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Negotiating jurisdiction in the workplace: A multiple-case study of nurse prescribing in hospital settings

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ABSTRACT

This paper reports on a multiple-case study of prescribing by nurse specialists in Dutch hospital settings. Most analyses of interprofessional negotiations over professional boundaries take a macro sociological approach and ignore workplace jurisdictions. Yet boundary blurring takes place and healthcare professionals renegotiate formal policies in the workplace. This paper studies the division of jurisdictional control over prescribing between nurse specialists and medical specialists in the workplace, and examines the relationship between workplace jurisdiction and legal jurisdiction over prescribing. Data collection took place in the Netherlands during the first half of 2013. The study used in-depth interviews with fifteen nurse specialists and fourteen medical specialists, non-participant observation of nurse specialists' prescribing consultations and document analysis. Great variety was found in the extent to which and way in which nurse specialists' legal prescriptive authority had been implemented. These findings suggest that there is considerable discrepancy between the division of jurisdictional control over prescribing at the macro (legal) level and the division at the micro (workplace) level.

1. Introduction

Governments increasingly see the shifting of tasks from physicians to nurses as a suitable policy response to current problems in healthcare, such as the shortage of physicians and rising costs (Buchan and Dal Poz, 2002; Horrocks et al., 2002; Lewis, 2001; Raad voor de Volksgezondheid en Zorg, 2002; Wanless, 2002). At the same time, the nursing profession is attempting to increase its professional status, using several strategies for occupational advancement (Gerrish et al., 2003). These joint developments have resulted in nurses taking up new positions – such as the role of clinical nurse specialist in the United Kingdom (Courtenay and Carey, 2009) and nurse specialist in the Netherlands (Van der Peet, 2010; Van Meersbergen, 2011) – and new tasks, one of which is the prescribing of medicines (Kroezen et al., 2012a, 2012b). In the Netherlands, nurse specialists work autonomously and make independent diagnoses and treatment decisions (see Box 1). Since January 2012, they have been legally allowed to prescribe medicines and have shared legal jurisdiction over prescribing with physicians. While medical associations initially showed reservations or even reluctance towards the introduction of nurse prescribing (Kroezen et al., 2012a, 2012b), their resistance gradually decreased and they instead cooperated with nursing associations at the legal level whilst trying to influence the arrangement of nurse prescribing in such a way that the outcomes would be as beneficial as possible for themselves (Kroezen et al., 2013a, 2013b).

When nurses take up new positions or take over tasks from physicians, professional boundaries are shifted, and the division of jurisdictional control between the medical and nursing profession is changed. Up to now, little is known about how nurse prescribing takes shape in everyday healthcare practice. In this paper, we examine the division of jurisdictional control over prescribing between nurse specialists (with a Master's degree in Advanced Nursing Practice) and physicians in the workplace, and study the extent to which workplace jurisdiction over prescribing resembles legal jurisdiction over prescribing. In other words, we examine the extent to which nurse specialists' legal prescriptive authority

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Box 1
Nurse specialists in The Netherlands.

Nurse specialists are registered nurses who have successfully completed a two-year Master's programme in Advanced Nursing Practice and have subsequently registered themselves in the Nurse Specialists Register (*Verpleegkundig Specialisten Register* in Dutch; (Verpleegkundigen & Verzorgenden Nederland, 2013). There are five nurse specialisms in the Netherlands, namely acute care, chronic care, intensive care, preventive care and mental health care (Dutch House of Representatives, 2011; Ministry of Health, 2011). Nurse specialists work autonomously at the interface between medical and nursing care, and treat defined groups of patients with whom they establish an individual care relationship. Since January 2012, they have been allowed to prescribe any licensed medicine for any medical condition within their specialism and competence. However, their prescriptive authority is part of the so-called 'experimental article' (Article 36a) in the Dutch Individual Healthcare Professions Act (*Wet BIG* in Dutch). This means that nurse specialists are allowed to perform reserved procedures, including the prescribing of medicines, for a trial period of five years. If this experiment is evaluated as having been a success, a final arrangement may be included in the law, granting nurse specialists permanent authority to perform reserved procedures, including prescribing. Apart from the legal framework provided by the government, there has been limited official support for healthcare organisations and/or individual nurse specialists on how to translate nurse specialists' prescriptive authority in everyday work practices. One important guide that has been developed in this regard is the 'Guide to the implementation of task substitution' (*Handreiking implementatie taakherschikking* in Dutch), jointly written by the Royal Dutch Medical Association (KNMG), the Dutch Nurses' Association (V&VN) and the Netherlands Association of Physician Assistants (NAPA) (KNMG, V&VN & NAPA, 2012).

resembles the way in which they are currently prescribing in everyday healthcare practice and what role medical specialists play in the prescribing process.

2. Jurisdiction in the system of professions

Because prescribing has traditionally been the sole domain of the medical profession (Buckley et al., 2006; Fisher, 2010; Goundrey-Smith, 2008), the expansion of prescriptive authority to include nurse specialists touches on issues of professional domains and competition between professions for jurisdiction over tasks. Jurisdiction is crucial for professionals because it is their means of continued livelihood (Bechky, 2003). Professionals who are recognised as experts in a certain area, in this case the area of prescribing medicines, typically possess a form of cultural capital whose ownership confers status and power (Mclaughlin and Webster, 1998; Petrakaki et al., 2012). Therefore Abbott (1988) labels jurisdiction – "the link between a profession and its work" – as the central phenomenon of professional life. Jurisdiction, in this sense, can be understood as professional control over the work itself and the knowledge mobilised within the occupation.

Since one profession can pre-empt another's jurisdiction or control over a task, professions exist in an interdependent system with competing jurisdictional claims. According to Abbott (1988), professions can claim jurisdictional control over tasks in several arenas, namely the legal arena, the workplace arena and the arena of public opinion. The particular arena in which jurisdictional negotiations take place shapes the form that they assume (Allen, 2000; Mizrachi and Shuval, 2005). In this paper, our focus will be on the workplace arena and the legal arena, and the relationship between these two.

Professional competition regarding jurisdiction over a task can have various outcomes. After all, not every profession striving for full jurisdiction will obtain it. Most professional conflicts over jurisdiction result in what are termed "limited jurisdictional settlements" (Abbott, 1988). These are alternatives to the situation in which one or more professions hold full jurisdiction over a task. In a jurisdictional settlement, professions share the jurisdiction over a task, whereby control is distributed between the professions to a greater or lesser extent equally, depending on the type of jurisdictional settlement concerned. Abbott (1988) discerns several types of jurisdictional settlement, including *subordination*, whereby an incumbent profession controls the division of labour for one or more subordinate groups, *intellectual jurisdiction*, in which the incumbent profession controls the cognitive knowledge of an area but allows practice by other professions and *client differentiation,* in which different segments of a profession serve different client groups.

In the Netherlands, nurse specialists' legal prescriptive authority is comparable to that of physicians. Both physicians and nurse specialists are allowed to independently prescribe any licensed medicine for any medical condition within their specialism and competence (see Box 1). However, it should be noted that physicians have a significantly wider field of competence. Nonetheless, in the legal arena, nurse specialists and physicians share full jurisdiction over prescribing. In general, however, formalised jurisdictions have a rather vague relation to professional workplace realities (Abbott, 1988). In the workplace, professional boundaries cannot be strictly maintained and healthcare professionals renegotiate formal policies (Sanders and Harrison, 2008; Spilsbury and Meyer, 2004). Allen (1997) for example showed how boundary blurring took place between doctors and nurses on a surgical and medical ward in a general hospital, and Snelgrove and Hughes (2000) likewise demonstrated the role blurring and informal crossing of boundaries that takes place between doctors and nurses. Hence, features of the work setting mediate the formal division of labour (Allen, 2000). Yet investigations of workplace occupational boundaries are rare. Most analyses of inter-occupational competition take a macrosociological approach, looking at the level of the professional field rather than the organisational level where interactions between professionals take place on a daily basis (Bechky, 2003). This is problematic, as organizations and individuals can mediate the influence of legislation on professional work jurisdictions and roles, and influence the extent to which shifts in professional boundaries take place in practice, for example by not formally recognising new sets of knowledge and skills in definitions of work roles and expertise, through training or in regulations (Currie et al., 2010). Some of the rare studies that have looked into the issue of enacted professional jurisdictions (e.g. Barley, 1986; Barrett et al., 2012; Currie et al., 2012; Salhani and Coulter, 2009) draw attention to the fact that purposive yet subtle actions of individuals and organisations, such as day-to-day adjustments, adaptations and compromises, can substantially change the division of jurisdiction on the work floor. The present study contributes to the literature by explicitly examining the link between the macro- and micro level by taking into