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Professional Identity within changing healthcare roles: exploring the third or hybrid space[1]

Sally Moyle and Richard Waller

Abstract

The ever-changing landscape of healthcare policy has impacted significantly on the development of nursing roles (Lloyd–Rees 2016), and consequently seen the growth and transformation of existing professions and introduction of new health care roles. Whilst the Emergency Nurse Practitioner (ENP) role is now well established within urgent care settings it has evolved in an *ad hoc* manner, responding to service demand. This has resulted in varying levels of job satisfaction and inconsistency in titles, uniform, and scope of practice.

Using photographs or images to describe their perceptions of the role, experience and perceived professional identity, participants reported moving away from their traditional nursing practice into something different that bought new challenges and often conflict. Applying Bhabha's (1994) concept of the 'third space' to our findings suggests that ENPs have adopted a hybrid role that is operating within a 'third (or hybrid) space', where new identity is formed. Our participants' uncertainty around this (and that of others) could negatively impact the development of professional identity during transition into this new role.

Key words

Healthcare policy

New roles

Third or hybrid space

Identity

Emergency nurse practitioners

[1] This chapter has been developed using extracts from the thesis, Moyle, S. (2017) Identity crisis within the role of the emergency nurse practitioner? An exploration of autonomy and identity. [Thesis] Faculty of Arts Creative Industries and Education, University of the West of England, Bristol.

Sally's professional story and context

My interest in professional identity began in the early 2000s when I was developing an academic programme of study for the emerging role of the Emergency Nurse Practitioner (ENP). I had been a practising ENP in the early 1990s and was one of the first to deliver the service in the hospital where I worked, having undergone a brief in-house two-week education programme without formal academic accreditation. I learnt the role 'on the job,' relying heavily on senior doctors to help and guide me. In the mid 1980s the nursing regulator at that time started to push towards a radical change to nurse education, with a move into higher education (HE) to develop a different type of nurse, one who questioned, critiqued, and was able to respond to the complex health system (UKCC 1986). When I moved into working in higher education, I was tasked with setting up one of the first accredited programmes to develop the role. This took the form of a level six and level seven (undergraduate final year and Master's degree respectively) continual professional development (CPD) short course (which later evolved into a PG Certificate as part of a Master's Degree in Advanced Practice). Since then, role expansion has become commonplace across many disciplines and I have listened with interest and frustration to countless tales from students who are unsure of their role, their title and scope of practice. Today, Advanced Clinical Practice (ACP) is framed around a well-defined, competency-based curriculum (HEE 2017).

However, practitioners who have moved into these new occupations still cite uncertainty around their role and there remain differences over pay, titles and working conditions (Lloyd-Reece 2016). Whilst there have been attempts to standardise the role in recent years, there is a body of evidence suggesting that varying levels of scope of practice, lack of standardised education pathways and role clarity exist (Anderson et al. (2020). However, there is less research on how these issues impact on perceived professional identity, and how this relates to job satisfaction, retention, and the role's success within an organisation.

Introduction

This chapter explores the concept of professional identity through a group of practitioners (n=13) who participated in a study conducted by the first author (SM) (and supervised by the second, RW), exploring their experience within the role and perceptions of professional

identity. Using photo (or image) elicitation and focus groups to explore their perceptions, several themes emerged in the original study. Concepts such as 'hybridity', 'third space' and transitions are explored in this chapter in light of the findings.

Policy Context

Demand for NHS services continues to increase year-on-year with the population in England predicted to increase by 4.2% over the next 15 years (NHSE 2023). This, alongside an ageing population, will result in increasing levels of service delivery complexity and a continual rise in multimorbidity and frailty. The recent publication of the NHSE Long Term Workforce Plan (LTWP) (NHSE 2023) predicts that by 2030 two-thirds of people over 65 will have multiple health conditions and a third of those will have mental health needs. The ever-changing landscape of healthcare has had a significant impact on the development of expanding nursing roles both within the UK and internationally and has seen the growth and transformation of existing professions and the introduction of new roles (Hoskins 2011). The LTWP (NHSE 2023) suggests that new roles such as Advanced Clinical Practitioner (ACP) and Physician Associate (PA) need to grow and will become an integral part of delivering a different model of care by harnessing digital and technological innovations.

At the time of the study The NHS Five Year Forward View (DH 2017) demanded a workforce that worked *'across organisation and sector boundaries'* promising education and training that '*equips the current workforce with the skills and flexibility to deliver new models of care'* (DH 2017 page 30). This was an important policy initiative of that time, with the development of the ENP role and others being a direct response to this and other policy initiatives that precede it.

The ENP role evolved against this backdrop and alongside the gradual development of a formal education programme to support the role. However, the more recent emergence of the Advanced Clinical Practitioner (with a well-defined role definition and education programme) has led some practitioners to further question the role definition of the ENP, and it remains uncertain where it sits along the Advanced Practice continuum. It is evident that despite a lack of standardisation in role definition and scope of practice the role of the ENP, as noted by Lloyd-Rees (2016), is a well-established role and one that continues to evolve within all urgent care settings both nationally and internationally (Anderson et al., (2020).

Figure 1 is a conceptual map that draws together the evolution of advanced practice against the backdrop of policy drivers for change incorporating the educational developments that have underpinned the evolution of the role to date.

Figure 1 Timeline of the evolution of advanced practice education and drivers for change

Figure 1 about here

Research Methods

Focus groups were selected as the primary method of data collection, followed by two single semi-structured interviews to offer a different perspective and triangulate results. Data was thematically analysed using Braun and Clarke's (2013) approach. Five broad themes emerged from the data which were further divided into sub-themes. Participants were asked to bring a selection of images which they felt represented their professional identity. Photo (or image) elicitation as a tool for data collection will be discussed later in the chapter. The images themselves were not part of the data analysis, however, participants used them to describe their perceptions of professional identity and bought their voices to the narrative. They were also used to illustrate the theme titles.

The research's aim was to explore aspects of identity and factors influencing it, for example, knowledge, autonomy, relationships, and organisational loyalty and therefore the focus groups were structured to explore these concepts. Focus groups were selected because their main purpose is to draw upon participants' beliefs, attitudes, and feelings by maximising the benefit of group processes (Freeman 2006). Barbour (2018) explains that group processes can help people explore and clarify their views and attitudes efficiently and encourage participation from those who feel they have little to say. Focus groups, therefore, allowed safe exploration of this, and they were designed to ensure maximum opportunity for exploration of feelings.

The following section highlights the value of participants knowing each other and the relevance of 'insider knowledge', as this was an important aspect for SM as primary researcher, having taught or worked with most of them previously.

The participants in each focus group knew each other. They were selected due to their place of work, (rather than being a random sample of ENPs), from across one Emergency Department (ED) and one Minor Injury Unit (MIU). We wanted to explore the experience of

ENPs working in two different types of setting (community hospital and acute trust) to compare perceptions around identity (understanding that within the ED there are other health professionals and doctors working together, whilst at the MIU, ENPs primarily worked alone). We were concerned that if the groups were mixed it would risk practitioners discussing how their roles differ, rather than concentrating on issues of identity and the influence of colleagues and organisational practise. There are also the practical aspects of getting groups of practitioners from different workplaces together, and the time required to ensure they felt comfortable sharing their experiences. Kruegar and Casey (2014) acknowledges that tensions exist around homogeneity and concedes that organisational contexts and practical concerns influence how researchers bring focus groups together. Consequently, the focus groups here were drawn from participants within each organisation separately, rather mixing groups. In addition, the focus groups were small (three and four participants), in part due to pragmatic considerations of releasing staff from clinical shifts and sharing lifts to the focus group location. However, when considering the topic, the experience of participants and potentially intimate nature of sharing their photographs, we felt having smaller groups would facilitate a more informal environment for sharing experiences. The focus group size was tested during the pilot study (n=4), where participants had the opportunity to express their views freely, suggesting the size of group afforded an intimate and safe discussion with all participants having an opportunity to 'have their say'. Participants suggested they felt more comfortable in a smaller group and were able to share photos and experiences freely, producing rich data for analysis.

Insider knowledge and ethical issues

Throughout the research we were aware of the first author's position within the study. The community of ENPs in the region was relatively small and everyone within that community knew each other, and as ENP programme lead, SM was well-known and highly regarded by them. Participants were keen to be involved in the study, as most had either worked with or had been taught by SM. We were aware this involvement could impact on the research process in terms of subjectivity and bias, with respondents potentially feeling 'pressurised' into consenting to the study due to a perceived power imbalance between the educator-researcher and the participants as past students (Seidman 2006). Finlay (2002) suggests the

researcher should be aware of such bias and endeavour to minimise its impact. To address this, the participants were visited in their place of work, and briefed on the study and given information leaflets. Written consent was gained via email at a later stage, allowing participants to think about their involvement in the study. Social desirability is also a potential problem highlighted within qualitative research, especially when in a group setting, and something that needs careful attention when designing a study. This occurs when participants respond in a manner they think will make them liked or more accepted (Krumpal 2013). We were aware of this possibility and although traditional characteristics of ED nurses counters such desirability bias, (as they are considered open and extrovert (Kennedy *et al*. 2014)), SM attempted to ensure all participants felt comfortable in voicing their opinions by encouraging them to have equal 'airtime' and agreeing ground rules when the discussions started. This was particularly useful when managing a group of participants who are comfortable with each other and is highly recommended.

The position of being an 'insider' within qualitative research can also be beneficial, and actively contribute to the collection and subsequent analysis of data. The participants expressed 'enjoyment' and feeling 'invigorated' at being able to discuss the issues, with some describing it as 'cathartic'. SM's insider knowledge and enthusiasm for the development of the ENP role over many years empowered the participants to feel they could express themselves freely. They described feeling upbeat after the focus group and motivated to develop some form of support network upon returning to work. It is, however, important to acknowledge that SM's professional background undoubtedly influenced how the data was interpreted and this needs further explanation.

It is well recognised within qualitative research methodology literature that the researcher will tell a different story from that told by participants (Braun and Clarke, 2013). Analysis of data involves interpretation, which is informed by the participants' subjective opinions, and the product of analysis often differs from the raw data. For some (Price 1996), this is disconcerting, and leads to the suggestion of a participatory approach whereby participants are active collaborators in the research process. However, Braun and Clarke (2013) assert that *'the story is our story about the data, not the participants' story, and our story may differ from theirs'* (p64). They go on to suggest that it is important to decide whether the analysis will be 'data driven' (the themes will depend on the data), or whether it will be 'theory driven' (the

data is approached with specific questions and coded around these). In this study we decided that the data-driven approach to analysis would be adopted. That is, the emerging themes came from the data. It is important to note, however, that when using this method of data analysis not all the study's research questions may be answered as the themes emerge from the data rather than the research questions themselves.

There are other advantages to researching an area with which you are familiar, something linking all professional doctoral researchers. For example, during the focus groups SM's knowledge of the subject matter enabled the discussion to flow easily since she could interpret colloquial language and acronyms without having to seek clarification. The following quote highlights the advantage of having 'insider' knowledge of the subject matter, since the language used was readily understood and did not need clarification which may have interrupted the conversational flow:

> *'When I am in navy, I still use my ENP skills, I will request X-rays and do bloods to speed things up, I am part of the nursing team. When I am in black, I am part of the ENP team which is a separate entity'. ENP 1*

(ENPs in the ED often have dual roles; sometimes they work in the main department as one of the nursing team, and wear navy blue, or they work as an ENP in the minor injury end of the department and wear a black uniform).

Corbin and Buckle (2008) agree, suggesting that the 'insider' researcher can synthesise concepts more quickly. SM was also able to 'push' the discussion on further at times through an ability to interpret the ENPs' understanding of the questions or prompts. RW would not have been able to do this, despite being a significantly more experienced researcher. Corbin and Buckle (2008) recognise that researchers using their own insight and experience has a positive effect on the group dynamic and provides further insight into the participants' responses.

Photograph elicitation as a tool for exploring participant perceptions

Images identified by the participants were used as 'prompts' to initiate a discussion about their perceptions of professional identity. It was made clear that they could be either personal photographs or images selected from another source such as the internet. Some participants

used their photos (or images) to illustrate their feelings, for example, one participant showed her frustration of the role by showing the group a photo of a woman screaming. Others used them in more general terms, for example, one participant used a picture of a meandering river to demonstrate her 'non-linear' career progression. Studying a group of practitioners who already knew each other was advantageous since they felt more comfortable 'exposing' their images to one another and had already formed relationships within the group and established a level of trust with each other. This had the advantage of not needing time to get to know each other and form relationships that would allow open and honest conversations. Participants were reassured that there were no 'rules' in relation to what type of images they presented. Rather, they were asked to bring any image they felt represented their professional identity. The aim was to create a different conversational dynamic, whilst adding a layering effect as participants drew on their own photographs and had the opportunity to discuss each other's. During the analysis of the focus group data, participant photographs were used to illustrate the themes that were identified, and to highlight perceptions when they were considered a useful adjunct to the narrative. In this sense the photographs were as Banks (2000) described, an 'illustration' of the text.

Use of photographs falls into the broad category of visual research approaches and has long been used by anthropologists for documentary purposes or as a tool to aid the research process (Collier and Collier, 1986). Visual aids have been increasingly used within social science research, with most employed to illustrate the narrative rather than analysis of the photograph itself (Banks, 2000). Visual images are also commonly used to elicit information from participants in interviews and are taken either by the researcher for the participant to comment on or by the participants themselves (Heisley and Levy, 1991). Pictures or images used by the participants are considered *'to reflect the participants' views and open a world that the researcher might not otherwise have access to or consider important'* (Warren and Karner, 2005 p171). Critics argue there can often be a strong element of bias within this type of data collection, because participants may select photographs knowing how they will be represented. However, this could be viewed as similar to a participant answering a question how they think the researcher wants them to. Another method of using photographs is to use pre-existing images. These are more commonly used to reconstruct events, relationships, and rituals. Participants might also use pre-existing photographs from the past as a contrast to

their current situation, or to indicate a change in their lives (Banks 2000). Today, many images will undoubtedly come from the internet, allowing participants to expand their ideas and create a different narrative than they might otherwise have with traditional photographs.

Photographs have traditionally been viewed as documenting reality and the 'truth' within research (Bogdan and Biklen, 2006). More recently however others suggest that photographs can destabilise the notion of 'truth', and that reality is a *'negotiated version of reality'* (Pink 2005, p20), where the researcher and participant bring their experiences together to form the negotiated reality. In this instance the photographs represent the experience of participants as they see it at that time, which might be different from how someone else views it at another time. Emmison and Smith (2012) suggest that visual data should be thought of not in terms of what the camera can record but of *'what the eye can see'* (p4). They argue that photographs are a means of preserving, storing, or representing information, rather than a source of data collection. This was certainly true in this study, as the images represented the participants' view at that time. It is quite possible that were the study to be replicated with the same participants, they may well choose different photos and have different stories to tell.

Findings and discussion

Five themes initially emerged from the data, each with sub-themes. These were considered in light of the literature and theoretical concepts explored within the study. From these five initial themes three overarching aspects were discussed: the role, career structure and education. Due to word limits in this chapter, only one aspect (the role), which includes concepts of transition, socialisation and the 'third space' as key factors to the role will be discussed here.

The role

One of the key findings from this study was that participants enjoyed their role and gained a huge amount of satisfaction from the job. Despite acknowledging that they dealt with uncertainty, conflict, and a degree of risk management within the workplace, participants described confidence in what they did and were proud of their role:

> *The reason I get out of bed in the morning is that I feel important about the job I do and that I feel privileged and trusted to prescribe. It makes my professional identity feel important. ENP 3*
>
> *It is something you have earned, we are not just nurses, and not everyone can do it, it is something to be proud of. ENP 7*

Participants also reported high levels of job satisfaction and self-confidence relating to delivering high quality care, clinical expertise, and pride from the autonomous nature of the role by delivering the '*whole package'* to patients. Some also reported feelings of uncertainty and frustration and were less confident in other areas of the role including relationships with other nurses, public perceptions of the role, continuing education, and career structure, as this participant outlines:

> *This is a photo of someone screaming; it represents that we still have to keep screaming about what we do and the role we have. ENP 10*

Lloyd-Rees (2016) also examined how ENPs viewed their role in a small qualitative study (n=8) and found high levels of job satisfaction and motivation despite respondents reporting issues of conflict with other nurses, a lack of understanding of the role outside the ED and concerns around remuneration and lack of clear educational standards for preparing for it.

There is a wealth of literature, for example, (Anderson *et al*., 2020) supporting patient satisfaction within non-medical extended roles, however, there is less literature examining role satisfaction from the emic perspective of the ENP. Hayes *et al.* (2010) however, identified three variables essential to nurse job satisfaction; inter-personal factors (autonomy, direct patient care, professional relationships, and educational opportunities), extra-personal including factors beyond their control such as pay, organisational policy and organisational constraints, and intra-personal factors such as personal resilience, education and experience. Desborough *et al*. (2013) identified similar characteristics in a study examining job satisfaction with a group of ENPs and identified that autonomy within the role was a key factor of satisfaction, but only when coupled with supportive and cohesive professional relationships with both medical and nursing staff. In addition, the ability to deliver high quality patient care was also identified as a factor supporting positive role fulfilment. Areas that were identified

as diminishing satisfaction within the Hayes *et al*., (2010) study included insufficient access to appropriate education, support and mentorship and lack of role clarity.

Self-confidence and self-esteem are linked to professional identity through the construct of self-concept (Johnson *et al.,* 2012). Positive self-esteem is also linked to positive performance (and job satisfaction) (Bjorkstrom *et al.,* 2008), and as noted previously studies have consistently demonstrated that ENPs perform as well as their medical counterparts in helping reduce waiting times and contributing to patient safety. This suggests that they have a strong sense of self-esteem, confidence and ability around the clinical aspects of the role. Given that self-esteem and confidence impact positively on professional identity, most participants here have a strong sense of professional identity relating to role clarity, clinical expertise and their levels of autonomy. They were, however, less certain about their identity in relation to other 'professional' aspects of their role such as perceptions of others, relationships and education, and their future career options.

The study participants clearly had a sense that they were 'different' from other nurses but were equally clear that they were not doctor substitutes. They tried to articulate what made them different, and for most the difference was linked to managing risk, litigation, and autonomy/responsibility.

> *If you make an error or one of your decisions are not sound (that is the risky bit) you know the sharks are underneath you* (shows a cartoon picture of a tightrope with sharks circulating underneath). *ENP 3*

Interestingly, whilst managing risk and the fear of litigation were important factors in determining what the ENPs did, this did not detract from their overall sense of job satisfaction. These findings are in line with older studies; for example, Tye and Ross (2000) found that managing risk and uncertainty, and a fear of litigation, were factors seen as a barrier to development, and the need for organisational support was apparent. However, despite these barriers a desire to progress the role boundaries was also evident in both this study and Tye and Ross's (2000).

Our participants also reported feeling disappointed with the lack of understanding of the autonomous nature of the role from senior managers:

> *I don't think they (management) understand we do more or less the same the exact same job as our medical colleagues. They don't understand the scope of what we do, but I do think they understand the impact and know a good thing when they see it. ENP 3*
>
> *I suppose they see us happily tick away; I don't think they understand us but appreciate we do a good job. I don't think they understand the level of stress and urgent and complex patients we see, even though we give them all the figures. We haven't had huge disasters here and huge incidents and until that happens, they don't understand the level of risk we deal with every day. ENP 6*

This was an important finding as retention within the NHS continues to be a challenge (NHSE, 2023) and as job satisfaction is linked to perceived levels of autonomy within the role (Desborough, 2013), constraints around this may be impacting on overall job satisfaction and therefore impacting on staff retention. In the Pill (2012) study autonomy in decision making was also identified as a significant component of the ENP's professional identity, but as with others (Desborough, 2013) she found factors impeding their autonomy included decisions made by doctors and managers which impacted directly on job satisfaction and arguably influenced their sense of identity.

Role transition

Participants in this study sensed some sort of 'transition' as they described '*moving away from their traditional nursing roots into something different' ENP 3*. They described being '*somewhere in between' (ENP4)* medicine and nursing, something described elsewhere as moving into the 'third' or 'liminal' space (Bhaba 1994), whereby practitioners are in moving into new role definitions, boundaries and practices. This is discussed in more detail later in the chapter. Role transition is a key element of successful implementation of the ENP role (MacLellan and Higgins, 2015) as the individual moves from a traditional nursing role into being an ENP as they redefine their role and re-establish themselves within the healthcare team (Santon *et al.* 2010). Transition involves the nurse moving away from the traditional

caring humanistic models of nursing practice and cultures into a sphere of practice incorporating a biomedical model of diagnosis, prescribing and treatment (Santon et al 2020). The literature examining the transition of nurse to ENP describes the experience as 'uncomfortable', 'difficult', 'stressful' and 'turbulent' (Newhouse, 2011).

Some participants in our study identified feeling guilty about the transition as they *'didn't feel like a nurse anymore'* and didn't *'relate to nursing'* in the same way.

> *Sometimes I feel guilty that I don't feel so much like a nurse anymore, even though that is where you were brought up. That grounding will never leave but I feel like I am almost living beyond that in terms of my role and how I see myself. ENP 2*

This echoes the literature around transitioning as ENPs move from a place of comfort and familiarity to a place of unknown territory (MacLellan and Higgins, 2015). Studies have examined the transition of a student nurse into a qualified nurse, and establishing a professional identity within this transition is seen as a key factor in relation to retention and confidence within their new role (Johnson *et al.,* 2012). In the same way that student nurses continue to engage in construction and deconstruction of their identity through clinical practice, interaction with other healthcare professionals and education, it appears that ENPs also undergo a continual change of identity as they transition into a new role through the same processes.

> *I think I am separate to both, somewhere in between, so I have a different head to certain nurses, and we have very different opinions to them. I can usually give a good rationale to the nurses on the 'shop floor' why I want to do something, because of the ENP stuff, so I don't necessarily relate to nurses, and I do a bit less nursing (I think) but I am not a doctor, don't want to be one and I don't relate to them either. I think we have our own identity, as an ENP rather than a nurse or doctor, it's a completely separate identity. ENP 4*

Bridges (2003) proposes that all transitions have three phases: an ending followed by a neutral zone and finally a new beginning. The first phase (ending) is associated with changing identity as the practitioner loses their status as a nurse but is not yet accepted as an ENP.

Bridges describes this loss of identity as the 'in-betweenness', as practitioners describe insecurity and uncertainty and confusion. The second phase (the neutral zone) is described as a period of being 'in limbo' as the ENP feels vulnerable with the new emerging identity and lacks self-confidence. However also within this phase new networks are developed and dynamic change and growth takes place. The third phase (new beginnings) involves new attitudes, new values, and new identities as the ENP adapts to their role. However, it is important to note that each phase is not time-limited and is a dynamic process with each practitioner moving through the phases at different times and speeds. This has implications for both practitioners and educators when supporting role transition.

Crafter and Maunder (2012) agree, suggesting that the transition process is a period of individual adjustment and an important element in shaping professional identity. They go further, suggesting that each period of readjustment depends not only on the practitioner (and their previous experience and background) but the acceptance and support of the healthcare team within which they work and organisational readiness for such roles in the workforce. In relation to this study, some participants were unsure of their alignment and whether they still felt like 'a nurse'. It would appear from the work of Bridges that some of the ENPs in this study were going through different phases of transition, as some were more experienced than others. It is worth noting here that the acceptance and support of others within the healthcare team also impacts on the transition. Participants in this study, and previous studies (Lloyd-Reece 2016) described some experiences of conflict from other nurses, uncertainty around teamwork and the perception that senior managers did not understand and support the role, all of which might impact on successful role transition. Previous experience and education preparation is also a key factor in determining successful transition and the development of identity.

Role Socialization

Professional socialization is the process whereby individuals acquire and integrate into their lives the expected knowledge, behaviours, skills and attitudes, values, roles, and norms deemed appropriate and acceptable to their chosen profession (Pilhammar-Andersson, 1999). Professional identity arguably develops through a process of socialization, and within health professions this most commonly this takes place during (or before) an educational

programme (Wilson and Startup, 1991). If we relate the 'transition' of ENPs to the process of socialization, ENPs are adapting their 'attitudes', 'values' and 'norms' (Oermann, 1999) as they move into their new roles and re-evaluate their position. It is arguable that the description that participants offered in this study around feelings of *'guilt'*, *'being separate'*, and feelings of *'uncertainty'* are characteristics of a socialization process (or transitional process), whereby practitioners are evolving into a new role with a different identity. However, it is worth remembering, that both the notion of socialization and transformation assumes that the role the ENP is moving into has an established and well-defined identity, with the practitioner 'knowing' when they have reached it.

The ENP role has evolved in an *ad hoc* manner over thirty years, without any formal educational requirements, and with a range of titles and varied role definitions (Anderson *et al*., 2020). It seems that for many practitioners working under the umbrella term of 'advanced practice' the lack of role clarity and uncertainty of definition has stopped them successfully transitioning into the third phase. This, in turn, has impacted on their professional identity and understanding of what they are, and left them situated in the second phase feeling isolated, uncertain or 'in limbo' (Bridges, 2003).

The 'third space'

Given these concerns, an alternative and arguably more relevant approach to the transitional model described above is offered here; that of the 'third space'. The 'third space' or 'in-between space' describes a phenomenon occurring when two different cultural systems come into contact, and those operating within this space often combine elements of both to create something unique (Jacobs and Brandt, 2012). Our participants articulated feeling that they draw on elements of both nursing and medicine to perform the role. One participant suggested, when showing a picture of a steep bridge, that it represents the *'meeting of minds, between the medical and nursing sides of me' ENP2*

> *It has evolved for me* (shows picture of a bridge). *This represents the meeting of minds if you like between the nursing and medical side of me. In order for me to do and be the practitioner I have had to merge the nurse and the medical side. ENP 2*

This resonates with the work of Bhabha (1994), who suggested that identity within the third space is not an affirmation of a pre-given identity. Similarly, Chulach and Gagnon (2015, p55) assert that '*identity for ENPs is actively constructed within a dominant discourse on knowledge, expertise, autonomy and healthcare'*, which aligns with the perceptions of our participants as they continue to use their nursing knowledge and their newly acquired medical knowledge to formulate *'a different knowledge'.*

Participants here explained a sense of feeling different and with *'a different head to other nurses'* ENP4. This echoes the description of the third space which has been described as *'a 'boundary zone' where two cultures meet, hybrid identities take shape and new discourses are created'* (Verbaan and Cox, 2014 p2). Our participants also described areas of conflict and tension between themselves and other nurses.

As one noted, junior nurses do not treat them in the same way as they do doctors:

> *You don't get treated in the same way as they (the shop floor/cubicle nurses) treat the doctors, which irritates me. It shouldn't be about 'he is a doctor', or 'she is an ENP', it's about the role you are fulfilling. You do get some that are quite reluctant. I do utilise them for bloods and things, it's not always easy. ENP 2*

Similarly, participants highlighted a reluctance amongst some junior nurses to carry out tasks given to them by ENPs. This tension is frequently reported in the literature (e.g., Lloyd-Rees, 2016), and often attributed to a change in role boundary and misunderstanding of roles, as exampled by this participant:

> *I don't think I truly understood the role until I started doing it so why would they understand. It's like when you were studying to be a nurse you thought you knew what you were going into and then when you qualify it's like 'oh my god!' ENP 4*

However, the notion of the third space goes further, suggesting that as traditional values and practices are scrutinised by others, resulting in cultural clashes (between nurses and doctors and between nurses and ENPs), there is constant renegotiation as boundaries change and redefined identities and cultures emerge with new values, philosophies, and practices

(Chulach and Gagnon, 2015). Further to this, Rashotte (2010) argues that during this period of redefining identity, ENPs often encounter challenges from others related to their constructed identity through their decision making, clinical expertise and an undermining of their years of experience. This further accounts for the conflicts described in this study (and the literature), and was clearly articulated by one respondent:

> *If you don't give them the answers they want, they (junior nurses) will go and ask a doctor, they go up the hierarchy. They put them in a higher esteem. I think they might understand the role, but the role is not valued as highly as it should be. ENP 4*

Bhabha (1994) suggests that this failure to recognise expertise and experience, coupled with a lack of recognition for the health outcomes that ENPs can provide, may result in a projected distorted identity for the ENP. Practitioners operating within this space need the skills to strategize and navigate through this turbulent discourse, and as the participants in this study alluded to this can be challenging, leading to feelings of guilt and uncertainty.

Conclusion

Revisiting the study several years later has been a valuable experience and given insight into how to support practitioners moving into new and often complex roles and situations. The assumption that taking on a new (advanced) role with greater autonomy is a simple linear process needs rethinking as practitioners in this study (and others) found the transition difficult, often involving conflict with other colleagues and uncertainty with new (or different) professional identities emerging. Bringing the work of Bhabha (1994) and the concept of the third or hybrid space into the discussion supports this notion and understanding this from the emic perspective of the practitioner could enable educationalists and employers to better support the transition,

Reflecting on the research process has given SM insight into her position as a novice researcher. Having insider knowledge was inevitable given the subject matter and whilst acknowledging potential challenges it was certainly a positive position as it allowed her to get close to the subject matter without having to translate language, acronyms and colloquialism during the focus groups. In addition, working with the community of practitioners she knew

enabled her to navigate the group dynamics, alongside the practical aspects of getting to the venue and ensuring a safe space which was easier than if the participants were unknown. This is certainly something we would encourage other novice researchers to consider when selecting their participants and method of data collection.

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