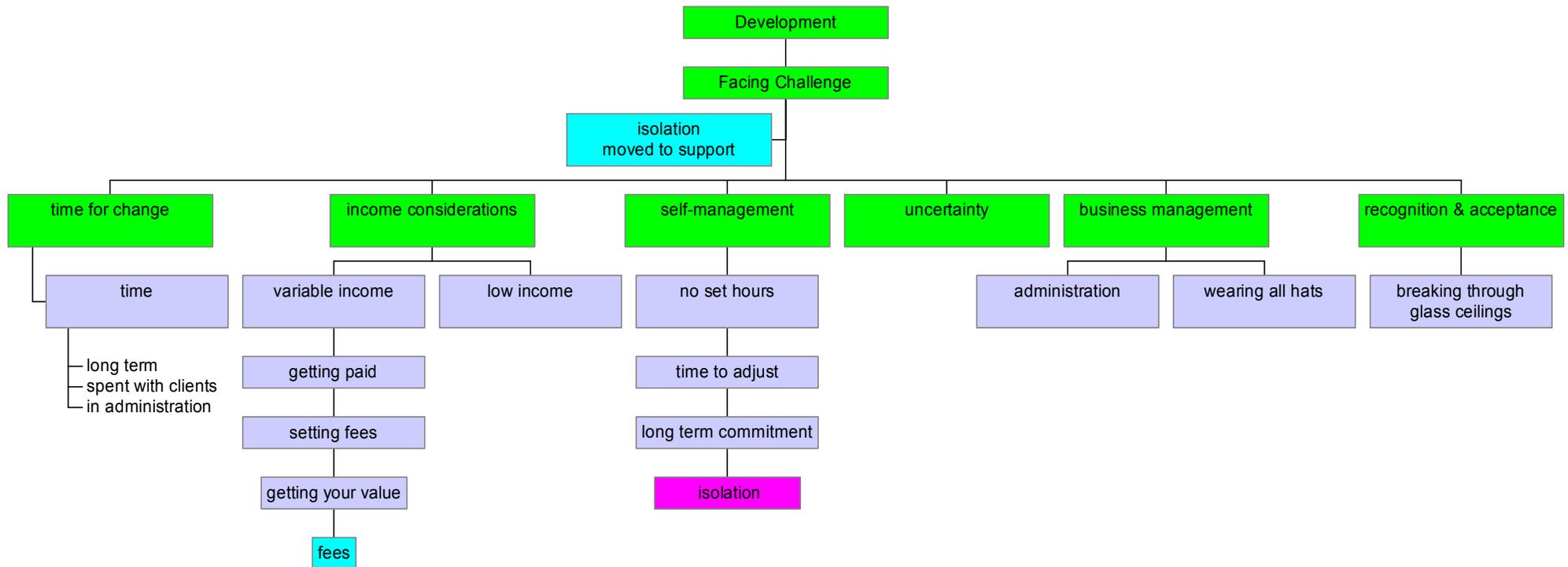


Figure 20: Audit trail to category 'facing challenge'.

Category 'Facing Challenge'

Only those who risk going too far will discover how far you can go.

-T.S. Elliot -

Facing Challenge represents the cutting points or turning points that respondents faced in their lives before going into business. The category also draws together many of the confrontational issues to be addressed in establishing a business. Embedded in the category are the significant breaks or '*critical junctures*' (Glaser 1978) that occur and indicate a time that change occurred. The prominent concepts in this category are time for change, which encapsulates some of the reasons why nurses move into private practice, opportunity for change and other challenges faced.

Time for change

Time for change came as an instigating factor in different ways for participants. Some had personal influences, for others it was professional issues that pushed the point. Examples include:

NO04, L2: Returned to nursing after mostly raising our children

NO35, L55: Impending redundancy led to my decision - I had not previously considered private practice as a career option and have been PAYE all my life.

NO47, L90: It became very obvious that my time as a senior lecturer was over. Time to move on & explore new things!

NO62, L199: I began in pp after 6 years on workcare and one year disability. It was my only way of returning to work. Inability to find work due to my disability status.

Recognising it is time to change is an important stage in stepping out into business. Entrepreneurs often opt out of traditional organisations because the locus of control is far removed and inhibits their ability to use imagination and be creative (Parker 1998). Entrepreneurs look to the future and perceive opportunity where others may not. They are pro-active, accepting the never-ending cycle of change, recognising that change relocates opportunity. In response to change, nurse entrepreneurs make themselves aware of emerging health care trends and acquire the skills demanded by those developments to arrive prepared to do well (Crow 1998).

Income considerations

Addressing financial matters is an unfamiliar activity for most nurses and a multifaceted issue. Receiving fair payment for services is complex, involving setting fees, charging fees and receiving payment. Some of the difficulties experienced by participants are expressed in the following quote:

NO47, L97: One of the hardest parts for me as a previous employee was to ask someone directly for money. Then to ask for a reasonable amount. I know I still under charge. Knowing your value is one thing - getting it is another.

NO14, L269: Financial support though not a requisite to forming a business would have been a help. We received no financial assistance or govt. grants - but fortunately overheads were low initially.

Furthermore, nurses have sometimes found that they must compromise what they offer in order to receive the income they need. Getting paid was a major issue raised.

NO54, L131: I changed from (a nurse practitioner consulting to older people and their families to an aged care specialist consultant) because people loved my help but didn't like paying.

The level of income or fee charged is also influenced by whom was the payee, for example, a private individual or an agency with extra resources and greater flexibility.

NO37, L68: Depends on circumstances of individual or if government is paying. Varies depending on funding or situation of requesting agency.

NO53, L122: Fees- varies tremendously from free to in excess of \$200/hour. Depends on skills required, hours/after hours required, complexity of client requirements, the market and competitor price range, how quickly the service is required etc.

Managing challenges

How the challenges are managed is often the factor that makes or breaks an attempt to establish a business. Participants believed particular personal abilities were important for dealing with challenges and that a high level of self-awareness was required.

SO22, L412: I think it is helpful to understand one's personality type e.g. MBTI - E.g. visionaries, leaders, intuitive gifts or being able to bring closure to gathered

information not getting overwhelmed when not accepted if a 'feeling type' not being stuck in process and system.

Adjusting to terminology commonly used to describe a business person was also a challenge for one participant. The use of the term 'entrepreneur' caused her to express dislike of the word use. It was interesting to note that of all the participants in the study, this was the only respondent to make this comment about the term 'entrepreneur'.

SO32, L32: Don't like this terminology. Suggestive of just a money making scam.

Different services or products require different levels and types of fees, depending on the nature of the task. A consultation as a single episode requires a different payment to a multi-session program, just as a home visit has a different structure compared to a consultation in the nurse's rooms.

NO49, L108: Education fees vary as there are circumstances, e.g. you really want to do the work & the available funds do not cover your usual fee, where you agree to work for a reduced fee.

NO55, L135: Having had personal experience of the efficacy of NLP for health and healing and positive change, I believed this combined with years of nursing experience would be a wonderful way to work on an individual basis.

Developing a stable income was a major concern and challenge, which often required the nurses to maintain some level of employment at start-up while trying to establish a client base. Existing legislation acts as a barrier to the effective use of private practice nursing

because it limits access to the medical funds in Medicare. Comments from participants referred to the low number of clients and the difficulty of being a one income family.

SO32, L218: Major income is from my fulltime position but I'd like to reverse this. It is not possible so obviously I need to get married!!

NO55, L367: There are too many client free days! Outside referrals take a long time to become established.

Administration issues

Increasing pressures in private practice presents a range of challenges for the nurse entrepreneur. In a business focused on providing quality services, time is a constant pressure.

NO62, L206: In my case it was a lot of hard work but I feel I am making a unique contribution in the area I work. I am also learning so much but no time to write about it! Also, time taken up by administration.

Increased consumer expectations, growing community expectations, financial pressures and a changing medico-legal climate all contribute to increased pressures. Coping with unfamiliar and multiple administrative tasks are major challenges frequently experienced and which cause frustration.

NO13, L35: Increased paper work, phone calls, coping alone with demanding & rude clients on a regular basis.

Breaking through glass ceilings

Several nurses expressed difficulty in 'breaking through glass ceilings', not only as nurses in business but also as nurses who are under-represented as partners in health care.

SO01, L164: Confidence in the area of speciality to commence private practice.

SO04, L165: Confidence in one's own ability.

NO54, L129: Breaking thru glass ceilings.

NO53, L121: providing own recognition, get more recognition, treated with respect, have skills being sought after, having people actually listen to you.

There are assumptions that nurses are not contenders but supporting characters in backstage roles. To cope with this, one participant considered it necessary to have the following ability.

NO47, L95: Ability to put aside the subtle and often unconscious' programming' of nursing, especially around power.

Coping with uncertainty

For private practice nursing to be accepted and recognised nurses will need to develop effective business and marketing strategies in order to gain access to the private health insurance industry. This is suggested in the data arising from participants

NO31, L286: I also think the lack of Medicare & private health reimbursement has helped us to take a strong business approach to what we do and be more entrepreneurial at how we "nurse"!

Although private practice gave increased flexibility in participants' lives, the reverse was dealing with the ups and downs of being in business, including the stress that this brings.

NO35, L60: PP is a roller coaster - what is an advantage one day is a poorer option the next. Next day - I think my choices here reflect my belief that like democracy "pp is the worst form of practice you can enter - except for all the other options!"

NO08, L245: Never sure of the next day.

NO07, L17: Disadvantage - unreliable staff, especially Christmas and school holidays.

In support of the study participants' comments, Smith (1996) describes three main barriers to private practice nursing. These concerns focus on the control that the profession and those external to the profession have over it and include the degree of support the nursing profession is prepared to give private practice nursing. In addition is the issue of reimbursement for services, which remains one of the most important social and political aspects to private practice nursing. Research is central to these issues and may provide the evidence that is required to support quality outcomes for clients, in terms of health care services, while providing a clear understanding of what the profession truly understands by private practice nursing.

Summary of Category 'Facing Challenge'

It is clear that private practice nurses are at the edge of the changing political landscape in health care. Breaking into new territory in health care presents challenges for nurses and other health care professionals when traditional models of nursing and health care delivery

are confronted. The need for fiscal restraint in health care has provided a trigger for reconsidering health care provision and provides nurses the opportunity to apply their expanded practice in a revised health care system. Discussion will now focus on the category *future opportunities*.

The theoretical construct 'future opportunities' was drawn from the concepts of 'advanced practice option', 'retention', 'recruitment' and 'training'. Changes in the name as concepts were integrated and categories reduced throughout the analysis process are shown in the model with, for example, the changing of name from 'the future' to 'future career options' as displayed in Figure 21.

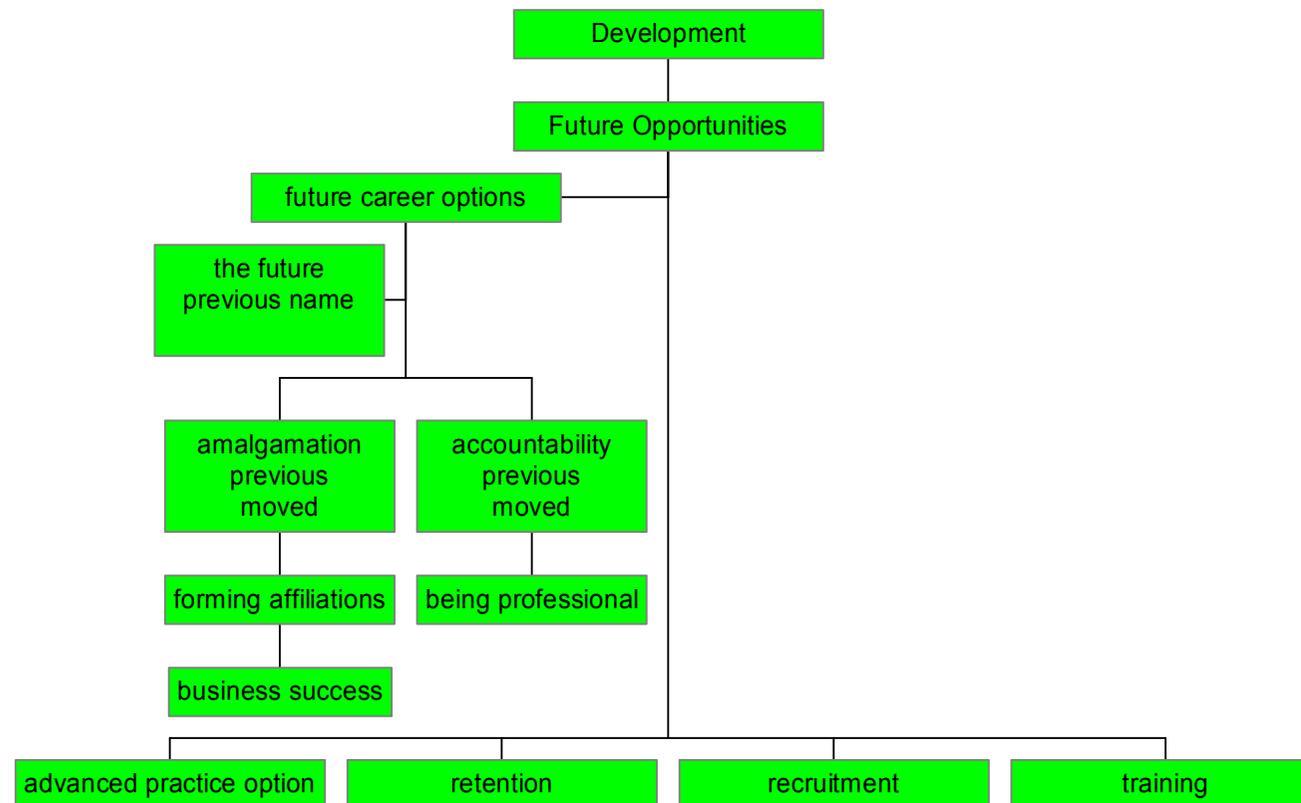


Figure 21: Audit trail to category 'future opportunities'.

Category 'Future Opportunities'

It is a paradox that in our time of drastic rapid change, when the future is in our midst devouring the present before our eyes, we have never been less certain about what is ahead of us.
- Eric Hofler -

Constructive suggestions from participants about how the nursing profession could develop linked the category *future opportunities* to the core category 'development'. *Future opportunities* represent a variety of recommendations for strategies that have the potential to increase career opportunities for nurses and address the recruitment and retention dilemma nursing currently faces.

Opportunities

Entrepreneurs look to the future and see opportunity. They are pro-active with the never-ending cycle of change, recognising that change relocates opportunity. Nurse entrepreneurs keep an eye on emerging health care trends and adapt in order to meet those demands (Crow 1998).

Pearson (2001) reported that 50% of respondents in an examination of major problems faced by nurses around the world identified status, morale and greater opportunities for promotion and career development as problems for nursing. This outcome is sustained by this study which found that of the participants in the study, 85.1% were looking for a new challenge, 74% were dissatisfied at work and 86.4% saw an opportunity to meet an anticipated need. The majority, (over 80% in all cases), did not find redundancy, redeployment or inability to find work a contributing factor to their decision.

SO25, L185: Opportunity for more flexibility in my life.

NO47, L99: Moved from Uni. to private practice as a career move.

NO71, L231: Had always wanted to give it a go, had the opportunity and grasped it.

Phelps (2001), stresses the importance of meaningful and approachable services as health consumers become more aware of their needs and are expectant of having those needs met. Consumers have become more active in seeking health services that meet their expectations. Meeting these expectations presents a challenge to the business nurse in the areas of costs and regulatory pressures (Phelps 2001). Deviance was found in the responses between participants concerning the degree they were able to distinguish the value of their service. This emphasised the difficulty nurses have in changing from being self-employed in a 'free' health arena to a private practice setting and charging for their services with confidence.

NO57, L 147: Is very difficult to cost an intangible service.

NO57, L 149: It is hard to cover costs if firstly the service is intangible and secondly some clients don't have the money to pay.

NO53, L 121: respect, having skills being sought after, having people actually listen to you.

Retention

Participants identified ways in which they could contribute to the growth in the number of private practice nurses while also expanding their businesses.

NO62, L209: If my fees were reimbursed I would be in a position to train and employ about 5 other nurses as so many who enquire and need the service say no because they cannot afford it.

NO40, L313: Increased flexibility in my life is what I needed and was one influencing factor in decisions.

Whereas once a job in nursing may not have been considered a job for life, times have changed and both female and male nurses now look to a career that holds a range of work options that will sustain them until retirement. Nurses who intend to work in nursing into their future and who aspire for self-achievement can be expected to have expectations of the professions.

NO56, L225: Helping people who "have tried everything else", in a new paradigm of health care. Seeing successful outcomes for previous chronic condition. Never being done! Always something to do especially if working in home clinic.

Career paths

Participants challenged nursing education to meet the needs of future career nurses. Participants considered hospitals to be a prime training resource that can provide the higher levels of skill and knowledge required in advanced practice.

NO31, L280: At present (& in the past) the "powers that be" have encouraged a generalist approach to care and this has decreased specialist nursing training opportunities. If we further enhanced the public hospitals as training grounds for

future nurse practitioners, specialist nurses & those wanting to go into independent practice we could give nurses some other options.

Porter O'Grady (1998) considers that the profession and health industry need to actively make use of the expertise nurse entrepreneurs possess in order to promote nursing through disciplinary leadership. Nurses and nursing could benefit from exposure to nurses who can demonstrate expertise and excellence in their fields, and who are able to facilitate creative and innovative practice, which ensures health focused outcomes.

NO35, L57: I had not previously considered private practice as a career option and have been PAYE all my life.

NO56, L222: I was no longer able to see myself working in the current system of health care.

Training

Some education curricula now include modules that enhance understanding of the process of consultancy and preparation of advanced practice. For example, on occasions the researcher has been invited to present lectures to post-graduate groups on this subject. Education in the area better enables nurses to develop the role of consultant and further develop their ability to contribute to the planning of future health care services. Practising as a consultant requires a range of entrepreneurial skills with which to assert the role and to ensure that the knowledge and skills of the nurse are articulated in an effort to influence health care from local to national level. Within their scope, nurses may provide expertise on a wide range of matters, for example project manager, researcher, expert witness, promoter of nursing, policy expert or clinical specialist.

NO56, L224: Nursing training does not prepare one for private practice.

NO52, L138: Not necessarily tertiary but study in area of practice.

NO31, L50: The trouble is, at the moment things are evolving and we are not looking at the future.

Advanced practice options

The development of advanced practice options for the future was considered essential for addressing issues of retention of nurses and attracting others into the profession by providing a career path.

SO05, L172: Private practice is an advanced practice option.

NO31, L279: I think that if we don't promote specialisation and independent practice we will see the nursing shortage worsen.

NO31, L283: Enhance the public hospitals as training grounds for future nurse practitioners, specialist nurses & those wanting to go into independent practice we could give nurses some other options.

In order to develop nurse entrepreneurs or to attract and keep them from leaving the profession, Parker (1998:15) recommends that the environment must allow them to assume some risk and gain and “be empowered with enough control and ‘right of way’ to be able to get things done”. The notion of consultancy as a sub-role of advanced practice is acknowledged and supported by Berragan (1998), who judges that the consultant in private

practice indirectly promotes excellence in practice through their work with nurses in a variety of clinical fields. With the constant change and rapid development of new technologies and implementation of new methods to improve and enhance the provision of services for clients, the consultant will become a significant part of the move to respond to each development. Consultancy in nursing brings new opportunities to provide support and enhance development for health care through practice-based initiatives and through organisational consultation. Nurse consultants in independent practice are centred on clients and their significant others and emphasise health promotion and illness prevention.

Summary of Category 'Future Opportunities'

Nurses in Australia have lacked legitimate status as autonomous practitioners as a result of issues related to education levels, professional status, legislation and lack of recognition in terms of scope of practice. In response to changes occurring in the health field and the demand, for extended, expanded nursing practice, registration authorities now take a role in the delineation of scope of practice. For example, in South Australia the Nurses Board confers the designation of 'nurse practitioner' to an individual after competency has been confirmed.

New demands for restructuring the delivery of health care provide the profession with opportunities to change the practice of nursing and increase its power bases. Research on redesign of health care delivery systems has shown quality and cost of care can be improved by delegating authority to the nurses who are responsible for the delivery of care.

The benefit of a nursing background for opportunities in professional and career advancement is asserted by Porter O'Grady (1998:34), who believes "the opportunities that nursing provides for the entrepreneur opens almost any door in health care". Entrepreneurial

opportunities in nursing are many and varied. Simpson (1997) reports many nurses are stepping beyond the boundaries of traditional practice and creating their own business or service centres. Opportunities include working on computer-based programs such as patient records, providing consulting services, developing policies and creating education tools.

Summary

This chapter provides an account of the five theoretical categories *support, being professional, business success, facing challenge and future opportunities*, which were identified during the course of the research and helped to form the core category *development*. Issues that the participants consider being significant in the journey of developing a private practice have been recognised and discussed in context with the literature. The value of a supportive environment that promotes the development of nursing practice is emphasised. The culture of the environment the nurse is situated in influences her ability to establish a successful practice and on the subsequent outcome for users and potential users. The role of education is acknowledged as instrumental to the development of the individual nurse and her / his practice. For a nurse in business, education needs to encompass both professional and business matters for maximum benefit. Achieving business success is dependent on several factors as highlighted by participants. Identifying a need or a demand for private practice nursing was not difficult in most situations. Problems from lack of infrastructure support such as reimbursement for clients' fees were more of a concern. Financial issues were considered one of the largest challenges or barriers faced. Others included issues of control over nursing and support by those within and outside the profession. Participants believed private practice nursing offers significant benefits to the profession with opportunities for career expansion, greater job satisfaction and ultimately, retention of nurses as a result of the creation of more desirable career pathways. They looked forward to seeing more opportunities open in the future with an increase in the number of

nurses in private practice.

The categories, namely, *support, being professional, business success, facing challenge and future opportunities* and main themes will now be woven together to tell the story at the centre of developing a nurse run business.

STAGE FOUR: DISCOVERY

CHAPTER TEN ~ TELLING THE STORY

This chapter will describe the core category as the denotation of the main concern for the participants. The story-line in Grounded Theory is that which carries the most emotional impact and is the central phenomenon around which all the categories are integrated and around which the grounded substantive theory is built (Strauss and Corbin 1990). Central to this is explanation of the basic social processes of developing a business and becoming a nurse entrepreneur that were exposed while conducting this research and which account for the actions and experiences of the participants.

The story-line

The core category in this thesis emerged from quantitative and qualitative data demonstrating the stages a nurse experiences as she becomes an entrepreneur and forms a private nursing practice. The nurse at the centre of this story is female and has had a broad range of experience in the development and implementation of nursing education and professional development programs. She feels she needs support and assistance from the industrial and professional arms of the profession to venture into business. She finds the notion rather scary to think about but she is focusing on her personal growth and on her process of change and this makes her also feel excited. She believes that she has skills and knowledge that can contribute significantly to the health sector and to the health outcomes for the individual. To widen the repertoire of products she offers she decides to include primary health services in her business plan. The way others inside and outside the profession behave towards and comment about her contributes to her feelings of worthiness. Networking has been personally satisfying, professionally rewarding and she found it essential for the growth and development of her business. She believes it is difficult to develop a successful business

without it. She feels strongly about maintaining her professional acumen through continuing professional development and networking with other nurses and health professionals. For her, private practice is an opportunity to realise the skills and abilities that she was not able to utilise in employment. She is proud of the meaningful relationship she has formed with clients and satisfied that she contributes toward them reaching their goals. The work does not bring the best monetary reward but it is better than working for an unappreciative boss for the same or less money. The nurse wants her services to receive equal consideration with other health service providers for reimbursement by private and public health insurers. This is considered vital for recognition and acceptance. Without this, clients will struggle to afford her services and she will struggle to make an adequate income. It seems that she is expected to take on a supportive and nurturing role without acknowledgement of her needs or giving her the support she needs.

The core category

The goal of Grounded Theory is to generate a theory that "accounts for a pattern of behaviour which is relevant and problematic for those involved" Glaser (1978:93). It also accounts for most of the variation in the pattern of behaviour and represents the main issue of concern for participants. The core category therefore represents the main theme being investigated and is related to most if not all of the other categories. Based on the revealing possibilities in everyday life while dealing with changes in the self and social milieu, 'development' emerged as the core category. The properties of change and opportunity within *development* describe the dynamics in the process of seeking personal and professional fulfilment. These properties made *development* relevant to the topic of private practice nursing and to those involved, but also, relate it meaningfully to the other categories.

Emergence of the core category

Through the process of collapsing concepts and constant comparison, the core category emerged. The core category accounts for most of the variation in the behaviour under investigation and helps to integrate the other categories (Glaser 1978). From the time it emerged, the researcher was comfortable with the core category, termed 'development'. It represented professional development for the nurse and the profession, and service development for the consumer, health sector and society as a whole. The substantive categories were named 'lack of support', 'being professional', 'business success', 'facing challenge' and 'future opportunities'. On reflection, 'lack of support' was changed to 'support' as the researcher felt 'lack of' did not necessarily apply to all the concepts.

A memo written by the researcher recalls the point at which the core category emerged:

15/04/02 - 08:49:11

I have the core category! - development. Funny, it didn't come with the bang I had expected. Examining all the properties of the substantive categories led to this. I have given it the properties - advancement, progress, expansion, growth, creation, forming, developing, striving, moving forward, moving out, enlargement, improvement. It incorporates the concept of change.

A model depicting the relationship of the theoretical categories with the core category is provided in Figure 22.

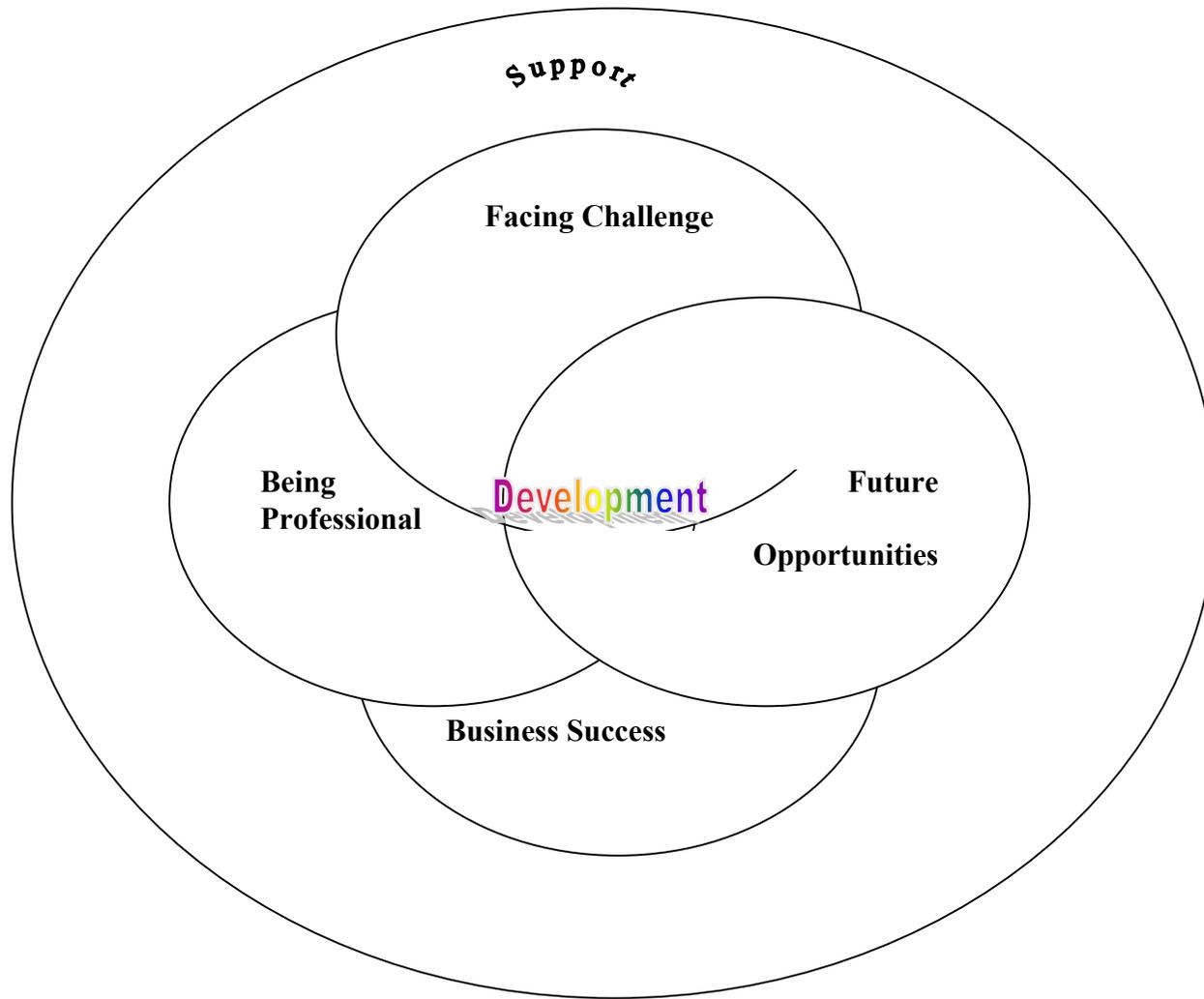


Figure 22: Relationship of core category with conceptual categories

Core category 'Development'

*Unless we are making progress every month,
every week, every year, we are going back.*

- Florence Nightingale -

From the analysis and integration of the data, *development* emerged as the category which integrated all the theoretical categories. *Development* is the core category that symbolises the concept of change and the chance for opportunity that these two concepts produce. Reflected in *development* are the properties of advancement, progress, creation, growth, forming, striving, moving forward and expansion. The context in which *development* occurs can be seen as infinite as it applies in a variety of settings, communities and cultures that are all influenced by, for example, economic, social, political, fiscal, historical and psychosocial factors. *Development* plays a role in the personalised growth of the individuals as they seek to optimise their skills, abilities and opportunities for business success. Facing challenges in the form of interruptions or '*critical junctures*' (Glaser 1978) and overcoming them leads to further expansion. The contributing outcomes are development of appropriate services for the consumer and further development of the health system for society or the population as a whole. Ultimately, the nursing profession has the opportunity to consider developing the range of career options it offers its members, resulting in a broader contribution to the health care system.

Perspectives in 'Development'

Development within private practice nursing has connotations from four perspectives. These perspectives make up the main elements addressed by the participants' and are, the individual nurses, the environments in which they function, the health arena and Nursing. Each theoretical category addresses issues related to at least one of these elements.

Development interacts with each theoretical category, in an effort to capture the interacting patterns of behaviour between them. For example, developing components within a supportive environment that provides assistance, information, guidance, acknowledgement and resources for those striving to move forward, should have mutual effects for both parties. Developing professional processes aimed at forming and maintaining the professional persona enhances the likelihood of achieving success in business and being a nurse entrepreneur.

Rewarded by this accomplishment an interaction of effects "leads to motivation to do the rewarded behaviour" but also motivation to confront challenges and seek more reward (Strauss 1987:76). This reciprocal, expansive, interdependence of interacting effects have a circular effect that provides the opportunity and opening for dealing with issues such as retention, recruitment and practice options in nursing.

Expansion

Participants recognised that with *development*, the profession of nursing moves forward and expands, promoting its effectiveness in the health arena. Opportunity is provided to address the problems of retention and recruitment that have plagued the profession in recent years.

NO31, L285: The trouble is, at the moment things are evolving and we are not looking at the future.

Entrepreneurship is a career option for nurses seeking to move their practice into a new domain. Nurse entrepreneurs face some distinct issues as they endeavour to offer a range of specialist nursing services from within a business structure. This creative development provides the health system with an opportunity to address needs within the health system by

utilising the services of private nurse consultants and practitioners. The implications for the health system include improved access to health services, improved economic efficiencies and health services that meet the needs of the population.

Opportunity

Development for nurses is in the opportunity to move into new areas of professional practice with improved flexibility. The possibility of increased income and the ability to "follow their passion" with the type of work they prefer are benefits. For many nurses, working in private practice allows them to measure their contribution to improving health outcomes. Developing personal-professional relationships with clients is part of the process that generates evidence on which to base practice and is part of the evaluation or feedback process that demonstrates whether or not changes to practices are appropriate, effective and efficient. *Development* is a complex but essential component of the environment that seeks to implement appropriate health services for successful health outcomes. Environments that:

Enable professional autonomy, control over practice and positive relationships between nurses and physicians will be ones in which nurses are able consistently to exercise professional judgement with positive results on the quality and outcomes of patient care (McCormack et al 2002:100).

Health services

Health care provision has seen a shift in health care management styles. New styles are driven by cost containment, advances in medical technology, re-organisation of care functions from secondary to primary and community institutions as well as development of nursing and medical specialisation (Offredy 2000). *Development* provides many benefits for the consumer, who seek targeted, appropriate health care services. A better range of health

services with increased access is a way of addressing the health needs of the population while addressing the fiscal needs of the economist. One of the ways this has been addressed in recent times is by the instigation of nurse practitioner programs in different states of Australia (New South Wales Health Department 1992; Department of Human Services 1999a, b). The Australian nurse practitioner debate started in New South Wales in 1990 when the then Minister of Health supported this more independent form of practice. In 1992, a working party was established to pursue the issues associated with nurse practitioners. The findings reported that nursing resources could be better utilised and that legal barriers constrained nurses from undertaking expanded roles (New South Wales Health Department 1992).

Developing the scope of practice

Schöen (1992) describes developing the scope of nursing practice as an issue of concern in nursing given the history of divisions held within the profession. Changes to nursing practice have occurred since the late 1980s when nursing underwent re-structuring in most states of Australia (Smith 1996). Consequently, the focus centred on recognition of clinical expertise rather than years of service and provided a career path for professional nursing practice. The role of the nurse in private practice evolved in response to consumer demand for diverse options in health care and from a necessity for the development of cost-effective methods of health services.

Nurses practise and interrelate within a context of autonomy supported by professional guidelines and legislation. The context in which practice occurs has an impact on user, professional and system outcomes. Orderly development of advanced nursing skills in the private practice setting enhances the concept of nursing as well as enhancing professional status and integrity. The development of primary health care roles focusing on disease prevention and health education is appropriately community based. Development of nursing

specialities in advanced practice settings to achieve positive outcomes for the nursing profession and professional practice enhances professional status and integrity.

Issues

The development of private practice nursing raises many issues associated with advanced nursing practice and these issues form the basis for much of the current discussion and debate on the scope of nursing practice for nurse practitioners. These issues include the nature of advanced practice, the role functions, credentialing, specialisation and reimbursement (Smith 1996). The social, economic and political forces on health care have stimulated a rethink in terms of service providers. The private practice nurse in the Australian context is an advanced practice nurse whose nursing practice is less likely to be task oriented and encompasses a broad range of activities from across the nursing spectrum.

It is evident that private practice will remain part of nursing practice and has become an issue that forms part of the health care agenda. Private practice is not confined to a single physical environment and can occur in any setting, as demonstrated by the many contexts represented by the participants in this study (Figure 23).

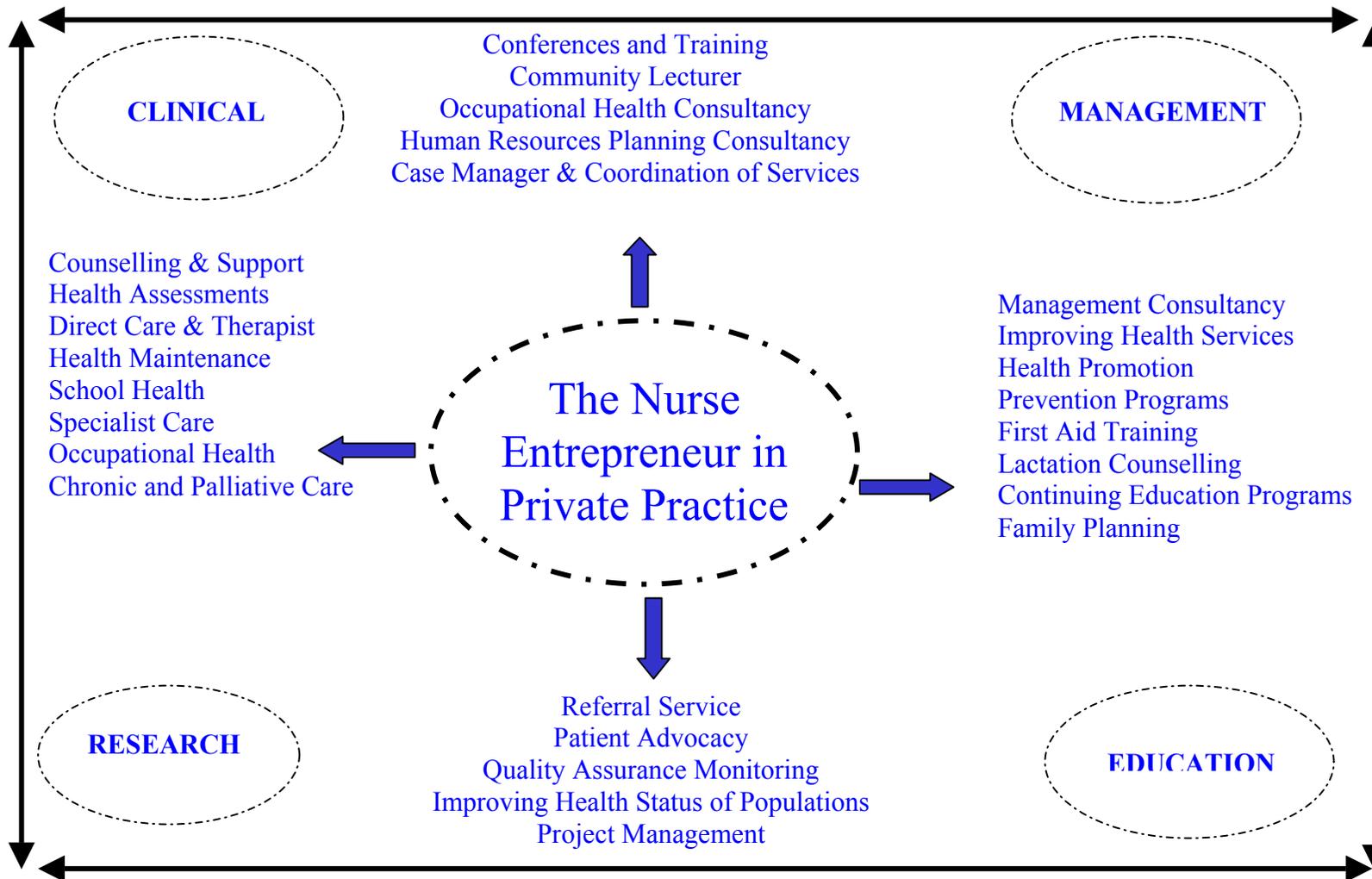


Figure 23: The nurse entrepreneur in private practice

Basic social processes

Basic social processes contain the core category in an inquiry even though they do not have to be the actual core category (Glaser 1978). The basic social process was discovered through the central analytical approach of process analysis. The ultimate goal of analysis was to account for change in the social world of the nurses being studied by identifying the basic social process that integrated the multiple parts of private practice nursing (Chenitz and Swanson 1986). The basic social process identified in this study of 'developing a business' is highly explanatory as it describes the structural stages experienced by the nurse entrepreneur in the process. Within this, the basic social psychological process of 'becoming a nurse entrepreneur' acknowledges the personal change and development which occurs for the nurse.

To draw the two processes together and show their relationships, the researcher developed a model (Figure 24) depicting the steps involved in developing a business and becoming a nurse entrepreneur. In this thesis, the basic social process contains two or more of six evolving stages in the development of a business. Stages occur over time and involve change in the context of turning points or interruptions at which point a previous stage may be returned to or advancement made to the next stage (Glaser 1978). As demonstrated in Figure 24, grouped together, the stages in the process act to bring together the different conditions occurring at each level. Each stage associates with *development* which in turn connects with each theoretical category. For example, the stage of identification relates to *business success* and *facing challenge*; becoming a business operator relates to *being professional*; being a business operator and operating relate to *all categories* and growth to *future opportunities and business success*. The transitions between stages may be triggered by any event that stimulates development of a new state, maintenance of the current stage or revisiting a

previous stage of the process (Glaser 1978). It is in this fashion that development of the nurse entrepreneur and the business advance.

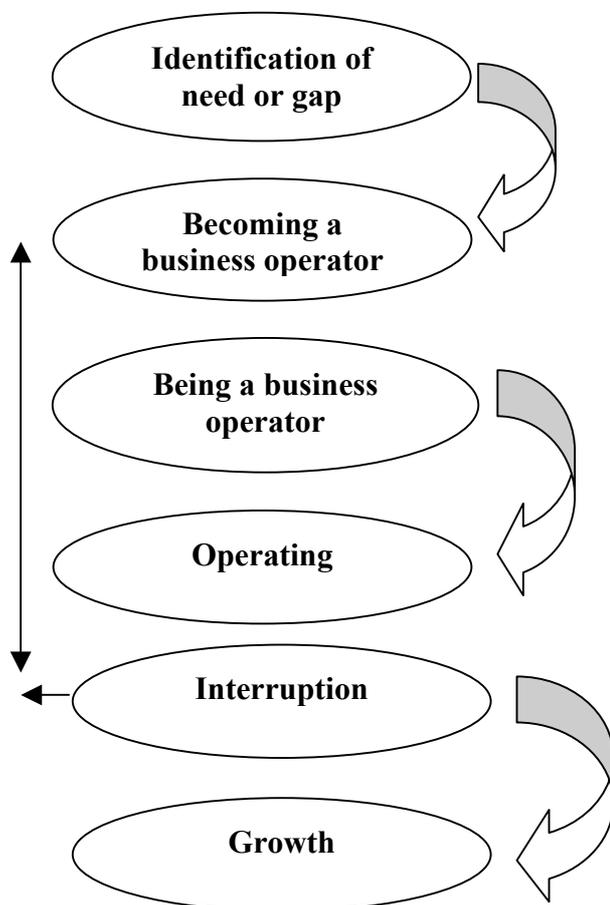


Figure 24: Stages in the development of a business

The basic social process in this thesis was found through discovery from an inductive approach to data that deduced theory. That is, 'developing a business' was found through a process of analysing information gained from a reasonably contained, informed group who were given the opportunity to express their knowledge. The basic social structural process 'developing a business' was theoretical coded as a process and therefore sequential parts were grouped together to give an account of business development occurring over time. Through the sequential grouping of steps that represent the stages an entrepreneur passes through, 'developing a business' processes the problem of how a business achieves success.

Once the basic social process was found, the researcher focussed on studying the concepts and properties within it to establish whether there were any other processes within it. The consequence of developing a business is becoming a nurse entrepreneur who operates a business. This underlying process symbolised the basic social psychological process of becoming a nurse entrepreneur, through which development the nurse prepares and readies herself to operate a business.

The notion of 'becoming' is a fundamental concept in a basic social psychological process. As a process, it involves time for change and transition stages as interruptions to the process. It is all-encompassing in that it comprehensively involves all aspects of developing into a nurse entrepreneur but can also adapt to suit individual circumstances. The dynamics of change are closely interwoven with 'identification' in which stage the nurse recognised she wanted change in her circumstances. Time to change signified the time when she was ready to name the process for achieving it.

Developing a business

Inherent in developing a business in private practice is a logical desire to succeed in a new venture. Several dimensions that affect the growth or deterioration of business success were identified. The first part of the process refers to the actions a person undertakes to develop a business. The dynamics of change are closely interwoven with 'identification' in which stage the nurses recognise there is a need for their services. Demonstrating a need for a service or recognising that there was a gap in existing services by an active demand for the nurses' skills provided a ready market for some. For others, this was not the case and building a viable client base was slow, often requiring part-time employment to be considered or maintained. Stepping out of the mainstream into self-employment created insecurity that needed a strong business approach with guts and determination to succeed. Embracing opportunities in order

to change direction was considered exciting but also involved facing risks that were sometimes difficult to cope with depending on the personal circumstances of and support structure around the individual. Forming affiliations with nurses and other health providers in business, especially through networking activities was strongly supported. These activities had the potential to increase knowledge, provide information, be supportive and increase referrals. Educational programs and the development of business networks could address issues identified around business management.

To achieve optimal success in this area of nursing, nurses in business need recognition from within both the public and private health systems, including recognition from peak nursing bodies. Differences in opinions of the type of supports needed were attributed to the different domains the nurse entrepreneurs worked in, as the needs of educators and researchers, for example, were not the same. Collegiality was demonstrated by non-clinicians frequently stating their support for clinicians to receive recognition through the reimbursement of their fees from third party insurers. As was found by Bonawit and Evans (1996), reimbursement was considered a major issue, signifying lack of acceptance and recognition of nurses as independent providers of health services and an issue which the profession needs to address. The problems contained within the issues associated with setting fees, charging fees and receiving appropriate payment involved much discussion and was one of the highest ranked issues. The provision of reimbursement fees for clients might assist nurses receive adequate fee-for-service.

The most valued advantages of private practice nursing were autonomy, increased personal and work flexibility and the opportunity to contribute to providing quality care that can make a difference for health outcomes. The personal and entrepreneurial characteristics of motivation, flexibility, accountability, commitment, self-discipline, good imagination,

creativity, willing to take a risk, an independent nature without necessarily wishing to work alone, perseverance, focus and vision were considered essential for success in private practice. Participants concur with Smith (1996) that a customer service focus with excellent planning skills are important factors in business.

The need for more self-employed nurses was expressed as some participants explained that their business growth was restricted due to insufficient nurses to attend the number of referrals. Suggested strategies to address this issue included introducing curricula on private practice nursing, promoting it as an advanced practice option and broadening the training applications within hospital environments. It was suggested that more support could be given to assist self-employed nurses cope with the stresses encountered in their work. The strategies recommended were appropriate continuing professional education, networking activities, financial assistance at start-up, reimbursement and teaching nurses how to care for themselves.

Setbacks that occur in the form of interruptions, for example, by changes in policy of another organisation that often refers work are incidences that need to be addressed to achieve a positive outcome so that growth can occur.

Becoming a nurse entrepreneur

The study identified that nurse entrepreneurs are both *in nursing and in business*. Nurse education curricula have, to date, not readied the nurse to become a business operator. For this and other reasons, nurses in this research undertook educational activities to equip themselves as business operators. The dynamics of change and growth refer to the personal and professional development of the nurse as she evolves through a process of change to advance her career by following an opportunity in the health system and developing her skills

to meet the challenge. Change and growth are closely interwoven with the basic process of developing a business where growth is considered an indicator of expansion, consolidation or successful enterprise.

This research established that most nurses and midwives were not in business because they were unemployable, unable to find work, or because they were redundant or re-deployed. Of importance to the participants were work satisfaction, being able to use distinct skills and abilities and being able to contribute to making a difference in health outcomes for individuals (Mundinger 1996). For some nurses, going into business had enabled them to return to nursing after raising a family, or suffering a back injury. For others, going into business was a better proposal than undertaking a hospital centred refresher course that was impracticable given their circumstances or was not their usual area of work or suitable for their changed circumstances. This indicates that nursing is being narrow and restrictive in its approach to considering what those who practise nursing want and thus needs to broaden the options available.

The potential of increased income when the business became established was an attraction for many nurses although the current level of understanding and knowledge of nurse run businesses is not at such a level as to ensure rapid financial returns. Because of this, maintaining an alternative income level when starting in business was essential for many participants. Although some nurses had the option of continuing a level of part-time employment, they also considered this hindered development of the business (Dinsdale 1998). The issue of isolation in self-employment raised different opinions but it was considered that in self-employment one is not alone professionally though it is easy to become isolated if working as a sole provider from a home based business.

Possessing experience in the product or service to be offered was considered a prerequisite for business success, which meant being able to gather this experience before establishing a business. Participants in the study admitted to an average of twenty-one year's experience prior to going into business, which demonstrated extensive experience. A network of other nurses in business or other individuals who could provide information, advice or support when required was considered highly desirable when becoming an entrepreneur. To obtain qualifications in the nurses' areas of speciality was considered more important than holding tertiary qualifications. The qualifications needed by the nurse depended upon the work undertaken with continuing education considered necessary to maintain an individual's knowledge and skill level (Stichler 2002).

Becoming a business operator involved the conditions of acquired knowledge and skills essential for success. Acquiring appropriate qualifications, skills or experience before stepping into business may be required to fulfil both legal and professional requisites. Post-graduate qualifications were strongly supported by participants. Acquiring additional qualifications or skills in order to increase the range of products offered by the nurse was considered necessary to enhance practice and credibility and maximise business success.

Participants placed great emphasis on continuing professional education as a requirement for credibility and success. The emphasis was particularly on education pertaining to the area of practice. Academic or tertiary education was seen as useful for developing critical and conceptual thinking skills. These preferences imply there is a need for flexibility when deciding educational needs for competence which may signify there is a place for self-directed continuing education programs.

The value of the relationship between nurses and patients was mentioned as well as positive attitudes with other health care providers. Nurses were valued by patients for providing a health option not otherwise provided. Job satisfaction was perceived to be a strong expectation by participants in the study. For some, it had been a fundamental reason for changing their career direction. Being able to use skills and abilities that could not be applied in another setting while contributing actively to optimising health outcomes were highly desirable. The perception of an elevated image through self-employment was of particular note, although there was also a suggestion that a participant's image had been higher before self-employment.

Theory generation

The Grounded Theory method of data analysis captured the reality of becoming a nurse entrepreneur and developing a business from the nurses' perspectives. This research has established that private practice nursing is a feasible mode of nursing practice that does not just happen but occurs as a result of a complex interaction of personal and professional characteristics. These characteristics include adequate professional and industrial support, responding to health service needs, professional competence, achieving success, personal attributes and taking opportunities as they arise. The theory of becoming a nurse entrepreneur that has emerged is that these characteristics are mutually dependent and interact to provide the opportunity for nurses to develop businesses. This thesis argues that nurses do not go into business because they are unable to get a job but are looking for career advancement, job satisfaction and options in providing health care. Private practice is an area of advanced practice that nurses choose when looking for an opportunity to fulfil their personal and professional needs. They aspire to be able to positively effect health outcomes for people who are seeking appropriate health care to optimise health outcomes. Private practice nursing offers health care and health services which fulfil a need in the health

system. Nurse entrepreneurs in private practice offer a range of clinical, educational, research and management services that support government initiatives to address issues in health while maintaining appropriately targeted health services.

The stories of nurses in private practice vary from person to person but some common concepts underpin these stories as indicated in the data. Drawing on stories provided examples of the extent participants were influenced in their practice by themselves, others and the environment (McMillan et al 1996). Through the process of looking for the participants' interactionist components with familial and social contexts, their symbolic interactions with their environments were revealed through their narratives.

Self-employed nurses consider education as fundamental for practical and theoretical knowledge and to enhance practice. A successful business is also dependent on education. The attainment of qualifications demonstrates credibility, professionalism and commitment. Qualifications in the area of speciality are considered the most important qualification to hold and continuing education is necessary for maintaining skills and credibility.

The major attractions of self-employment are autonomy, flexibility and providing quality care or services that make a difference to health outcomes. Success is influenced by the degree of support received from the public and private health sectors and the nursing profession as a whole. Going into business has enabled some nurses to return to nursing after raising a family, or having been on long-term sickness benefits and may offer an alternative to the limited options offered by hospital refresher courses.

The substantive theory developed in this thesis provides a link between research data and formal theory. Extending the substantive theory by linking it with a formal theory raises it to another level making it more general and more qualified in its explanations (Glaser 1978).

A substantive theory on nurse entrepreneurs developing a business connects directly to what is generically known as 'attribution theory' (Shaver et al. 2001). Working on principles from theories of social attribution, this theory attempts to offer a "scientific account of the way in which people explain their own action and the action of others" (Shaver et al 2001:6). These principles share a relationship with Symbolic Interactionism which underpins Grounded Theory which is used to describe people's behaviour.

It has been established that those who undertake activities necessary to develop business opportunities are different from those who choose other career paths (Katz 1992). As demonstrated in this thesis, in being prepared to exploit opportunities and undertake risks, entrepreneurs make a series of choices as they engage in the process of starting a business. Shaver et al (2001) propose that this is intentional action that involves repeated attempts to exercise control over the process in order to achieve success. Used to describe any quality or characteristic that can be ascribed to a person, attributes explain the causes or factors for entrepreneurial behaviour. Factors can be internal to the person and external in the environment as borne out by the results of this thesis. In this thesis, these factors are varied and include individual desires, available resources, expectations, prior experience, optimism, attitudes, action-orientation and a wide variety of personal dispositions (Shaver et al. 2001). Acting as both an internal and external force, participating in this research may have an impact on nurses who participated and encourage them to understand their entrepreneurial interests.

Summary

The major findings from this Grounded Theory study led to the development of a substantive theory on the development of a private nursing practice from the nurses' perspective. Any deviant cases identified were not significant enough to change the theory. Four broad concepts are embraced by the theory: 1) the person or nurse; 2) their environments; 3) health; and 4) Nursing. The theory outlines the conditions necessary for developing a business in terms of the structural, personal and professional requirements. The nurses in this study placed great emphasis on the psychosocial elements involved and described their experiences of these elements as requiring more than basic support industrially and professionally. However, under conditions of facing insufficient support and many challenges they were unprepared for, there was a strong feeling gained from the data as well as stated, that "private practice sure beats all the other options!"

The final stage for this research that re-visits the purpose for undertaking the study, the implications for practice and the need for further research will be presented in the last chapter. Recommendations are also presented that need to be considered to advance the future of nurses in private practice.

STAGE FIVE : FINAL REPORT

CHAPTER ELEVEN ~ REVISITING THE PURPOSE

The main purpose in undertaking this research study was to develop a credible theory that spoke for the everyday reality of private practice nurses. To accomplish this the researcher undertook a combined Grounded Theory and Delphi technique study to investigate the perceptions of private practice nurses on issues facing them in their everyday practice and business development. In this process, comprehensive socio-demographic and statistical information on this group of nurses was collated. The theory and underlying basic social processes are relevant for an additional reason. They afford an insight into the type and range of work undertaken by self-employed nurses and expand upon the little that is known. The blending of quantitative and qualitative data in a single analysis enhanced theoretical insights on the multiple aspects illustrated in the data. A discussion of the most important findings, and limitations of the study now follow. Lastly, the theory provides firm direction for private practice nursing.

Summary and conclusions with respect to the stated objectives and review of the findings

The findings of this study revealed that self-employed nurses are highly experienced, well qualified, work in diversity, but often need to supplement their self-employed income to achieve a satisfactory income level. Working in private practice assists nurses to gain greater control over their practice with the additional benefits of increased professional autonomy and improved self-esteem. Although gaining power and independence, achieving greater remuneration and prestige are given as reasons for nurses entering private practice; it appears that this is not the case for all. It was apparent from the findings that the lure of increased

income is not an influence as often there is reduced, unstable income, but rather greater job satisfaction is evident. Self-employed nurses are predominantly female nurse entrepreneurs, who conduct a business in order to earn a living or contribute to the family income. Their success is aided by the characteristics of assertion, accountability, commitment, self-discipline, motivation, flexibility, skill and commitment, with a focus on customers derived from good planning skills.

The facets of the conceptual model developed from the anecdotal literature were verified by the findings of both the quantitative and qualitative data. Illustrations of the meanings or relationships in the data helped to clarify important concepts and furthermore, served as a method of corroborating the understandings gleaned from the statistical analysis.

Of significance in the findings is the fact that most participants were not unemployed at the time they decided to establish a business and that their decision was based on choice rather than the need for work. Other than the need to maintain an income stream, other reasons for over a third of participants continuing with part-time employment after establishing their businesses were not identified in this study. Business establishment as a medium to long-term development was borne out by the participants' length of time in private practice and supported by the literature (Still et al. 1990; Bailey 1998; Bergman 1998; Joel 1999). To assist nurses to succeed in their ventures, access to information and education units on business development are strategies for the profession to consider. It is possible that this will include industrial support through an established business industry body or nursing industry body similar to that afforded to general practitioners.

As discussed in Chapter 10, developing a business is a basic social process (Glaser 1978) and an outcome of certain quite well defined but interrelated factors. For example, development

doesn't occur without challenges and opportunity to take on risks and new ventures. The consequences of development within the profession are on future opportunities for nurses and on potential business success. For personal and professional development to occur, certain conditions such as peer, professional and industrial support are necessary. Incorporated within developing a business is the context in which development occurs as nurses act and interact in an arena of need. However, developing a business is itself also a strategy, and in so being it is a way of enhancing career opportunities for nurses and assisting to address the issue of recruitment and retention in the nursing workforce.

Ten main priorities for self-employed nurse entrepreneurs in their decision making were identified through Delphi technique. The element of time is a prominent factor, which influences the right time to make career decisions as well as the amount of time to spend with clients. Other main concerns include:

- Getting value for your services; charging and setting fees.
- Having or being able to access the right qualifications.
- Having good professional image both within and outside of nursing.
- Achievement in job satisfaction and personal fulfilment.
- Managing an unstable income.
- Provision to and access to appropriate continuing professional development.
- Having a demand for services.
- Equity of fee reimbursement for clients.
- Being able to use personal skills.

Nurse entrepreneurs work in a variety of practice configurations and are located in different settings. One possible explanation for this is that they often work in different domains in

order to maximise their scope. The range of fees for services is very broad and influenced by practical and emotive factors. It appears that self-employed nurses are highly educated and multiply skilled, and also need to be independent and self-reliant as being in business is not "money for jam". Being creative as an entrepreneur and combining knowledge of nursing and health in a business framework does not discard nursing, but seems to strengthen the business and professional approach. A high proportion of participants held nursing or non-nursing degrees in addition to nursing speciality diplomas and certifications. In addition, many had specific credentials or accreditation in another therapy or skill and indicated membership of a wide range of other professional organisations. Membership of carefully selected organisations is known to be able to facilitate the success of nurses in private practice (Stichler 2002). The nurse may wish to join organisations that represent their area of interest or to enhance personal growth and expertise. Other organisations may be chosen for the purpose of professional advancement and representation generally.

Private practice nursing has gone the full circle from many years ago when private duty nurses provided mainly domiciliary services to both the poor and wealthy and has emerged from the past to the present with a vast change in its façade (Abel-Smith 1960). It has evolved from an era where those who employed private nurses were often attended by unqualified nurses who supplied unsatisfactory service to self-employed nurses of today who are well qualified and experienced (Abel-Smith 1960).

Today, nursing plays a pivotal role in the planning and provision of health services to the population. Recognition of the importance of free enterprise in the form of private practice nursing and the dedication of strategies and resources to support it would enable individual nurses to find it easier to launch into new areas of opportunity. The meanings around independence and autonomy are found to be relative to the individual professional setting. It

is possible that professionalism requires accountability and working in partnership with different health teams. Thus the nurse is appropriately placed to collaborate and participate with other health care providers and policy makers to refine primary health care models and the service structures that support them (White and Begun 1998). Though this research did not attempt to assess consumer opinion of nurse entrepreneurs, it appears from statements made by the participants that to the consumer, the value of the professional is measured by their conduct, competence, proficiency and expertise. For the nurse, this includes education and preparation as it seemed important for the nurse to have knowledge in nursing as a tool to apply in a business practice. This finding lends support to the assumption that adaptability to market demand is governed by business approach and flexibility.

Limitations on where a nurse may practice rest in the realm of competence of the individual nurse and the ability to deliver a professional service to the client within the scope of the nurses' registration. As an entirety, self-employed nurses do not appear to understand their colleagues' work and the different meanings in being self-employed. Some appear reticent to accept the terms 'entrepreneur' and 'in business' as having meaning for themselves and assign harsher interpretations to them such as operating a fraudulent business.

This study represents an initial effort to determine aspects of private practice nursing that those who work in the area deem important. The findings of the research suggest that there are difficulties for nurses in building a large client base, particularly in the clinical area, although there is demand for their services. The numbers of responses to the section on research indicate there are few nurses who offer research services as part of their business profile. The dilemmas experienced by participants suggest clinicians have a different range of difficulties, which seem to be more client focused. These difficulties include fees for services, referrals and recognition of their services. Consultants and educators also

experience difficulty achieving adequate payment but appear to be able to charge a higher hourly fee as would seem the norm for these types of services. Comments from rural nurses imply that differences exist between remote, rural and metropolitan areas. The reasons could be due to economic differences, attitudes to health care and geographical location. Therefore, it appears important for nurses in private practice to be diverse in the products they offer to maintain a viable business and leave opportunities open.

The survey method of data collection has shown to be a useful technique to gather a broad amount of information of relative depth. The quantitative analysis identifies discrete factors as sources of influence and the qualitative analysis reveals influential processes occurring over time. Using both methods together enhances the validity of the study as the possibility of arriving at alternative interpretations of the data is reduced due to the extent both helped to shape the results, thereby arriving at convergence. Further investigation could be undertaken to explore the views of the clients of nurse entrepreneurs and their health outcomes.

Increasing awareness in the nursing profession and health sector on various aspects of private practice nursing, may lead to the overall care and support of those who seek the expertise of private practice nurses being improved. As we look to the future the potential of private practice nursing is important to consider as it also provides the opportunity for skilled and experienced nurses to remain in nursing after leaving the acute health sector.

With the use of Grounded Theory, the meanings inherent in the social world of the self-employed nurses have been discovered and interpreted from the perspectives of the nurses themselves. The adoption of a qualitative method has complimented and enriched the quantitative data. The conduct of the systematic Grounded Theory process has allowed the theory generated to emerge from the data as it was discovered. Nursing knowledge of private

practice nursing as a new domain has been enhanced by the use of Grounded Theory in this study, which discovered the underlying social processes of developing a business and becoming a nurse entrepreneur.

The developed theory led the researcher to infer that the reasons for nurses owning and operating a business are different for each person. For some, it may be that they are looking for excitement through boredom or lack of motivation in their present job, or an opportunity arises to try something different. For others, it is a calculated decision, which is planned with precision and launched with a promotional strategy and publicity, or it may be an opportunity that presents at just the right time. These opportunities may transpire because of significant changes in the nurse's personal life or career direction and which may require she or he to seek a new direction in life and nursing practice.

This study endorses the findings of other literature and previous studies on the phenomenon of self-employment. As an original study on private practice nursing in Australia, it contributes additional interpretations and explanations to these findings and relates them specifically to Australia.

Limitations of the study

Several factors need to be considered in interpreting the findings of this study, including the assumptions underpinning the study design, research method and sample size. The researcher acknowledges a high number of participants were sourced from the Royal College of Nursing Australia database and the resulting gender mix of participants was low, which could be seen to limit the degree to which one can draw conclusions from its results. In addition, for a study attempting to deliver a national perspective there were no participants from the Northern Territory. Nevertheless, the similarities found in the comparisons, together with the

study's sampling technique and the satisfactory response rate, support the belief that the respondents' characteristics and the proportion of nurses in self-employment are representative of the population. It is clear that the study design and method enabled participants to generate priorities for the conduct of a nursing business.

The researcher acknowledges non-sampling errors may occur due to error in reporting on the part of both respondents and researcher. For example, inappropriate wording of questions, misunderstanding of the data required, inability or unwillingness to provide accurate information and mistakes in answers to questions may have occurred. Errors may also have arisen during processing of the survey data through mistakes in coding and data recording. However, this was minimised by checking and rechecking data entry.

As the information in this report is based on information from nurses primarily accessed through a single database, the results may differ from those that would have been produced if all self-employed nurses in Australia had participated in the survey. Utilising focus groups had been considered for this study. Given the time constraints of nurses in private practice and in some instances their remoteness, financial considerations and inability to access modern teleconferencing facilities, this was not possible.

The response rate for the study provided reliable information on the major factors confronting nurses in private practice. A consistent panel enhanced the reliability of the results. As Greator and Dexter (2000) assert, experts dropping out of a Delphi study between rounds may end in the resultant consensus not being representative of the panel, thus a drop out rate of three nurses in this study between rounds was acceptable.

The outcome of the study was that a number of important aspects regarding becoming a nurse in business and the experiences of being a nurse in business were identified along with additional information provided about these aspects. The study explored the influences on nurses to establish private practice, the advantages and disadvantages of being in private practice, the barriers encountered and the personal characteristics and skills required. It was interesting that some participants commented that the advantages of being self-employed outweighed the disadvantages.

In relation to the utilisation of Grounded Theory in this study, potential researcher bias when coding the qualitative data was addressed through consultation with supervisors. Their independent view provided a balance to the researcher's prior knowledge and previously formed opinions of this area.

Relative to this study, the Delphi technique showed to be a reliable technique as many themes in the conceptual model were supported by the data obtained. As asserted by Delbecq, Van de Van and Gustafson (1977) who estimate the average Delphi study takes 44.5 days, a Delphi technique takes time. A potential limitation of the Delphi technique occurs should the individual who monitors the study have bias that distorts the results or imposes too restrictive a process on the participants, not allowing consensus to occur (Moore 1994). Delphi technique lacks the incentive of face-to-face communication, which may result in participants or researchers feeling detached and create communication or interpretation difficulties. In this study, one way of countering this was to provide as much personal contact as possible, for example personalising letters and responding to personal communications. A quick turn around time between questionnaires was encouraged and aimed at reducing respondent attrition by maintaining attention and motivation.

Moreno-Casbas et al (2001) argue that lack of agreement regarding an adequate size of the panel in a Delphi study and the lack of evidence that results obtained may be reproducible also affects the validity of the study. Content validity is increased by the use of participants who have knowledge and an interest in the topic. No common agreement of what level of consensus is adequate has been determined, so the level used is at the researchers' discretion and depends upon sample numbers, aims of the research and responses. Consensus levels have been known to fluctuate between 51% and 80% (Hasson et al. 2000). As a result of the original nature of this research, the researcher established the meaning of consensus to be agreement amongst at least 51% of the respondents. The attrition rate from the first round was attributed to the unknown extent of accuracy of the database and the inclusion/exclusion criteria of participation in the study. Response bias was reduced in the second Delphi round as a result of a high response rate (94%).

The lack of opportunity for participants to elaborate or discuss their viewpoint is a potential weakness of the Delphi Technique. This was overcome in this study by allowing participants to add comments to statements and provide qualitative data, which helped to increase the validity of the study. As reported, the large majority of participants took up this activity. Concepts originating from the participants' comments in round one were structured as to provide a means of debate or discussion in the subsequent round (Hasson et al. 2000). Overall, given the limitations of the Delphi technique it was considered the most appropriate method to gather the opinions of nurse entrepreneurs, to identify influences on their decision-making and to highlight the issues specific to their work environment.

The strength of the Delphi technique in this thesis was enhanced because of the 'expert' literature being applied to assist in the formation of the Delphi statements. In effect this acted as a third round of Delphi (Stewart et al 1999, Twycross 2001). It is becoming increasingly

more common for two to three rounds of Delphi to occur depending on the Delphi study design and data saturation.

Implications of results

Moves for nurses to extend and expand their practice seems to suggest that with development within the profession and with organisational change, the trend to self-employment and the establishment of small businesses will continue in all areas of nursing practice. Self-employed persons as a group have many similarities irrespective of their discipline, background or the type of business they conduct. Recognising nurses as one set within this group has interesting implications in terms of health policy development and in the provision of services and the nurturing of this distinct social change in nurses' employment opportunities. National nurses' associations have an important role to play in supporting the ongoing evolution of nurse entrepreneurship in private practice settings. They also have a responsibility to support and evaluate the results of this trend in terms of health outcomes and nurses' sense of professional wellbeing.

Nurses need to do more than come to terms with each other in order to recognise private practice nursing. They also need to further develop nursing practice options and reach out to their counterparts to build a broad base of support for nursing goals. A number of attitudes still have to change for nursing to achieve its full potential. Entrepreneurial nurses must realise that they have a strong leadership position and must make their recommendations and expectations clear.

Being futuristic and expanding nursing's world-view has significant implications for both nursing and health care. An understanding of the business dimensions of nurse business operators is important for the overall recognition and response to those nurses. By increasing

awareness amongst different peak nursing bodies and health professionals on various aspects of private practice nursing, the acceptance and support for this area of nursing practice can be improved.

The findings of the study have implications for nurse education and structuring of the profession as they show that most nurses feel marginalized by the perceived general lack of recognition of nurses in business by the profession. Results could also be considered in the development of strategies to aid the current struggle to recruit and retain nurses, improve access to health care services and decrease costs of ambulatory health care. The practicability for advanced nurse education curriculum to address some of these matters should not be overlooked.

Suggestions for future research

The high levels of agreement seen between the participants on so many issues associated with private practice nursing indicates there is consensus on what is perceived to be important for this group of nurses. Equally important, however, are those few areas where the agreement levels are less strong. Further work needs to be carried out to tease out possible reasons for the discordance, to ascertain why nurses hold different views on the same topic. More importantly, studies that delve into the outcomes associated with the work of nurses in private practice have much to offer in increasing knowledge of this area and how it benefits the health sector.

This study expands on the little that is known authoritatively about self-employed nurses. It considers an innovation that is developing nursing practice and illuminates what nurses know with an opportunity to inform others. Further research may lead to additional understanding of this dynamic area of practice. The data provided by this study provides a benchmark

against which subsequent data can be compared and from which further studies can be built. Research needs to investigate the advantages of private practice nursing for the population and health system and how their contribution affects health outcomes. Other recommendations include studies that keep pace with entrepreneurial nursing and developments in health care provision and in doing so:

- Examine the needs and expectations contemporary nurses have for their future when embarking on nursing;
- Investigate the benefits of private practice nursing for the health system;
- Investigate the benefits of private practice nursing for the consumer;
- Investigate the influence of private practice nursing on health outcomes.

The researcher suggests that research such as this would consider all aspects of private practice nursing, including the outcomes of the work of educators, clinicians, researchers and consultants.

Researcher's position on the findings

The researcher can conclude with certainty that a theory on private practice nursing was developed and that the identified social processes were able to explain significant amounts of variance in behaviour. This is original research of its type and as such is unique. Other studies have not included such a broad area of research of this group of nurses. The findings from this study contribute new knowledge about private practice nursing by providing a theory which emerged from data provided by the nurses and therefore reflects what is happening at the practice setting. It shows how nurses become nurse entrepreneurs, what it is they do, where they do it and why. It also provides links to advanced nursing practice and specialty nursing.

The researcher's prior assumptions were not founded, as the majority of nurses did not enter private practice due to redundancy or redeployment but mainly as a matter of choice.

Often the researcher has found that people in the community confuse nurse practitioners and nurses in private practice, not realising the difference. Although participants were not specifically asked at any time, it was interesting that at no time in the research did participants raise issues associated with the defining features of nurse practitioners, such as prescribing medications and ordering diagnostic pathology, although others outside of the study did query if these were issues. Respondents did not express these features, which have been assigned to the newly formed 'nurse practitioner' positions, as a need for successful enterprise. As a result, although this study did not explore nurse practitioners, the researcher would argue that nurses in private practice and nurse practitioners do not necessarily share similar features except perhaps, in some clinical areas. Reference to this point is made by Wilson and Jarman (2002). It must be conceded that private practice nursing is broader and encompasses much that is not clinical in nature.

Since the data for this research were gathered, professional indemnity insurance has become a major issue for self-employed nurses, and midwives in particular. This was not revealed as a concern in the data, which may be due to the timing of data collection and the effects on world economy following the terrorist bombing of the World Trade Centre in the United States on September 11th 2001.

Concluding statement

My central thesis

This research has revealed very important knowledge about the processes within which nurse entrepreneurs develop a business and why this phenomenon occurs. Whilst private practice is

a choice nurses make, as it is not forced upon an individual, it is influenced by discrete factors which have been systematically outlined.

Highly qualified and experienced nurses seek to utilise their skills and knowledge and achieve professional fulfilment and personal development. They wish to contribute to positive health outcomes for the population and be recognised for doing so. Private practice nursing is one way this can be achieved. To do this nurses need the support of all peak bodies in order to face the challenges involved in establishing a business, so that they can achieve their goals and succeed in business. This also requires career choices to be made available within the profession. Nursing as it stands appears to restrict nurses' options by focusing strongly on hospital based nursing, and does not acknowledge nurses' need of a long-term career. Refresher courses for those returning to nursing should reflect the diversity of nurses' portfolios and not only be available in hospital settings. Nursing tends to limit those unable to continue nursing in the tertiary health sector by not encouraging opportunities of nursing in other areas such as private practice. With alternative options available, their knowledge and skill is retained in nursing and thus nursing has a broader context in the health field.

In accordance with these defining features, private practice nurses, working autonomously, whether as clinician or consultant, take responsibility and accountability for outcomes and continuing education. They work in collaboration with other health care providers, are expert in their special practice area, recognise the limits of their knowledge and practice and meet the competency standards for advanced practice in their special practice area. In addition, they add value where services exist or offer additional health care options to provide services where gaps exist.

It is evident that private practice is a career option and may be chosen by those who wish to take advantage of opportunities and to take on new challenges. There is a demand for nurses to market their skills as other health care professionals do and this has the potential of improving the range of health services available. Providing nurses with the opportunity to be more entrepreneurial in nursing could lead to increased work satisfaction, development of nursing practice arenas and higher retention rates within the profession. If hospitals encouraged an increased scope for advanced practice positions in specialist areas then options for nurses could increase. A gap exists for nurse education curricula to address the education needs of planning, management and business issues identified in this study and for the profession to increase its levels of support for entrepreneurial nursing practice.

This thesis has identified that private practice nursing is an innovative development that offers opportunity for personal and professional development for many nurses. However, the profession has not yet responded. Responsibility for advancing the profession lies with a plethora of professional nursing bodies and specialty organisations pursuing the challenge to articulate either a generic or specific role definition of advanced nursing practice. Accepting private practice as one area of advanced nursing practice which may occur within generic settings releases the profession to consider it as a strategy to address recruitment and retention in nursing. In addition, Government may wish to consider the options for improving high-cost health care and nurse regulatory bodies are challenged to take into account directions in policy which promote this area of practice.

There is further development required in this innovative and expanding area of the nursing profession.

"Risk"

To laugh is to risk appearing a fool;

To weep is to risk appearing sentimental;

To reach out for another is to risk involvement;

To expose feelings is to risk exposing your true self;

To place your ideas, your dreams before the crowd is to risk their loss;

To love is to risk not being loved in return; To risk is to risk dying

To hope is to risk despair To try is to risk failure.

But risks must be taken because the greatest hazard in life is to risk nothing.

The person who risks nothing does nothing, has nothing, is nothing.

He may avoid suffering and sorrow but he simply cannot learn, feel, change, grow or love.

Change by his servitude he is a slave, he has forfeited freedom.

Only a person who risks is free.

~ Author Unknown ~

APPENDICES

**APPENDIX I: PUBLICATIONS ARISING FROM MATERIAL
PRESENTED IN THIS THESIS**

APPENDIX I.I

APPENDIX I.II

APPENDIX I.III

APPENDIX I.IV

APPENDIX I.V

APPENDIX II: GRANTS RECEIVED TO SUPPORT THIS THESIS

APPENDIX II.I



2 April 2001

DIVISION OF STUDENT AND STAFF
SERVICES

IAN CREAGH
EXECUTIVE DIRECTOR
STUDENT AND STAFF SERVICES

ADELAIDE UNIVERSITY SA 5005
AUSTRALIA

TELEPHONE +61 883034001

FACSIMILE +61 8 8 303 5206 1

an.creagh@adelaide.edu.au

Ms Anne Wilson
20 Penzance Street
GLENELG SA 5045

Dear Ms Wilson

OFFER OF ADMISSION AND SCHOLARSHIP

I am delighted to offer you a Medical Research Scholarship and admission to postgraduate study at Adelaide University in 2001. Details of the offer are summarised below:

SCHOLARSHIP TITLE:	Medical Research Scholarship - Alfred and Ferres Scammell
SCHOLARSHIP VALUE:	\$17,267 (tax free) per annum
SCHOLARSHIP DURATION:	3 years
PROGRAM:	Doctor of Philosophy
PROGRAM DURATION:	4 years
FACULTY:	Faculty of Health Sciences
DEPARTMENT/ SCHOOL/CENTRE:	Department of Clinical Nursing
ATTENDANCE MODE:	Full-time
OFFER LAPSE DATE:	13 April 2001

Further details about your scholarship, program of study and how to accept the offer are given in the attached 'Conditions of Award' and 'Postgraduate Research Offer Schedule'. Please read them carefully and contact the Scholarships Office on 08 8303 3044 or via email at scholarships@adelaide.edu.au if you require further information.

Congratulations on your success. I look forward to receiving your enrolment documentation in the near future and welcoming you into our research community.

Yours sincerely

IAN CREAGH
Executive Director, Student and Staff Services

cc: Head, Department of Clinical Nursing

**APPENDIX III: PRESENTATIONS TO LEARNED SOCIETIES
AND REVIEW GROUPS**

APPENDIX III.I

APPENDIX III.II

APPENDIX III.III

APPENDIX III.IV

APPENDIX III.V

APPENDIX III.VI

APPENDIX III.VII

APPENDIX III.VIII

APPENDIX III.IX

APPENDIX III.X

**APPENDIX IV: PUBLICATIONS ASSOCIATED WITH THIS
THESIS**

APPENDIX IV.I

APPENDIX IV.II

**APPENDIX V: UNSOLICITED ACKNOWLEDGEMENTS FROM
PARTICIPANTS**

APPENDIX V.I

Personal communication: D Stevens 23/11/00

Well done! You are doing a great job of dissecting private practice & getting down to some often neglected elements of it. I'll look forward to the results of all this.

All the best,

Dorothy Stevens
Nurse Consultant and Continence Advisor

APPENDIX V.II

From: M Trigg
Date: 23/11/00
To: "Anne Wilson" <anne.wilson2@adelaide.edu.au>
Subject Re: Research on nurses in business

Dear Anne,

I'm just finishing my Master's Degree also. Would love to be in touch with you if I can help in any way. Apart from living in a rural area, wife of dairy farmer, mother of 13, 15, 18 year olds, midwife, maternal & child health nurse, lactation consultant in private practice, immunisation provider for the local shire, Grad. Dip in perioperative nursing and community health I have an interest in ongoing education and research.

M. Trigg
Nurse Consultant

APPENDIX V.III

From: "Robins, Michelle" <Michelle.Robins@mh.org.au>
Date: Wednesday, May 1, 2002 12:56 pm
To: "Anne Wilson" <anne.wilson2@adelaide.edu.au>
Subject Re: Research on nurses in business

Anne,
Loved your article in the Collegian.

Michelle Robins
Diabetes Educator, Wound Consultant
Melbourne Extended Care and Rehabilitation Service

APPENDIX V.IV

From: "Jill Beattie" <jbeattie@bigpond.com>
Date: Sunday, May 19th, 2002 9.59 am
To: "Anne Wilson" <anne.wilson2@adelaide.edu.au>
Subject Re: Publication on nurses in business

Congratulations Anne!!!

Cheers, Jill
Nurse Consultant

APPENDIX V.V

From: bkeane@ausmed.com.au>
Date: Thursday, June 24th, 2038 11:54 pm
To: "Anne Wilson" <anne.wilson2@adelaide.edu.au>
Subject Re: Research on nurses in business

Thanks Anne
I read the Collegian article - nothing there to criticise.
I move house today - moving out, moving in and moving on.
Email and PO Box remain unchanged.

Regards,

Bernadette
Nurse Consultant

APPENDIX V.VI

From: "Roslyn Turnley" <rturnley@bigpond.net.au>
To: "Anne Wilson" <anne.wilson2@adelaide.edu.au>
Subject: nurses in business
Date: Wed, 10 Jul 2002 10:30:47 +1000

Dear Anne,

Many thanks for sending your article to me.
Congratulations on all the work you have done.
I do like your Conceptual Model.

some comments:

Internal Influences:

It is interesting to me that I have only ever thought perhaps that others view the Nurses role as subordinate since I have been in business. In the past when I was employed I always felt valued and appreciated. It is only since going it alone that I have come to realise how different is the perception of the nurse who works alone, especially as I do in an area of Complementary Health.

This attitude particularly from doctors who usually are in the habit of generally referring to mainstream practitioners.

I am a member of the Steering Committee for the Boroondara (Camberwell, Hawthorn and Kew) Business Network here in Melbourne and in the Health Sector we are looking at this very issues from the point of view of the consumer.

Challenges:

It would be hard to imagine any one thinking about being self employed before they had experienced many facets of Nursing and life. I would certainly wonder if 3-5 years was any thing like long enough.

regards and best wishes

Ros

ROSLYN TURNLEY

Nurse Consultant

Complementary Therapy

PATHWAYS TO POTENTIAL

'Take the step for positive change'

Relaxation, Mind Body Awareness,

Health and Healing.

From: "Roslyn Turnley" <rturnley@bigpond.net.au>
To: "Anne Wilson" <anne.wilson2@adelaide.edu.au>
References: <975f139780d1.9780d1975f13@adelaide.edu.au>
Subject: Re: nurses in business
Date: Sat, 13 Jul 2002 22:20:09 +1000
Subject: Re: nurses in business

Dear Ros, thank you for this note. Would you be able to elaborate a little on your comments on the view of the nurses role, the perception of the nurse who works alone, the attitude from doctors and the issue you mention you are working on. This would help me understand what you mean, as it seems important. Anne

>

It is interesting to me that I have only ever thought perhaps that others view the Nurses role as subordinate since I have been in business. In the past when I was employed I always felt valued and appreciated. It is only since going it alone that I have come to realise how different is the perception of the nurse who works alone, especially as I do in an area of Complementary Health.

I have reached this conclusion after speaking to a number of doctors about my work and have subsequently received only a minimal number of referrals

In the past I was always valued for expertise and professionalism in everything that I did and in this was judged on conventional Nursing skills most recently as a School Nurse where I was able to introduce where appropriate Relaxation , Visualisation and Imagery most effectively in a number of healing situations using as a basis for this my qualification and experience as a Master Practitioner of Neuro Linguistic Programming. I think one of the difficulties has probably been perhaps the 'product' rather than the nurse. But for me I am the nurse with most effective additional new skills to offer.

The nurse who works away from mainstream and not in an institution.
Breaking new ground.

I guess it is never as simple as one issue only and may have nothing to do with perception of nursing and maybe just my work does not fit their model. There is also the issue that I am ineligible for a provider number at this time and other people, as in Health providers, are in my experience quite quick to make decisions related to the ability of the consumer to pay with out consulting them. As a result of this doors are closed before they have a chance to open, for example at a local Rehabilitation Hospital I was told that the patients would not be able to afford me!!!!!! They weren't even consulted (this comment came from another Nurse!!!!!!).

Generally my referrals are now coming from word of mouth and my brochures and as a result of my continual networking.

I also work, mostly voluntarily at this stage with a small amount of paid work, at the newly established Swinburne University Hospital which combines Mainstream Care with Complementary care and I look forward to more flow on referrals from there. My Nursing background is certainly appreciated there. At SUH there will be more opportunity to network with the medicos as they begin to appreciate the added well being and healing experienced by their patients in this setting, as they have the opportunity to choose from many healing modalities.

This is where Swinburne is wonderful. The opportunity and ethic is fantastic. I am fortunate to have the continuing opportunity to visit on a regular basis.

I am also fortunate that I do not have to rely wholly on my business for income or I would have been on the proverbial street long ago. I have the luxury of being able to persevere with my passion with the knowledge and the benefits of expanding awareness and positive change it brings to both my clients and me.

I am a member of the Steering Committee for the Boroondara (Camberwell, Hawthorn and Kew) Business Network here in Melbourne and in the Health Sector we are looking at this very issues from the point of view of the consumer.

The Economic Department has commissioned a company to undertake Market Research in the general community to ascertain their interest and utilisation of allied Health Services including Complementary Therapies and how they find and choose practitioners. I will be most interested in the outcome of this as hopefully guidance will emerge as a result of this as to how the consumer and practitioner can learn about each other and meet.

I hope this discussion is helpful.

Regards and best wishes

Ros

ROSLYN TURNLEY

Nurse Consultant

Complementary Therapy

PATHWAYS TO POTENTIAL

'Take the step for positive change'

Relaxation, Mind Body Awareness, Health and Healing

APPENDIX V.VII

From: B Keane
Date: 10th December 2002-12-27
Re: NIPP research

Hi Anne

Good to hear you are progressing well with your research Anne - validated findings about Australian nurses in private practice are much needed for the development of professional understanding.

Best wishes,
Bernadette

Bernadette Keane,
Nurse Consultant and Book Publishing Co-ordinator/Production Manager and
Conference Planning Consultant,
Ausmed Publications Pty Ltd
www.ausmed.com.au

APPENDIX VI: ETHICS APPROVAL

Royal Adelaide Hospital.
Medical Administration
Level 3, Margaret Graham Building Royal Adelaide Hospital
North Terrace, Adelaide 5000
8222 4139 South Australia
Telephone: (08) 8222 5345
Facsimile: (08) 8222 5936
14 June 2000

Ms A Wilson
20 Penzance Street
GLENELG SA 5045

Dear Ms Wilson,

Re: "Self-employed nurses - expanding the realm of nursing practice." RAH Protocol No: 000607

I am writing to advise that ethical approval has been given to the above project. Please note that the approval is ethical only, and does not imply an approval for funding of the project.

Human Ethics Committee deliberations are guided by the Declaration of Helsinki and N.H. and M.R.C. Guidelines on Human Experimentation. Copies of these can be forwarded at your request.

Adequate record-keeping is important and you should retain at least the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them if necessary, in the future. The Committee will seek a progress report on this project at regular intervals and would like a brief report upon its conclusion.

If the results of your project are to be published, an appropriate acknowledgment of the Hospital should be contained in the article.

Yours sincerely,

Dr M James Chairman
RESEARCH ETHICS COMMITTEE

APPENDIX VII: LETTER, ROYAL COLLEGE OF NURSING, AUSTRALIA



9 May 2000

Dr Andrea Averis FRCNA
Coordinator Clinical Teaching and Research
Department of Clinical Nursing
University of Adelaide
ADELAIDE SA 5000

Dear Dr Averis

I wish to advise that Ms Anne Wilson FRCNA has permission to access members of Nurses and Midwives in Private Practice, Australia (NAMIPPA) through Royal College of Nursing, Australia. This access is granted for the purposes of Ms Wilson's tertiary studies.

Yours sincerely

Rosemary Bryant
EXECUTIVE DIRECTOR

APPENDIX VIII: LETTER OF INVITATION

ANNE WILSON
20 Penzance Street
Consultant Nurse Practitioner
Glenelg 5045 South Australia
Email: awilson@dove.net.au
Telephone: (08) 8295 5875 / 0419 030 436 Facsimile: (08) 8295 5870

Dear Colleague

As a nurse or midwife who receives at least some of your income from private practice, you are invited to participate in this research of Australian nurses and midwives who are self-employed in private practice. The study seeks to explore the personal and professional characteristics of this group of nurses and midwives, as well as revealing details of their scope of practice.

It is hoped that the study will give participants the opportunity to express their opinions and views on issues impacting on self-employed nurses. Results from this study may in the future benefit the cause of these nurses as well as assist the nursing profession and others to gain a broader understanding of a developing area of nursing and midwifery practice.

A comprehensive report including the results will be written and compiled. I plan to present the results of my research in a national nursing conference, in nursing journals and in research seminars. A summary of the findings will be sent to all participants.

Your participation and time is appreciated and valued. If you would like further information about any aspect of the project, please contact Dr. Averis, Dr. James, or myself as mentioned on the Information Sheet.



*Anne Wilson RN, RM, BN, MN
PhD Student, Department of Clinical Nursing, University of Adelaide*

APPENDIX IX: INFORMATION SHEET FOR RESEARCH PARTICIPANTS

You are invited to participate in this study of nurses and midwives who earn some or all of their income from self-employment (private practice). The study seeks to explore the reasons why nurses and midwives move into private practice and to gather information on the scope of services they offer. This is a research project, and you do not have to be involved unless you wish to. If you do not wish to participate, you will not be affected in any way, either personally or professionally.

As a volunteer, you are invited to participate by:

1. Completing a Delphi survey questionnaire to collect data about the factors that influenced your decisions to start private practice and the personal and professional characteristics that are needed. A modified questionnaire will be repeated until consensus on an issue or between participants is reached. You have the right to withdraw without penalty at any time.
2. If the questionnaire is emailed to you please print it for completion by hand, and return by fax or post using the reply paid information given at the end of the questionnaire.
3. Following the questionnaire, should you give your permission, you may be invited to participate further.

Personal confidentiality will be maintained throughout the survey. You are not required to put your name on the questionnaires unless you choose to do so. Information received from participants will be stored securely.

Possible Risks and Benefits

It is not anticipated that participants shall directly benefit from participating in the study, other than by being given the opportunity to express opinions and contribute to a body of knowledge that has particular interest and future potential value for them. Results from this study may in the future benefit nurses and midwives in private practice and assist the nursing profession to gain a broader understanding of this developing area of nursing and midwifery practice. Volunteers will not be exposed to any foreseen risk by participating in this research.

You have the right to participate or not as you choose, to withdraw at any stage, and to request that information you supply is not used. No payment shall be made to any person participating in the study. Should you require any further information please do not hesitate to contact the investigator directly: Anne Wilson RN (08) 8295 5875 or her Principal Supervisor, Dr. Andrea Averis on (08)

8222 5525. If you wish to discuss aspects of the study with someone not directly involved, please contact the Chairman of the Research and Ethics Committee, Dr. James, Royal Adelaide Hospital, on (08) 8222 4139.

APPENDIX X: SURVEY QUESTIONNAIRE 1

Do you receive at least some of your income from being self-employed in private practice (business)?

YES / NO (please circle one). If NO, please return the questionnaire in the reply paid envelope, if YES please proceed.

Instructions to participants:

Please tick the appropriate box/es for each question.

If you find there is insufficient space for your comments, please attach a separate page.

Socio-Demographic Information

1. Your age: _____ years

1.1 Your sex: F / M (please circle one)

2. What is the postcode where you live?

3. What is the postcode/s of your main place/s of business?

a

b

4. Where did you do your initial nurse training?

Training Hospital

a

University/College

b

In which State of Australia or Country? (please specify) _____

c

5. Were you unemployed at the time of going into private practice?

Yes No

5.1 If no, where were you working?

Public Hospital

a

Private Hospital

b

Community

c

Other

6. What proportion of time do you work for yourself?

Full time 38 hours/week or more

a

Part time 30-38 hours/week

b

20-30 hours/week

c

10-20 hours/week

d

less than 10 hours/week

e

irregularly/occasionally

f

7. Other than being self-employed are you employed by some-one else?

No (go to next question)

a

Yes

b

7.1. If yes, how much time do you spend as an employee?

30-38 hours/week

a

20-30 hours/week

b

- 10-20 hours/week c
- less than 10 hours/week d
- irregularly/occasionally e

8. How long have you been in private practice?

_____ year/s

Comments _____

9. In what year did you first start in private practice? year _____

10. In what year did you first become a registered nurse? year _____

11. Please indicate the configuration/s you practice in:

Solo a Partnership b Company c

12. Do you employ staff? No a Yes b (Please describe type of staff employed)

13. Do you work from:

- Home office or consulting rooms a
- Doctors' rooms b
- Institution/s c
- Rented office d
- Clients' homes e
- Shared premises with other health professionals f
- Group based practice with other nurses g

If you share offices with other professionals please state the nature of the practitioners (eg. Doctors, Chiropractors, etc):

14. What are your current qualifications:

- RN a RM b RPN c EN d
- Undergraduate nursing degree e
- Post-registration nursing degree f
- Post Registration certificates/diplomas (describe) g
- TAFE or trade qualifications (describe) h
- Other qualifications

(describe) _____

Comments _____

15. Please indicate your membership/s of professional organisations (nursing & non-nursing):

- Royal College of Nursing, Australia a
 Australian Nursing Federation b
 College of Midwives c
 College of Mental Health Nurses d
 Others (please specify)

Comments _____

16. Please rank the areas of practice you have worked in in the last 12 months (1=most time worked).

- Clinical _____ a
 Education _____ b
 Consultancy _____ c
 Research _____ d

17. Please rank the type of clients you work with in order of amount of time worked in the last 12 months (1=most time worked).

- Individuals _____ a
 Groups _____ b
 Institutions _____ c

18. What preparation did you need to undertake to be in private practice?

Influencing Factors

(Those factors, personal, internal or external that influenced your decision to become self-employed).

Please tick the boxes that most indicate your rating of the question:

19. Your decision to move to private practice was influenced by:

	1	2	3	4	
	strongly agree	agree	disagree	strongly disagree	
Redundancy	<input type="checkbox"/> a				
Redeployment	<input type="checkbox"/> b				
Unable to find work	<input type="checkbox"/> c				
Looking for a new challenge	<input type="checkbox"/> d				
Dissatisfaction in the work place	<input type="checkbox"/> e				
Wishing to use other skills/knowledge	<input type="checkbox"/> f				
To meet an existing need	<input type="checkbox"/>				
To meet an anticipated need	<input type="checkbox"/> h				
Other reasons (please describe)					

Comments _____

20. Post-graduate qualifications are essential for developing, managing and running a private practice:

1	2	3	4
strongly agree	agree	disagree	strongly disagree
<input type="checkbox"/> a	<input type="checkbox"/> b	<input type="checkbox"/> c	<input type="checkbox"/> d

Comments _____

21. The following are advantages of being in private practice:

	1	2	3	4
	strongly agree	agree	disagree	strongly disagree
Autonomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> a
Flexible working hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> b
Increased income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> c
Increased work satisfaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> d
Own boss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> e
Able to use skills/talents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> f
Control over decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> g
Wider variety of functions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> h
Making a difference in health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> i
Providing quality patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> j
Enhanced personal/professional image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> k
Other (please describe)				

Comments _____

22. The following are disadvantages of being in private practice:

	1	2	3	4
	strongly agree	agree	disagree	strongly disagree
Reduce/variable income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> a
24 hour responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> b
Lack of 'team' support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> c
Unspecified work hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> d
Other (please describe)				

Comments _____

23. The following are barriers to conducting a private nursing practice

	1	2	3	4
	strongly agree	agree	disagree	strongly disagree
Acceptance of the changed nursing role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> a
Lack of public knowledge about what nursing offers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> b
Lack of reimbursement from private health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> c
Lack of reimbursement from public health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> d
Attitudes of other health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> e
Attitudes of other nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> f

Lack of industrial support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g
Difficulties with referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h
Lack of collegial/professional support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i
Other (please comment)					

Comments _____

Entrepreneurial Qualities

Those personal and professional characteristics that enable a person to be undertake challenges and step outside the traditional framework.

24. The following characteristics are required to be a nurse entrepreneur.

	1	2	3	4	
	strongly agree	agree	disagree	strongly disagree	
Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a
Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b
Ambition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c
Assertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d
Accountability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e
Commitment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f
Self-discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g
Independent nature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h
Good listener	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i
Desire to work alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j
Creative/Inventive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	k
Good imagination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	l
Willing to take a risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	m
Other (please describe)					

Comments _____

25. The following skills and/or knowledge are required for being in private practice.

	1	2	3	4	
	strongly agree	agree	disagree	strongly disagree	
Business know-how	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a
Management skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b
Planning skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c
Multi-skilled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d
Customer service focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e
Previous business experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f
Other (describe)					

Comments _____

Scope of Practice: (please complete those areas that are relevant to you)

Clinical: Practice involving the direct or indirect provision of care to individuals or groups. Includes counselling, and 1:1 teaching where health status and clinical improvement can be attributed to the outcomes of teaching / counselling processes.

26. Please describe the type of services you provide and to whom:

27. How many clients/patients do you see on average per week (please tick an option):

- | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50 |
| <input type="checkbox"/> a | <input type="checkbox"/> b | <input type="checkbox"/> c | <input type="checkbox"/> d | <input type="checkbox"/> e | <input type="checkbox"/> f |

28. What type of clinical problems do clients present with:

29. How are you remunerated for your services?

- | | |
|------------------------|----------------------------|
| Client/patient direct | <input type="checkbox"/> a |
| Workcover | <input type="checkbox"/> b |
| 3 rd Party | <input type="checkbox"/> c |
| Other (please explain) | |

Comments

30. How much do you charge for your clinical services per hour?

	Free	\$1-20	\$21-40	\$41-60	\$61-80	\$81-100	\$101-120	\$121-140	\$141+
1 st Consult:									
Your Clinic	<input type="checkbox"/> a								
Their home	<input type="checkbox"/> b								
Follow-up:									
Your Clinic	<input type="checkbox"/> c								
Their home	<input type="checkbox"/> d								

31. Approximately how long (hours/minutes) do you spend with each client?

- a. Initial Consult _____ hours _____ minutes
 b. Follow-up Consult _____ hours _____ minutes

The Following Questions relate to services you may provide of an Educational, Consultancy or Research nature. If these areas of practice apply to you please complete the following questions and then proceed with the relevant other section/s.

32. How much do you charge for Educational, Consultancy or Research services per hour?

	Free	\$1-20	\$21-40	\$41-60	\$61-80	\$81-100	\$101-120	\$121-140	\$141+
One session:									
1. Education	<input type="checkbox"/> a								

2. Research
3. Consultancy

Group of sessions

1. Education
2. Research
3. Consultancy

Preparation Time

1. Education
2. Research
3. Consultancy

Comments _____

33. On average, how many Educational/Consultancy/Research courses/sessions do you provide per week ?

	0	1-10	11-20	21-30	>30
Education	<input type="checkbox"/>				
Consultancy	<input type="checkbox"/>				
Research	<input type="checkbox"/>				

34. How are you remunerated for your services?

- Client/individual direct a
- Organisation b
- Other (please describe)

Comments _____

Education: where the aim is that nursing knowledge is transmitted rather than a change in health status of the people being taught. Usually a course/session guide or curriculum is involved.

35. Please describe the type of educational services you provide and to whom:

Consultancy: the provision of skills and resources to solve problems and issues of consumer clients such as businesses, industry, hospitals, universities, nursing homes etc. Teaching may be involved but less formally than with education. The general intent is active problem solving and framing rather than direct action to affect health status.

36. Please describe the type of consultancy services you provide and to whom:

Research: fee for service scientific, social or market research of a quantitative and/or qualitative nature. You may be the chief investigator or an assistant involved in your own or another's research program.

37. Please describe the type of research projects you are involved in and for/with whom:

Thank you **very much** for your assistance. Please return the survey form by **Fax to (08) 8295 5870** or by Mail to **Reply Paid 67654, Anne Wilson, 20 Penzance Street, Glenelg SA 5045** or in the envelope provided. I would also like to explore some of these issues in more detail. If you are willing and able to participate in further stages of the research please contact me or return the slip at the bottom of this page.

EXPRESSION OF INTEREST

YES I (first name).....would like to participate further in the research on nurses and midwives in private practice in Australia. Please contact me on/at:

YES I know of another nurse/midwife who would be interested in taking part. (Please provide contact details)

Additional Comments

If you would like to make some additional comments please do so below:

APPENDIX XI: SURVEY QUESTIONNAIRE 2

Dear Colleague,

Thank you for having participated in this research on self-employed nurses and midwives who conduct a private practice or business. The participation in the study so far has been pleasing and I have been most touched by some of the messages and comments shared with me. In this second round, I am exploring further some of the points from the first survey and would appreciate your opinions. Once again, information is confidential and personal details revealed are not shared with anyone else. Ethical requirements as explained in the original information to you will be adhered to. If you wish to discuss aspects of the study with someone not directly involved, please contact the Chairman of the Research and Ethics Committee, Dr. James, on (08) 8222 4139 or Dr. Andrea Averis on (08) 8222 5525

Thanking you, Anne Wilson

Instructions to participants:

- Please tick the appropriate box/es for each question.
- If you find there is insufficient space for your comments, please attach a separate page.

1. When starting in private practice it is preferable to combine private and employed work.

Strongly Agree	Agree	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. When preparing for business the following are necessary:

	Strongly Agree	Agree	Disagree	Strongly Disagree
Business management skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Networking abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience of the product/service offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education in the area of specialty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Nursing is not just a job, it's a vocation.

Strongly Agree	Agree	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Family commitments influenced my decision to go into private practice.

Strongly Agree	Agree	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Wanting to make a difference in health outcomes influenced my decision to go into private practice.

Strongly Agree	Agree	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Potentially, increased income is an advantage of self-employment.

Strongly Agree	Agree	Disagree	Strongly Disagree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Private practice is a roller coaster - what is an advantage one day maybe a “downer” the next.
 Strongly Agree Agree Disagree Strongly Disagree
8. Increased professional recognition is an advantage of self-employment.
 Strongly Agree Agree Disagree Strongly Disagree
9. To be self-employed, qualifications are necessary in the following areas.
- | | Strongly Agree | Agree | Disagree | Strongly Disagree |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Business management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Area/s of specialty | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Masters Degree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Graduate Diplomas | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diplomas/Certificates | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
10. Lack of professional “supervision” is a concern in private practice/business.
 Strongly Agree Agree Disagree Strongly Disagree
11. Professional image is downgraded in private practice/business.
 Strongly Agree Agree Disagree Strongly Disagree
12. Continuing Professional Education is necessary in business/private practice.
 Strongly Agree Agree Disagree Strongly Disagree
13. Lack of industrial support is a concern.
 Strongly Agree Agree Disagree Strongly Disagree
14. The attitudes of other nurses are a barrier/drawback.
 Strongly Agree Agree Disagree Strongly Disagree
15. Nursing is not viewed as a professional business/enterprise as are other health professions are eg. Physiotherapists.
 Strongly Agree Agree Disagree Strongly Disagree
16. Generally, it is not realised nurses’ roles have changed.
 Strongly Agree Agree Disagree Strongly Disagree
17. To be able to work alone is a necessary pre-requisite.
 Strongly Agree Agree Disagree Strongly Disagree
18. The low status of nurses & nursing contributed to my decision to consider private practice/business.
 Strongly Agree Agree Disagree Strongly Disagree
19. Self-employment gave me increased flexibility in my life.
 Strongly Agree Agree Disagree Strongly Disagree

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Private Practice is a way of staying in the workforce.	Strongly Agree	Agree	Disagree	Strongly Disagree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Financial support is necessary for success during establishment of the business.	Strongly Agree	Agree	Disagree	Strongly Disagree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. A supportive family is essential for success.	Strongly Agree	Agree	Disagree	Strongly Disagree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Putting a monetary value on my service is difficult.	Strongly Agree	Agree	Disagree	Strongly Disagree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Private Health Funds do not recognise nurses' services to the same degree as to other health professionals.	Strongly Agree	Agree	Disagree	Strongly Disagree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. In business skills are sometimes learnt on the job.	Strongly Agree	Agree	Disagree	Strongly Disagree
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. To be a successful business person/entrepreneur you need to be able to:	Strongly Agree	Agree	Disagree	Strongly Disagree
Persevere & be hardy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have personal stress management techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be determined	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ignore instilled nurse "programming"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Network effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be a lateral thinker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a "pro-active" mindset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have good self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have focus & vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you **very much** for your assistance. Please return the survey form by 21.12.00 by **Fax to (08) 8295 5870**, or by Mail to **Reply Paid 67654, Anne Wilson, 20 Penzance Street, Glenelg SA 5045** or in the envelope provided.

ADDITIONAL COMMENTS (if you wish to add any comments please do so below or on an extra page).

APPENDIX XII: FEEDBACK TO PARTICIPANTS ON THE DELPHI STATEMENTS

Dear Participant,

Thank you for your generous participation in the surveys and research to date. For your interest I have outlined some of the information received.

Apart from in a few cases, the majority of participants were in agreement with each other in their opinions on the statements made in each questionnaire. The majority also either agreed with or strongly agreed with the majority of the statements.

The situations where there was disagreement with either the statements or between participants are listed below:

- The majority of participants strongly disagreed redundancy was an influence
- The majority of participants strongly disagreed redeployment was an influence
- The majority of participants strongly disagreed they were unable to find work
- Participants were initially undecided whether increased income was an advantage and then the majority agreed that potentially, increased income is an advantage of self-employment
- The majority of participants disagreed acceptance of the changed nursing role was a barrier
- Participants were equally divided as to whether assertion was required
- The majority of participants disagreed a desire to work alone was required
- The majority of participants disagreed previous business experience is required for private practice
- The majority of participants disagreed family commitments influenced their decision to go into private practice
- The majority of participants disagreed business management qualifications are necessary
- The majority of participants disagreed a Masters Degree is necessary

- The majority of participants disagreed that the lack of professional “supervision” is a concern in business
- The majority of participants disagreed professional image is downgraded in private practice/business
- The majority of participants disagreed the low status of nurses & nursing contributed to their decision to business

Currently, I am analysing the written comments that have been made on so many of the questionnaires. My aim is to understand the most pressing issues according to you all as entrepreneurs. At this stage I am unsure as to when or how I will collect further data. I may contact you in the future and have kept the contact details many of you sent. Please continue to participate if you can. Your input is very much appreciated. I will notify you in the future when a more detailed report is available or, if journal articles are published.

With Gratitude

Anne

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