The evolution of advanced nursing practice: gender, identity, power and patriarchy

LEWIS, Robin <http://orcid.org/0000-0003-2134-506X>

Received: 23 March 2021 | Revised: 24 February 2022 | Accepted: 26 February 2022

DOI: 10.1111/nin.12489

ORIGINAL ARTICLE

Nursing Inquiry WILEY

The evolution of advanced nursing practice: Gender, identity, power and patriarchy

Robin Lewis

Applied Health and Social Care Research Centre, College of Health, Wellbeing and Lifesciences, Sheffield Hallam University, Sheffield, UK

Correspondence
Robin Lewis, Applied Health and Social Care Research Centre, College of Health, Wellbeing and Lifesciences, Sheffield Hallam University, Sheffield S10 2BP, UK.
Email: r.p.lewis@shu.ac.uk

Abstract

To address longstanding workforce shortages, increase efficiency and control the costs associated with the modern health-care provision, there has been a worldwide policy to promote increased flexibility within the health-care workforce. This is being done primarily by extending the 'scope of practice' of existing occupational roles into what is referred to as 'advanced' practice. The development of the advanced practice nurse (APN) has occurred within the context of a shortage of medical staff, and the need to control cost. However, the means by which substantially repurposed occupational groups such as these, are incorporated into complex, hierarchical organisations such as the UK national health service (NHS) remains poorly understood. Using modern sociological theory, the development of the APN role has been examined in terms of *power*, *control*, *professional identity and gender relations*. Each of the theoretical approaches used adds to the quality of the discussion, although none provide a comprehensive picture. However, when synthesised, they do provide an enhanced insight into the evolution of the role. It is argued here that by critically examining the development of the APN role, this will enable both a better understanding of, and the means to influence, its future direction of travel.

KEYWORDS

advanced practice, boundary work, closure, identity, medicine, nursing, occupation, profession

1 | BACKGROUND

The health-care environment in developed countries such as the United Kingdom (UK), Australia, Canada and the United States (US) is extremely challenging, the COVID-19 pandemic notwithstanding. In an attempt to address longstanding workforce issues, increase efficiency and control the spiralling costs associated with the modern health-care provision, there has been a worldwide strategy to promote flexibility within the health-care workforce. This is being done primarily by extending the 'scope of practice' of existing occupational roles into what is referred to as 'advanced' practice (King et al., 2015). The term advanced practice is used here to denote the extended activity, over and above any usual activity, undertaken by health professionals such as nurses, paramedics, physiotherapists, podiatrists, occupational therapists and radiographers.

Over 20 years ago, Barton et al. (1999) wrote that '*The nurse practitioner is an evolving concept introduced to the UK in the last decade* [and] *this comparatively recent introduction in the U.K. has generated considerable debate on the definitive nature and implications of this developing health care role*'. Fast forward and Nadaf (2018) note

that the issue with new roles in the UK is that conceptually there is still a significant degree of confusion as to the nature of the role. Nadaf summarises the current debate in one simple question: '*…what is advanced clinical practice, and when does it stop being nursing?*' (p. 91).

2 | ADVANCED PRACTICE NURSING: CONTEXT AND HISTORY

As Hamric and Hanson (2003) note, nursing has, in the past, typically reacted in an ad hoc way to unmet needs within the health-care system, particularly when patient care was being compromised. This meant nurses 'filling the vacuum' and taking on clinical activities that were either not valued by doctors or where there was an insufficient supply of doctors to carry out those activities effectively. In this way, a precedent was being set, as nurses extended the range of their practice to fill these gaps in patient care.

The concepts of 'extended' or 'advanced practice' are therefore not new, and well-established occupations such as nursing have always evolved their practice in response to the prevailing workforce conditions within which they operate (Hill, 2017). The advanced practice role has been in existence in nursing for over 40 years (Hamric & Hanson, 2003). It was first developed in the US and Canada in the 1960s in an attempt to widen access to high-quality health care. In both the US and Canada the evolution of advanced practice gave rise to new roles such as *nurse anaesthetist*, *clinical nurse specialist* (CNS) and *nurse practitioner* (NP). The title 'advanced practice nurse' (APN) began to appear more widely in the nursing literature during the 1970s as the role began to develop and flourish outside of the US and Canada (Cooper et al., 2019). It is also at this point that the proliferation of roles leads to some further fragmentation of the role into different genres (Begley et al., 2013). The most widespread of these roles was the CNS. As the name implies, this is a specialist practice role in which the practitioner develops significant expertise in a specific area of health care. However, during the latter part of the 20th century, the more generalist advanced practitioner role also gained a foothold, and its popularity began to increase (Hamric & Hanson, 2003). By the 1990s, the role had come to the attention of the Royal College of Nursing (RCN) in the UK. In an attempt to clarify the role in the UK, the RCN described a 'nurse practitioner' (NP) in terms of:

> '*a nurse who has undertaken specific undergraduate* study, who is responsible for autonomous clinical decisions, who uses skills not usually exercised by nurses in differential diagnosis, screens patients for disease, develops preventative care management and who may refer or discharge patients*'
>
> (Royal College of Nursing, 1997)
>
> *Note the reference to undergraduate study

In the UK, note that the first reference is to an NP rather than an APN. Already we see differences in the nomenclature of the role, as 11 years later, the International Council of Nurses (ICN) go on to define an 'Advanced Practice Nurse' (APN) as:

> '*… a nurse who has acquired, through additional graduate education (minimum of a master's degree*), the expert knowledge base, complex decision-making skills and clinical competencies for Advanced Nursing Practice, the characteristics of which are shaped by the context in which they are credentialed to practice*'
>
> (International Council of Nursing, 2008)
>
> *Note the reference to postgraduate study

A further 10 years elapsed and Health Education England (HEE), the agency responsible for health-care education and training in England (but not the UK), decided upon the term 'Advanced Clinical Practitioner' (ACP). This term is used to denote all non-medical extended practice roles *in England* but not the UK as a whole. The water in the UK is being further muddied, as Health Education England (HEE) now define 'advanced clinical practice' as being:

> '*Delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision making. This is underpinned by a master's level award or equivalent* that encompasses the "four pillars" of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence. It includes the analysis and synthesis of complex problems*'
>
> (Health Education England, 2018)
>
> *HEE does not specify what constitutes an equivalent qualification to an MSc.

3 | THE CURRENT SITUATION: ADVANCED NURSING PRACTICE WORLDWIDE

The various definitions that are now being used worldwide to describe advancing nursing practice talk in terms of 'higher-level' decision-making, expert knowledge, clinical competency and recommend that any practising APN should possess a minimum of a master's degree. However, beyond this rather superficial consensus, there is little true agreement. The various titles, phrases and definitions associated with advanced practice are indicative of a longstanding and unresolved problem (Cooper, 2001) in that there is no real consensus on how best to define, implement and embed advanced practice nursing into the organisation and delivery of health care (Sheer & Wong, 2008).

In terms of an overview of the current situation, the Organisation for Economic Co-operation and Development (OECD) working paper from 2010 *Nurses in Advanced Roles: A description and evaluation of experiences in 12 developed countries* (Delamaire & LaFortune, 2010) is a useful starting point. Clearly, there are a wide variety of different systems and models for the organisation and delivery of health care worldwide. These include state-provided health care funded through direct taxation such as the UK National Health Service (NHS), US state-funded health insurance (e.g., Medicaid and Medicare), private health care funded through personal health insurance and social health insurance (such as that used in Germany; Dubois et al., 2005). Although over 10 years old, the OECD paper examined the experience of advanced practice in 12 developed countries, including the UK. It provides a valuable insight into the state of advanced practice in countries where it is well-established such as the US, and countries where it is still in its infancy such as Poland.

The OECD paper identifies some of the key issues that have arisen but do not attempt to either explain or analyse them. The paper does however identify some of the main drivers for the current development of the APN role. The first, and most pressing of these is the shortage of medical staff. There are wide variations in the composition of the health-care workforce worldwide. The numbers of doctors and nurses, and the ratios between the two occupational groups vary significantly even in developed countries. According to the OECD, the number of APNs will be greatest in countries where there are relatively low levels of doctors and a higher-than-average nurse to doctor ratio. The second driver is the need to keep health care spending under control. Modern health care is expensive and by delegating tasks from more expensive doctors to less expensive APNs it is argued that care may be delivered at a lower cost or that 'more may be provided for less' (Imison et al., 2016). The extent to which the use of APNs may reduce costs is however open to debate. The third driver is inextricably linked to cost containment, and this is the need to provide high-quality health care in the context of the changing demand for care. This involves improving access to care and to enhance the continuity of the care that is delivered (Delamaire & LaFortune, 2010). This is reflected in an ageing population, living longer but not necessarily better, with a concomitant increase in chronic diseases, and the need to prevent unnecessary hospital admissions. The APN role has proved well-suited to this type of chronic disease management where it has been used. The final, more tangential driver identified in the OECD paper is that the APN role will improve career prospects for nurses and increase the attractiveness of nursing as an occupation, particularly in those countries where nurses are not as highly valued or as well paid as other equivalent roles (Dubois et al., 2005).

These drivers are, in the main, the original factors that led to the inception of the APN role in the 1950s and 1960s (Hamric & Hanson, 2003). However, there is still no obvious explanation as to why, 50 years later, despite these clearly powerful drivers for change, many of the same debates and arguments regarding the APN role are still taking place in the 21st century. It is argued here that to understand the nature of advanced practice, it is necessary to examine the sociological theory of professions and of large hierarchical organisations such as the UK's National Health Service (NHS). The development of the APN (Delamaire & LaFortune, 2010) has occurred primarily within the context of a shortage of medical staff, and the need to control cost. However, the means by which substantially repurposed occupational groups are incorporated into complex, hierarchical organisations such as the NHS remains poorly understood (Hall, 2005).

4 | THE RELATIONSHIP BETWEEN MEDICINE AND NURSING: THE SILLY GAMES WE ALL PLAY

> *'In the beginning, the relationship between doctors and nurses was clear and simple. Doctors were superior. They had the hard knowledge that made ill people better. The nurses, usually women, were good but not necessarily very knowledgeable…'*
>
> Radcliffe (2000)

Over the years, there have been various theoretical approaches developed in sociology to help us to understand the concepts of *power, social control, professional identity and gender relations* in the workplace. This paper will consider the power relationship between medicine and nursing within the context of the development of advanced nursing practice (Allsop, 2006).

It may be argued that the foundations of modern sociological theory can be traced back to the work of Max Weber and Karl Marx. In particular, modern sociological understanding is informed by Weber's views on organisational stratification, power, status and the bureaucratic nature of the state (Huff, 1987). In addition, Marx's views on capital, class and the nature of the state also provide us with the context for the current geopolitical landscape (Marx, 1976).

In the 20th century, much of Weber's work stratification had been forgotten (Huff, 1987). Early attempts at a new sociological analysis of the work environment (referred to as the trait approach) were largely discredited by Johnson (1972) for presenting an idealised, largely uncritical view of the professions' own perceptions of themselves as being 'a cut above' other associated occupational roles. The subsequent 'social interactionist' perspective (see Hughes, 1958) was seen as the first real attempt at a serious sociological interpretation of work, occupations and the professions (Riska, 2008). In Hughes' view, the professions were viewed in terms of a status that was socially constructed (Riska, 2008).

Later sociological analysis (e.g., Larson, 1979) built upon Hughes' work and explored the huge influence exerted by the medical profession in the US during the 1970s. Weber's work was revisited and updated to reflect a 20th-century perspective. The resultant 'neo-Weberian' approach was developed and subsequently adopted as the main theoretical framework by which to understand the power of medicine, and its power relationships with the other associated

health-care professions. This neo-Weberian view of the professions was further expanded to include a neo-Marxist perspective (see the collected work of Waitzkin and Witz) in which the links between medicine, capitalism, corporate biomedicine and pharmaceuticals were also subject to intense sociological scrutiny. Following on from the neo-Weberian views on professions, the more culturally 'acceptable' post-modern perspectives of Bourdieu and Foucault revisited the ideas of social control, power and gender in the 1980s. In the 21st century, interprofessional collaboration emerged from health-care research as alternative to the classic sociological view of power and professions (D'Amour et al., 2005).

It may be useful at this point to discuss what is meant by a *profession* as opposed to an *occupation* (Lawrence & Suddaby, 2006). An occupation simply refers to any given job and the activities involved in carrying out that job. A profession is a much more nuanced concept related to the occupational activity. Johnson (1972) viewed a profession as a legitimised means of controlling occupational activity. Hearn (1982) crucially viewed a profession as an occupation *in which men predominate*, for which there is an extended period of education and to which access is tightly controlled. Hearn's definition is important as it provides a *gendered* interpretation of power relations within the workplace. In addition to the professions, there were also semi-professions. These were occupations in which women predominated, and which were seen as serving an existing profession (Hearn, 1982). This was the basis upon which the relationship between nursing and medicine began in the late nineteenth and early twentieth century (Witz, 1990).

Later, Stein's seminal work (1967) on the relationship between medicine and nursing characterised the relationship as a game of power in which the players on both sides were complicit in tacitly maintaining the workplace status quo. As part of the game, nurses suppressed their knowledge and expertise in the face of medicine, but gently manipulated the junior doctors into carrying out their clinical requests. Since Stein's original study, much has changed in the way that nursing has developed as an occupation, but it is argued that the power differential remains the same. To paraphrase Radcliffe (2000), '*the capacity to cure trumps dealing with distress every time*'.

5 | POWER AND SOCIAL CONTROL: THE MEDICALISATION OF LIFE, DEATH AND EVERYTHING IN BETWEEN

The increasing medicalisation of life (Zola, 1972) means that medicine exerts an influence that extends well beyond illness into aspects of the family, mental health, sexuality, lifestyle, death and dying. People were (and still are) largely accepting of medical advice and by extension, medical paternalism (Coburn, 2006; McKinlay & Marceau, 2002). Much medical activity is therefore *socially and culturally embedded* (Coburn, 2006; Price et al., 2014). Starr (2004) viewed the dominance of medicine in terms of the power to control the actions of others through its cultural authority. Waitzkin (1989) also uses the term 'social control' to describe the processes by which medicine maintains its power and status in society. This idea of social 'control' resonates with Bourdieu's (1989) idea of a social world, within which individuals and groups cohabit. The construction of this world is based upon the perceived relative power of the different groups.

6 | THE DOMINANCE OF MEDICINE WITHIN HEALTH CARE: SOCIAL CAPITAL AND HABITUS

Unlike Marx's definition (1976) of *capital*, Bourdieu described the use of capital in the context of social control. The classical Marxist view of capital as the means of making profit through buying and selling is reimagined by Bourdieu, with capital seen in terms of a resource that has the potential to confer value or power upon those in possession of that resource. Forms of capital identified by Bourdieu (1989) include *social*, *economic* and *cultural*. Bourdieu therefore describes societal control in terms of the possession of a surfeit of social capital. Social capital may be present in the form of *knowledge*, *skills*, *information* or *influence* which can then be used within existing networks. Access to, and the exploitation of, social capital is therefore seen as a means of reinforcing existing power differentials within the workplace.

Bourdieu contends that the status of groups such as medicine is maintained through the constant mobilisation of social capital. It is argued that since medicine is able to mobilise higher levels of social capital than nursing, this has been instrumental in maintaining the power differential between the two occupational groups (Huby et al., 2014). Some other forms of capital such as cultural capital are more easily recognised. For example, the possession of an educational qualification enables the individual to legally adopt the title of 'doctor' and the securing of state regulation of these titles is seen as one way to secure status and legitimise social capital. Within any given workspace, the dominant professional group also displays what Bourdieu refers to as *habitus*. Bourdieu views habitus as providing a frame of reference for a relational understanding of 'one's place and the place of others' within this workspace. The characteristics of a professional group such as medicine are produced by its habitus, and this enables the onlooker to determine the position relative to medicine of any other group, such as nursing, operating within that workspace.

Murphy (1984) noted that as power and prestige are scarce resources, the dominant group in any situation will seek to control access to these commodities. Complex, multi-faceted organisations such as health care are particularly prone to this type of activity, as the monopolisation of strategic positions within the organisation (known as positional property) is a key tactic used by the dominant group to establish and maintain its occupational jurisdiction (Liberati, 2017).

So, supported by the power of the state and with a surfeit of capital at its disposal, medicine has been able to protect its right to self-governance and by extension its own workplace autonomy (Willis, 2006). Through this, medicine has retained the ability to create, legitimise and control the practices that affect health-care

delivery as a whole. As a consequence, medicine has been able to favour its own jurisdictional claims and to control the division of labour within health care to its own advantage. The ability to influence decisions regarding the organisation of roles and responsibilities within the health-care team means that medicine has been able to contain and control the practice of nursing, and by extension the practice of APNs (Harrison & Ahmad, 2000).

7 | CLOSURE THEORY: THE PRACTICE OF WIELDING OCCUPATIONAL POWER

The nature of medicine's power relations with the other occupational groups in health care means that medicine will seek to attenuate any policies or strategies which may pose a threat to its occupational jurisdictions (Currie et al., 2012). Arising from a neo-Weberian perspective, 'closure' theory (Witz, 1990) refers to the processes by which power is mobilised to enhance or defend a group's share of any given resource. This involves the exercise of power in a downwards or sideways direction, in which the dominant group restricts and controls access to those resources. Closure theory sought to provide an understanding of the practices by which the status of one group is maintained at the expense of other groups operating within that environment (Chua & Clegg, 1990).

Witz (1990) clearly identified the importance of gender in her analysis of workplace power relations. She argued that the relationship between gender and inter-occupational control and subordination is crucial to our understanding of the power relations within health care. She finessed the concept of closure to address the dominance of medicine, and the control that medicine is able to exert over the division of labour. She used the term *demarcationary* closure, in which a dominant profession, in this case medicine, aims for inter-occupational control of health care through the regulation of other related occupations such as nursing. The gendered analysis of the relative positions of medicine and nursing provide a useful framework though which to understand this dominance. In addition, she noted that demarcation was concerned with the creation and control of the *boundaries* between occupations. By being in a position to influence policy decisions regarding the organisation of roles and responsibilities within health-care delivery, medicine is able to supervise, contain and control the practice of other subordinate or associate professions (Chua & Clegg, 1990). The concept of boundaries and workplace jurisdiction will be examined in more detail later in this paper.

8 | PROFESSIONAL KNOWLEDGE: 'KNOWLEDGE IS MOST DEFINITELY POWER'

Starr (2004) argued that medicine's cultural authority is in fact derived from the value placed upon medical 'knowledge' by society. In addition, the seminal work of Friedson (1984, 2000) established that the acquisition and control of a unique body of occupational *knowledge* is one of the key issues in understanding the power of a profession. A number of other authors (e.g., Larson, 1979; Waitzkin, 1989; Witz, 1990) have also identified the importance of controlling access to that professional knowledge. Larson (1979) refers to this process as gaining 'cognitive exclusiveness' to a distinct body of knowledge that has a practical application. The importance of knowledge as a vehicle for power is further emphasised by Foucault (1980). The development of 'medical' knowledge is considered to be an example of scientific knowledge, which Foucault argues is key to the development of the disciplinary power that medicine exerts over health care. According to Foucault, power and knowledge are inextricably linked and could be expressed as a single concept: 'power-knowledge'. If you ascribe to the somewhat controversial view that nursing (and by extension the APN) uses what is predominantly medical knowledge in its practise, Foucauldian power-knowledge may help to explain some of the power differential that exists between medicine and nursing (Foucault, 1980).

As a profession, access to medicine is guarded by a significant period of education and training, that is controlled and regulated by the profession through 'credentialing'. This is the process by which possession of the qualification(s) needed to practise legitimately, is established. In addition, it is asserted that there must be a professional body that oversees and certifies the profession, which is legally underwritten and supported by the power of 'the state' (Johnson, 1972). The power of the state, in terms of supporting medicine, is crucial to our understanding of the position that medicine has occupied in health care. The way in which access to the profession and to the associated professional title(s) is tightly controlled resonates with Bourdieu's (1989) ideas on cultural capital, and the political link between the state and the enduring legitimacy of 'elite' professions.

9 | THE DIVISION OF LABOUR: WHO DECIDES WHO DOES WHAT?

Given the enduring dominance of medicine over the other health-care groups, the next issue to examine is that of workplace jurisdiction. The process of establishing workplace jurisdiction (Srivastava et al., 2008) determines the legitimate right to undertake a particular type of work or bundle of tasks (Maxwell et al., 2013). As Allen (2007) notes, new occupational roles have, by definition, no established or agreed jurisdiction. Therefore, to be successfully embedded into existing health-care structures, there is a need to negotiate and agree legal and workplace jurisdiction for the new role not just at a local, context-specific workplace level, but at a wider, macro level. To achieve this, the legitimacy of the new role has to be actively constructed in relation to other roles, primarily medicine (Liberati, 2017).

Occupational boundaries originate from neo-Weberian closure theory (Witz, 1990), and are the arbitrary, abstract delineations that serve to distinguish the occupational jurisdiction of one group from another. This is done to establish 'who does what' (Lamont &

Molnar, 2002). These boundaries are traditionally conceptualised as barriers, and 'boundary work' refers to the process of creating, maintaining, blurring or shifting these occupational boundaries (Lamont & Molnar, 2002). Fournier (2000) argued that the construction and maintenance of the boundaries that define and separate these different occupations are crucial to the development of an occupation or profession and, once established, demand constant 'boundary work' to preserve them.

Clearly, medicine has limited motivation to sanction any occupational boundary changes unless it is perceived to be in its own interest (Huby et al., 2014). From a neo-Weberian perspective, Witz (1990) described the way in which medicine has maintained control of health care through the adroit management of the boundaries between medicine and other allied occupations such as nursing. The evidence shows that medicine has historically developed a number of effective strategies to address occupational boundary disputes in health care (Currie et al., 2012; Fournier, 2000).

Understanding Fournier's (2000) boundary work is extremely important in the context of developing a flexible workforce. Adjustments to professional boundaries were historically couched in the classical Marxist language of inter-occupational 'struggle' (e.g., Larkin, 1983). Where there is outright disagreement between two occupations, the language of inter-occupational 'struggle' may still apply, however few boundary disputes between medicine and nursing result in outright conflict (Nugus et al., 2010).

Most modern theory tends to focus upon less overtly confrontational approaches to boundary work. In general, it is argued that the adoption of more socially collaborative, negotiated approaches by medicine obviate the need for conflict. The way in which occupational power is routinely exercised by doctors within a multidisciplinary team (MDT) may be understood using Strauss' (1978) ideas of negotiated order. This is used to articulate a softer, more nuanced, but nonetheless assertive maintenance of the power differential that exists between medicine and nursing. Strauss' negotiated social order considers negotiation to be a fundamental aspect of the way in which complex organisations such as the NHS function. The use of micro-level interprofessional negotiation between nurses and doctors is seen as the way in which, at the meso level, formal organisational structures may be established and maintained (Liberati, 2017; Melia, 1984).

Conversely, it may be that what we see here is a modern, updated version of the doctor-nurse game first identified by Stein (1967) and Stein et al. (1990). Whilst ostensibly working together, doctors within the MDT will seek to subconsciously maintain the 'natural' social order, in which medicine is at the apex. The natural self-assurance that comes with longstanding professional status and the associated cultural authority it accrues makes it easy for medicine to negotiate the right to be 'in charge' of any patient care decisions and thereby avoid outright conflict with the subordinate groups, such as nursing, with which they deal (Coburn, 2006). Medical students (and nursing students to a lesser extent) continue to be socialised, albeit subconsciously, in the view that doctors play a greater role than other occupational groups in the decision-making processes over patient care (Nugus et al., 2010).

Current health policy worldwide has identified 'teamwork' as an effective way of relaxing occupational boundaries in the delivery of health care, and thus enabling more flexible working practices. Due to the nature of the work, health care is one area in which individuals from different occupational groups are required to work closely together. However, as Comeau-Vallee and Langley (2020) note, teamworking requires the various occupational groups to examine the boundaries that define and therefore separate their roles.

There are now numerous examples of interprofessional boundary work in which the members of the team are able to effectively collaborate through a process of accommodation and 'boundary blurring' (Meier, 2015). In these situations, the occupational boundaries are successfully relaxed, so that they cease to be a barrier to interprofessional teamwork. However, it is argued that in spite of this, higher status groups such as medicine may simply seek to replicate their position at the apex of a multidisciplinary team. Despite working together 'for the good of the patient', the dominant group will try to ensure that 'social position', occupational status and existing hierarchies are maintained. They will also seek to preserve the 'social order' (the power relations amongst the various occupational groups). The constant reference to social control, social order and social capital is indicative of a hierarchy that is socially constructed, and there would appear to be a good level of agreement between the different sociological perspectives on this.

10 | 'OCCUPATIONAL IMPERIALISM': WHO DOES THE DIRTY WORK NOW?

Larkin (1983) coined the term 'occupational imperialism' to describe the tactics adopted by dominant professions such as medicine in advancing their aims through the constant acquisition of higher-status skills and roles, whilst simultaneously delegating lower status roles to subordinate groups (see Hughes, 1958). So far, boundary work has been considered in terms of medicine protecting its occupational territory from counter-hegemonic groups. In the face of medical dominance, occupational imperialism may provide a potential explanation for the increasing numbers of APNs with health care. Where it is perceived to be in the dominant profession's interests, the delegation of lower-level tasks and other activities no longer considered vital to that profession becomes another, more subtle, way for medicine to maintain its occupational status and control over health-care delivery (Witz, 1990).

The expansion of medication prescribing to nursing through the findings of the Cumberlege report (Department of Health and Social Security,1986) is a good illustration of the use, by medicine, of occupational imperialism. Following the Cumberlege report, a small group of nurse specialists (c.f. APNs) were *given* jurisdiction over the prescription of medication, an activity that had previously been the sole domain of medicine (Cooper et al., 2019).

However, although 'nurse prescribers' obtained the legal right to prescribe from the full British National Formulary (BNF), the 'permission' to take on these tasks at a local level remained primarily under the aegis of medicine. In reality, the impact of workplace jurisdiction (and by extension medical hegemony) in the ad hoc way that these new roles have developed over the years cannot be overstated (Nadaf, 2018). The perceived benefits to medicine of 'enabling' other occupational groups to take on specific, discrete tasks such as prescribing was clearly at the forefront of its thinking. For example, in UK general practice, the ability of an APN to run a minor illness clinic and to prescribe their own medication without reference to a general practitioner (GP) is an attractive proposition for the GP.

It is argued that within any sphere of activity, the profession with the highest status will effectively 'cherry pick' the most desirable and high-profile roles, delegating the less-glamorous 'dirty work' to other groups of lesser power and status (see Hughes, 1958; Nancarrow & Borthwick, 2005). Similarly, Willis (2006) uses the term 'vertical substitution' to describe the process by which lower status occupational groups take on aspects of the work of a higher status group. It is clear from the evidence that the extent of the vertical substitution is regulated and controlled by the dominant occupational group or profession (Nancarrow & Borthwick, 2005).

11 | PROFESSIONAL IDENTITY: WHO AM I?

Identity, identity, identity is the crisis can't you see…? (X-Ray Spex, 1978)

Having reviewed some of the theoretical approaches underpinning the development of a profession, nursing's perceived lack of 'real' influence within health care and the consequent lack of control over the APN role becomes more understandable. There are, however, a number of other issues that need to be considered. The incoherent, confusing, and disjointed approach to giving advanced practice nursing roles a clear identity has contributed to the sluggishness of developing, implementing and above all sustaining these roles (et alDelamaire & LaFortune, 2010; Leary et al., 2017; Nadaf, 2018). In addition to the various definitions of advanced practice, the proliferation of job titles, acronyms (NP, ANP, APN and ACP to name but a few) and types and colours of uniform all contribute to the perception of the APN as a nebulous, malleable, slightly 'fuzzy' temporary solution to a specific problem rather than a longer-term reality with a future (Leary et al., 2017).

The development of a positive, coherent identity (see Andrew, 2012; Bryant-Lukosius et al., 2016; Goodman, 2016; Maxwell et al., 2013) is an important milestone in the establishment of a successful profession or new occupational role (Johnson et al., 2012). Historically occupational or professional identity has been defined in terms of a *self-concept* or self-image based upon a set of unifying beliefs, values, motives and experiences. It has been seen as the individual's perceived position within society and the way in which the individual interacts with others (Andrew, 2012; Bryant-Lukosius et al., 2016; Goodman, 2016; Maxwell et al., 2013). Although self-concept and professional identity are similar in nature, they are often, and incorrectly, conflated.

Professional identity may be viewed in terms of a career, occupational or, as in nursing, a vocational identity (Johnson et al., 2012; Skorikov & Vondracek, 2011). A person's professional identity is therefore seen as a significant part of their overall identity and is complemented by, but separate to, their self-concept (Sutherland et al., 2010). It is effectively a sense of self that is derived from and sustained by the individual's occupation or professional role (Melia, 1984). In simple terms, the individual is defined by their role. The idea that, as a doctor, they will take the lead on the clinical care of a patient is indoctrinated into medical students from the very beginning of their medical training (Nugus et al., 2010).

However, the ideas of self-concept and professional identity are a rather simplistic and flawed way of understanding the development of professional identity since they do not adequately explain how new roles (such as the APN) develop their own identity as they emerge from other more established occupational groups (such as nursing). The transition from a more defined, 'boundaried' role such as nursing to a much 'less-boundaried' role such as the APN is complicated and fraught with difficulty (Anderson et al., 2019). Sluss and Ashforth (2007) developed the idea of *relational* identity to help to explain the changes to identity caused by the transition from one role to another. They argued that relational identity occurs at an individual and cultural level. At the individual level, relational identity refers to the way in which two interacting individuals with different roles enact their roles, and the way in which each actor is perceived by the other. This relational identity is both *role-based* and *person-based*, so that as the nurse moves from their existing role to the new APN role, they will continue to interact with other clinicians, but the interactions will be framed by both the new APN role and the way in which the trainee APN behaves in that role. In terms of the health-care 'hierarchy', the transition from nurse to APN may be viewed both positively and negatively by both medicine and nursing. The way in which the 'new' APN is viewed will depend upon both the perception of the role and the perception of the individual undertaking that role.

12 | WORKING IN A 'PINK COLLAR PROFESSION': GENDER AND THE PROVISION OF HEALTH CARE

The continuing predominance of women within nursing (and therefore in the APN role) means that the inter-occupational power relations between medicine and nursing must always be considered within the context of *gender*. Radcliffe (2000) again sets the tone:

> *'The nurses, usually women, were good but not necessarily very knowledgeable. They were in charge of folding pillowcases and mopping brows. Nurses didn't*

cure patients; on the whole they still don't. They were just nice to them while they waited to get better…'

As we know, from a neo-Weberian perspective, power and patriarchy are inextricably linked (Witz, 1982). Patriarchy is defined here as *'a complex network of social and occupational relations, within which men tend to dominate women'* (see Hearn, 1982). In his seminal work *Birth of the Clinic*, Foucault (1971) described the appearance of patriarchy within health care in terms of the 'medical gaze'. This is widely interpreted as a type of 'male gaze', in which the human body is looked at, objectified, and dissected in a 'scientific', unemotional way, separated from its humanity. Although nursing is closely allied to medicine, its feminine 'gaze' is seen as radically different to that of medicine (Foucault, 1971). The emphasis upon an *emotional*, *empathetic* and *compassionate* response to health care (see Goodman, 2016; Price et al., 2014) is at odds with a masculine, medical profession that continues to reinforce a professional patriarchy through its values, ways of thinking and activities. Similarly, the control over emotion is a key tenet of 'hegemonic masculinity' (e.g., Connell, 2005) and by extension, medicine. Drawing heavily from Gramsci's work on cultural hegemony (Gramsci, 1971; Simon, 2005), Connell (2005) developed the idea of 'hegemonic masculinity' to examine and explain the cultural practices that create and maintain male dominance over women in society and within the workplace. Connell argued that hegemonic masculinity, in which control over emotion embodied the predominant view of what it meant to be an 'alpha male', and that this perception was achieved largely through the power of male 'culture, institutions and persuasion' (Connell, 2005).

The longstanding patriarchal links between hegemonic masculinity, the professions and occupational power are evident in modern society (Goodman, 2016). In the 21st century, gender discrimination still remains an issue for many professional groups (Goodman, 2016; Nadaf, 2018). Women are still under-represented at a senior level in many occupations and the gender pay gap (Williams, 2013), in which men are paid more than women in equivalent roles, is still widespread (Royal College of Nursing, 2020). The nature of gender discrimination in the workplace has already been examined from both a neo-Weberian and neo-Marxist perspective, as has the patriarchal basis on which work has historically been organised. Gendered exclusion has, over the years, prevented women from accessing the knowledge, skills, education and credentials to enter professions such as medicine (Larkin, 1983).

More recently, Becker (1993) developed the idea of human capital theory (HCT). Based upon economic theory, Becker looked at the links between an individual's education and their subsequent income and career advancement. Women's human capital, in terms of their education, qualifications and work experience has traditionally been viewed as lower than men's (Riska, 2008). As Watts (2008) notes, this disparity often resulted in gender segregation within the workplace. This segregation still occurs in so-called lower-status occupations such as nursing, where women predominate (Williams, 2013). However, contrary to the view that it is the patriarchal structures created by the established institutions that serve to exclude women from the professions, 'preference theory' argues that women actually make deliberate, family-orientated choices to work in occupations such as nursing which are less well regarded (Hakim, 2007). This alternative view, that gender segregation within health care occurred as a result of the active career choices made by women, is clearly contentious but has clearly contributed to the continuing social construction of nursing as a *vocation* suitable primarily for women (Acker, 1990).

It is argued here that the enduring gendered discourse prevalent within nursing has both devalued and eroded the role, so that the skill of caring is viewed as a characteristically feminine trait, taken for granted rather than valued and rewarded (Chua & Clegg, 1990; Royal College of Nursing, 2020). This gendered discourse has historically referred to nursing in terms of *vocation*, *moral character*, *subservience* and *service* (Chua & Clegg, 1990) in which the qualities of the 'good nurse' and the 'good woman' were seen as one and the same. The links between moral character and femininity were embodied in the idea of nursing as being only suitable for *single women of impeccable moral standards*. The findings from the recent Royal College of Nursing (RCN) report *Gender and Nursing as a Profession: valuing nurses and paying them their worth* (Royal College of Nursing, 2020) demonstrated beyond doubt that this longstanding gendered discourse has had a significant, negative impact upon nurses' pay and their prospects for career advancement.

There were a number of other unanticipated consequences arising out of this gendered discourse. For example, it resulted in nursing being labelled as a semi-profession. The language used in Hearn's (1982) view of a semi-profession may, in itself, be seen as patriarchal and out of date, but is reflective of the views of gender that predominated in the 1980s. As Radcliffe (2000) notes, in reality little has changed. This is primarily because the power in the nurse-doctor relationship is still mediated by the patient and the general public. To again paraphrase Radcliffe, *'If in doubt, ask the patient who is in control. The public may love its angels, but it holds its medics in awe…'*.

Nursing pursued professional status for many years, often with mixed fortunes (Allen, 2007). From the campaign for state-sponsored nurse registration onwards, nursing's professional project (Witz, 1990) has been focused upon gaining control over the provision of certain skills, tasks and competencies. The concept of a professional project involves the application of exclusionary occupational closure strategies to 'stake a claim' over certain resources and opportunities (Parkin, 1979). Larson (1979) refers to the idea of a new profession needing to develop its own 'cognitive exclusiveness' to a distinct body of knowledge. In the UK, nursing's professional project has been therefore focused, in recent times, upon developing, refining and controlling nursing's occupational knowledge through the auspices of higher education (Scott, 2008). Until the 1990s, nurse education had been predicated upon addressing local hospital workforce requirements through an apprenticeship-type model with education and training largely provided 'on the job'. Although degree courses had

been available in the UK since the 1970s, Project 2000 was the first real attempt in the UK to link nursing to higher education through the provision of specific university courses in nursing (Macleod-Clark et al., 1996). Nursing's professional project in the UK initially advocated diploma-level education, however by 2009, nursing had become a 'graduate entry' profession.

Nursing in the UK had achieved its aim, and the consensus view now is that nursing is definitely a profession. However, it is indisputable that nursing, and by extension the APN role, remains predominantly female and that historically, at least, it has served, and been subservient to, medicine. Whilst the increasing complexity and sophistication of health-care delivery has had the effect of moving nursing away from purely feminised emotional labour 'at the bedside' (Goodman, 2016) to a more technologically focused practice, the percentage of men entering nursing in the UK has remained stubbornly low at around 5%–10% (Ross, 2017). It is argued here that nursing is still viewed as being at odds with the prevailing hegemonic 'masculine' view of a suitable occupation for a man (Ross, 2017).

In comparison, medicine has become increasingly attractive to women as a profession (Riska, 2008), such that female registered medical practitioners made up approximately 46% of the medical workforce in 2017 (General Medical Council, 2020), and due to the numbers of female medical students in training, medicine will very soon become a predominantly female profession. It may be argued that in the pursuit of professional status, the feminine, caring traits of nursing that have previously attracted women to the profession are no longer emphasised and are actively downplayed (Riska, 2008). Radcliffe (2000) argues that by doing this, nursing has simply made bright women choose to be doctors instead of nurses.

In conclusion, each of the various sociological theories reviewed, from the 'classical' neo-Weberian and neo-Marxist sociology, through Bourdieu and Foucault, to the current thinking on interprofessional working, have been considered within the context of power, identity and gender in health care. Each of the approaches has its proponents and its critics. None of the theoretical approaches provides the complete answer, but when viewed as whole they offer an invaluable insight into the development of advanced nursing practice. It is argued here that to influence and direct the future development of advanced nursing practice, we need to understand its evolution. This will enable us to make informed choices over where and how the APN 'fits in' to the health-care structures, what an APN *is* and what it *does*. To decide whether APNs need to develop an occupational identity, and whether or not it needs to be sufficiently distinct from nursing to establish the role as a separate entity. These are all important issues that need to be, but have not as yet, been definitively addressed.

CONFLICT OF INTEREST

The author declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no data sets were generated or analysed during the current study

ORCID

Robin Lewis https://orcid.org/0000-0003-2134-506X

REFERENCES

Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organisations. *Gender & Society*, *4*(2), 139–158. https://doi.org/10.1177/2F089124390004002002

Allen, D. (2007). What do you do at work? Profession building and doing nursing. *International Nursing Review*, *54*(1), 41–48. https://doi.org/10.1111/j.1466-7657.2007.00496.x

Allsop, J. (2006). Medical dominance in a changing world: The UK case. *Health Sociology Review*, *15*(5), 444–457. https://doi.org/10.5172/hesr.2006.15.5.444

Anderson, H., Birks, Y., & Adamson, J. (2019). Exploring the relationship between nursing identity and advanced nursing practice: An ethnographic study. *Journal of Clinical Nursing*, *29*, 1195–1208. https://doi.org/10.1111/jocn.15155

Andrew, N. (2012). Professional identity in nursing: Are we there yet? *Nurse Education Today*, *32*, 846–849. https://doi.org/10.1016/j.nedt.2012.03.014

Barton, T., Thorne, R., & Hoptroff, M. (1999). The nurse practitioner: Redefining occupational boundaries? *International Journal of Nursing Studies*, *31*(1), 57–63. https://doi.org/10.1016/s0020-7489(98)00058-3

Becker, G. (1993). *Human capital: A theoretical and empirical analysis with special reference to education* (3rd ed.). University of Chicago Press. http://www.nber.org/books/beck94-1

Begley, C., Elliot, N., Lalor, J., Coyne, I., Higgins, A., & Comiskey, C. (2013). Differences between clinical specialist and advanced practitioner clinical practice, leadership, and research roles, responsibilities, and perceived outcomes (the SCAPE study). *Journal of Advanced Nursing*, *69*(6), 1323–1337. https://doi.org/10.1111/j.1365-2648.2012.06124.x

Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory*, *7*(1), 14–25. https://www.jstor.org/stable/202060

Bryant-Lukosius, D., Spichiger, E., Martin, J., Stoll, H., Kellerhals, S., Fliedner, M., Grossmann, F., Henry, M., Herrmann, L., & Koller, A. (2016). Framework for evaluating the impact of advanced practice nursing roles. *Journal of Nursing Scholarship*, *48*, 201–209. https://doi.org/10.1111/jnu.12199

Chua, T., & Clegg, S. (1990). Professional closure: The case of British nursing. *Theory and Society*, *19*(2), 135–172. https://www.jstor.org/stable/657545

Coburn, D. (2006). Medical dominance then and now: Critical reflections. *Health Sociology Review*, *15*(5), 432–443. https://doi.org/10.5172/hesr.2006.15.5.432

Comeau-Vallee, M., & Langley, A. (2020). The interplay of inter- and intraprofessional boundary work in multidisciplinary teams. *Organisation Studies*, *41*(12), 1649–1672. https://doi.org/10.1177/2F0170840619848020

Connell, R. (2005). *Masculinities* (2nd ed.). Polity Press.

Cooper, M., McDowell, D., & Raeside, L. (2019). The similarities and differences between advanced nurse practitioners and clinical nurse specialists. *British Journal of Nursing*, *28*(20), 1308–1314. https://doi.org/10.12968/bjon.2019.28.20.1308

Cooper, R. (2001). Health care workforce for the twenty-first century: The impact of non-physician clinicians. *Annual Review of Medicine*, *52*, 51–61. https://doi.org/10.1146/annurev.med.52.1.51

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. (2012). Institutional work to maintain professional power: Recreating the model of medical professionalism. *Organisation Studies*, *33*(7), 937–962. https://doi.org/10.1177/2F0170840612445116

D'Amour, D., Ferrada, M., & Rodriguez, L. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, *19*, 116–131. https://doi.org/10.1080/13561820500082529

Delamaire, M., & LaFortune, G. (2010). *Nurses in advanced roles: A description and evaluation of experiences in 12 developed countries*. OECD. https://doi.org/10.1787/18152015

Department of Health and Social Security. (1986). *Neighbourhood nursing: A focus for care* (Cumberlege Report). HMSO.

Dubois, C., Nolte, E., & McKee, M. (2005). *Human resources for health in Europe*. Open University Press. https://researchonline.lshtm.ac.uk/id/eprint/19270

Foucault, M. (1971). *The birth of the clinic*. Tavistock Press.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings* (pp. 1972–1977). Pantheon.

Fournier, R. (2000). Boundary work and (un)making of the professions. In N. Malin (Ed.), *Professionalism, boundaries, and the workplace* (pp. 1–20). Routledge.

Freidson, E. (1984). The changing nature of professional control. *Annual Review of Sociology*, *10*(1), 1–20. https://doi.org/10.1057/9781137355621_19

Freidson, E. (2000). *Professionalism: The third logic*. Polity Press.

General Medical Council. (2020). *The state of medical education and practice in the UK*. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

Goodman, B. (2016). The missing two Cs – Commodity and critique: Obscuring the political economy of the gift of nursing. *Journal of Research in Nursing*, *21*(4), 325–335. https://doi.org/10.1177/2F1744987116630023

Gramsci, A. (1971). *Selections from the prison notebooks*. International Publishers.

Hakim, C. (2007). Women, careers, and work-life preferences. *British Journal of Guidance & Counselling*, *34*(3), 279–294. https://doi.org/10.1080/03069880600769118

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, *19*, 188–196. https://doi.org/10.1080/13561820500081745

Hamric, C., & Hanson, A. (2003). Reflections on the continuing evolution of advanced practice nursing. *Nursing Outlook*, *51*(5), 203–211. https://doi.org/10.1016/S0029-6554(03)00158-1

Harrison, S., & Ahmad, W. (2000). Medical autonomy and the UK state 1975 to 2025. *Sociology*, *34*(1), 129–146. https://doi.org/10.1177/S0038038500000092

Health Education England. (2018). *Multi-professional framework for advanced clinical practice*. https://hee.nhs.uk/sites/default/files/documents/HEE%20ACP%20Framework.pdf

Hearn, J. (1982). Notes on patriarchy, professionalisation and the semi-professions. *Sociology*, *16*(2), 184–202. https://doi.org/10.1177/2F0038038582016002002

Hill, B. (2017). Exploring the development and identity of advanced practice nursing in the UK. *Nursing Management*, *24*(5), 36–40. https://doi.org/10.7748/nm.2017.e1607

Huby, G., Harris, F., Powell, A., & Pinnock, H. (2014). Beyond professional boundaries: Relationships and resources in health services' modernisation in England and Wales. *Sociology of Health & Illness*, *36*(3), 400–415. https://doi.org/10.7748/nm.2017.e1607

Huff, T. (1987). Review of Weberian sociological theory. *American Journal of Sociology*, *92*(6), 1525–1527. http://www.jstor.org/stable/2779853

Hughes, E. (1958). *Men and their work*. Free Press.

Imison, C., Castle-Clarke, S., & Watson, R. (2016). *Reshaping the workforce to deliver the care patients need*. Nuffield Trust. https://www.guanaitong.com/uploadfile/2018/0905/20180905153611722 1.pdf

International Council of Nursing. (2008). *Definition and characteristics of the role: Nurse practitioner and advanced practice roles*. https://international.aanp.org/Practice/APNRoles

Johnson, M., Cowin, L., Wilson, M., & Young, H. (2012). Professional identity and nursing: Contemporary theoretical developments and future research challenges. *International Nursing Review*, *59*(4), 562–569. https://doi.org/10.1111/j.1466-7657.2012.01013.x

Johnson, T. (1972). *Professions and power*. Routledge.

King, O., Nancarrow, S., Borthwick, A., & Grace, S. (2015). Contested professional role boundaries in health care: A systematic review of the literature. *Journal of Foot and Ankle Research*, *8*(2), 33–42. https://rdcu.be/cGwLW

Lamont, M., & Molnar, V. (2002). The study of boundaries in the social sciences. *Annual Review of Sociology*, *28*, 167–195. https://doi.org/10.1146/annurev.soc.28.110601.141107

Larkin, G. (1983). *Occupational monopoly and modern medicine*. Tavistock.

Larson, M. (1979). *The rise of professionalism: A sociological analysis*. University of California Press.

Lawrence, T., & Suddaby, R. (2006). Institutions and institutional work. In S. R. Clegg, C. Hardy, W. R. Nord, & T. B. (Eds.), *Sage handbook of organizational studies* (pp. 251–254). Sage.

Leary, A., Maclaine, K., Trevatt, P., Radford, M., & Punshon, G. (2017). Variation in job titles within the nursing workforce. *Journal of Clinical Nursing*, *26*, 4945–4950. https://doi.org/10.1111/jocn.13985

Liberati, E. (2017). Separating, replacing, intersecting: The influence of context on the construction of the medical-nursing boundary. *Social Science & Medicine*, *172*, 135–143. https://doi.org/10.1016/j.socscimed.2016.11.008

Macleod-Clark, J., Maben, J., & Jones, K. (1996). Project 2000: Perceptions of the philosophy and practice of nursing. *English National Board*. https://eric.ed.gov/?id=ED398406

Marx, K. (1976). *Capital* (Vol. 1). Progress Publishers.

Maxwell, E., Bailie, L., Rickard, W., & McLaren, S. (2013). Exploring the relationship between social identity and workplace jurisdiction for new nursing roles: A case study approach. *International Journal of Nursing Studies*, *50*, 622–631. https://doi.org/10.1016/j.ijnurstu.2012.10.015

McKinlay, J., & Marceau, L. (2002). The end of the golden age of doctoring. *International Journal of Health Services*, *32*(2), 379–416. https://doi.org/10.2190/2FJL1D-21BG-PK2N-J0KD

Meier, N. (2015). Collaboration in healthcare through boundary work and boundary objects. *Qualitative Sociology Review*, *11*(3), 60–82. https://doi.org/10.18778/1733-8077.11.3.05

Melia, K. (1984). Student nurses' construction of occupational socialisation. *Sociology of Health & Illness*, *6*(2), 132–151. https://doi.org/10.1111/1467-9566.ep10778231

Murphy, R. (1984). The structure of closure: A critique and development of the theories of Weber, Collins, and Parkin. *British Journal of Sociology*, *35*(4), 547–567.

Nadaf, C. (2018). Reflections on a debate: When does advanced clinical practice stop being nursing? *Journal of Research in Nursing*, *23*(1), 91–97. https://doi.org/10.1177/2F1744987117751456

Nancarrow, S., & Borthwick, A. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health & Illness*, *27*(7), 897–919. https://doi.org/10.1111/j.1467-9566.2005.00463.x

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J., & Braithwaite, J. (2010). How and where clinicians exercise power: Interprofessional relations in health care. *Social Science & Medicine*, *71*(5), 898–909. https://doi.org/10.1016/j.socscimed.2010.05.029

Parkin, F. (1979). *Marxism and class theory: A bourgeois critique*. Routledge. https://doi.org/10.4324/9780203831632

Price, S., Doucet, S., & Hall, L. (2014). The historical social positioning of nursing and medicine: Implications for career choice, early socialisation and interprofessional collaboration. *Journal of Interprofessional Care*, *28*(2), 103–109. https://doi.org/10.3109/13561820.2013.867839

Radcliffe, M. (2000). Doctors and nurses: New game, same result. *British Medical Journal*, *320*, 1085–1521. https://doi.org/10.1136/bmj.320.7241.1085

Riska, E. (2008). The feminisation thesis: Discourses on gender and medicine. *Nordic Journal of Feminist and Gender Research*, *16*(1), 3–18. https://doi.org/10.1080/08038740701885691

Ross, D. (2017). Challenges for men in a female dominated environment. *Links to Health and Social Care*, *2*(1), 4–20. http://openjournals.ljmu.ac.uk/lhsc

Royal College of Nursing. (1997). *Nurse practitioners: Your questions answered*. http://live.nhsggc.org.uk/media/224398/RCNNursePractitioners.pdf

Royal College of Nursing. (2020). *Gender and nursing as a profession: Valuing nurses and paying them their worth*. https://www.rcn.org.uk/professional-development/publications/pub-007954

Scott, S. (2008). 'New professionalism': Shifting relationships between nursing education and nursing practice. *Nurse Education Today*, *282*, 240–245. https://doi.org/10.1016/j.nedt.2007.04.004

Sheer, B., & Wong, K. (2008). The development of advanced nursing practice globally. *Journal of Nursing Scholarship*, *40*(3), 204–211. https://doi.org/10.1111/j.1547-5069.2008.00242.x

Simon, R. (2005). *Gramsci's political thought: An introduction*. Lawrence & Wishart.

Skorikov, V., & Vondracek, F. (2011). Occupational identity. In K. Schwartz, & L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 441–456). Springer.

Sluss, D., & Ashforth, B. (2007). Relational identity and identification: Defining ourselves through work relationships. *Academic Management Review*, *32*(1), 54–65. https://doi.org/10.5465/amr.2007.23463672

Srivastava, N., Tucker, J., & Draper, E. (2008). A literature review of principles, policies and practice in extended nursing roles relating to UK intensive care settings. *Journal of Clinical Nursing*, *17*, 2671–2680. https://doi.org/10.1111/j.1365-2702.2008.02481.x

Starr, P. (2004). Social transformation twenty years on. *Journal of Health Politics, Policy and Law*, *29*(4), 1005–1019. https://www.muse.jhu.edu/article/175031

Stein, L. (1967). The doctor-nurse game. *Archives of General Psychiatry*, *16*(6), 699–703. https://doi.org/10.1001/archpsyc.1967.01730240055009

Stein, L., Watts, D., & Howell, T. (1990). The doctor-nurse game revisited. *The New England Journal of Medicine*, *322*, 546–549. https://doi.org/10.1056/NEJM199002223220810

Strauss, A. (1978). *Negotiations: Varieties, contexts, processes, and social order*. Jossey-Bass.

Sutherland, L., Howard, S., & Markauskaite, L. (2010). Professional identity creation: Examining the development of preservice teachers' understanding of their work as teachers. *Teaching and Teacher Education*, *263*, 455–465. https://doi.org/10.1016/j.tate.2009.06.006

Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior*, *30*(2), 220–239. https://www.jstor.org/stable/2137015

Watts, A. (2008). Career and family choices in the presence of uncertainty. *Discussion Papers*, 60. http://opensiuc.lib.siu.edu/econ_dp/60

Williams, C. (2013). The glass escalator revisited: Gender inequality in neoliberal times. *Gender & Society*, *27*(5), 609–629. https://doi.org/10.1177/2F0891243213490232

Willis, E. (2006). Introduction: Taking stock of medical dominance. *Health Sociology Review*, *15*(5), 421–431. https://doi.org/10.5172/hesr.2006.15.5.421

Witz, A. (1990). Patriarchy and professions: The gendered politics of occupational closure. *Sociology*, *24*(4), 675–690. https://doi.org/10.1177/2F0038038590024004007

Zola, I. (1972). Medicine as an institution of social control. *Sociological Review*, *20*, 487–503. https://journals.sagepub.com/doi/pdf/10.1111/j.1467-954X.1972.tb00220.x

How to cite this article: Lewis, R. (2022). The evolution of advanced nursing practice: Gender, identity, power and patriarchy. *Nursing Inquiry*, e12489. https://doi.org/10.1111/nin.12489