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Research article

The enemy within: Power and politics in the transition to nurse practitioner

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ABSTRACT

Background: The period of transition from registered nurse to nurse practitioner is often challenging. While adjusting to their autonomous role, nurse practitioners need to create and define a distinct role for themselves within practice contexts that may be unfamiliar, sometimes unwelcoming and inhospitable. During this time of transition, nurses need well developed negotiation skills and personal attributes including resilience, tenacity, fortitude and determination.

Purpose of the research: The purpose of the research reported in this paper was to explore the transition experiences of 10 newly endorsed nurse practitioners in Australia during their first year of practice. This paper focuses on power, control and political manoeuvring that negatively impacted the 'nurse practitioners' transition. A qualitative approach using a modified version of Carspecken's five stage critical ethnography, informed by focused ethnography, was the methodology selected for this study. Methods included observations of practice, journaling, face to face and phone interviews which were recorded, transcribed and analysed thematically.

Results: "The enemy within" emerged as a dominant theme highlighting issues of power, powerlessness and politics dominating the participant's experiences. Power struggles amongst nurses, both overt and covert, and the deliberate misuse of power were frequently encountered. Many of the participants felt powerless and ill-prepared to negotiate the challenging situations in which they found themselves. Many lacked the skills needed to address the negative behaviours they experienced.

Conclusions: This paper reports on the experiences of 10 newly endorsed nurse practitioners during their transition to the nurse practitioner role. The impact of the political climate at the time of this study had an undeniable influence on many of the participants' transition experiences. Competition for the limited numbers of designated nurse practitioner positions led to hostility between senior nurses and, in some contexts, a jostling for power, control, prestige and position. Rather than camaraderie, cooperation and collaboration, many of the participants described feeling besieged, undermined and alienated. The new nurse practitioners felt isolated, unwelcomed and unsupported. Several felt burnt out and abandoned their aspirations to be become a nurse practitioner. They left and returned to practice as a registered nurse.

Introduction

Whilst Nurse Practitioners (NP) were established in the United States fifty years ago, the first NPs were authorised in Australia in 2000 (Berg & Roberts, 2012). NPs practice in most developed countries making valuable and essential contributions to health care using a holistic model of care, as distinct from the curative model of medical practice (Brykcznski, 1999; Elsom, Happell, & Manias, 2009; Gould & Wasylkiw, 2007).

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In Australia, as in other countries in the world, NPs are highly educated, advanced practice nurses who function autonomously to provide high quality healthcare to people living in metropolitan, rural and remote communities. The Nursing and Midwifery Board of Australia, [NMBA] defines an NP as '*a registered nurse who is educated and endorsed to function autonomously and collaboratively in an advanced and extended clinical role* (2016, p. 1)' To be eligible to apply for endorsement, nurses must have successfully completed studies in an NMBA accredited Master of Nursing (Nurse Practitioner) program, one year full time, or equivalent, and provide evidence of three years of advanced nursing experience, or equivalent within the previous six years. NPs must demonstrate highly developed knowledge, attitudes and advanced skills in their nominated specialisation to become endorsed by the NMBA (2016). Currently, there are 1214 endorsed NPs in Australia (O'Connell, 2015), which, compared internationally, reflects slow growth. The obstacles and challenges experienced by NPs as they transition to their new role (Lowe & Plummer, 2013; MacLellan, Higgins, & Levett-Jones, 2015a) may account for some of this.

Background

Australian researchers have recognised for some time that there are many dubious political, cultural and economic imperatives that prevent NPs achieving their full potential (Gardner, Gardner, Middleton, & Della, 2009; Turner, Keyzer, & Rudge, 2007). Educationally, clinically and professionally, the NP's transition pathway is long, difficult and challenging (Hill & Sawatzky, 2011; MacLellan, Levett-Jones, & Higgins, 2015; Pop, 2011; Spinks, 2009) requiring much planning, patience, tenacity and resilience to achieve.

Brown and Olshansky (1997) explored the experiences of new NPs following their introduction to the health workforce. Their theoretical model, *From Limbo to Legitimacy,* captures the transition of new NPs highlighting the complexities of transition (Brown & Olshansky, 1997). Whilst there was opposition to the NP role initially from allied health disciplines (Gould & Wasylkiw, 2007; Kelly & Mathews, 2001) it was the opposition and resistance from medical practitioners and, surprisingly, nurses, that was most confronting; with some NPs feeling betrayed by their nursing colleagues (Brown & Draye, 2003; Lloyd Jones, 2005). Whilst concerns about the blurring of boundaries between nurses and doctors have been noted, Brykcznski (1999) argues that the impact of NPs on safe and cost effective care to the community should be acknowledged. Unfortunately, despite the passing of time, the proliferation of NPs and the evidence of their positive impact on health care, some NPs continue to struggle for acceptance (Szanton, Mihaly, Alhusen, & Becker, 2010; Yeager, 2010).

Despite a body of research about NPs (Gardner et al., 2010; Gardner, Gardner, & O'Connell, 2013; Middleton, Gardner, Gardner, & Della, 2011), there is little known about the experiences, issues and concerns of Australian NPs transitioning to the role (MacLellan, Higgins, & Levett-Jones, 2015b). While there are a growing number of research studies addressing the effectiveness of NPs, their scope of practice (Carryer, Gardner, Dunn, & Gardner, 2007b; Gardner & Gardner, 2005), competencies and standards (Gardner, Hase, Gardner, Dunn, & Carryer, 2008), clinical guidelines (Carryer, Gardner, Dunn, & Gardner, 2007a) and other clinical issues relating to the role (Middleton et al., 2010), these studies fail to take into account factors that influence transition, retention and attrition of new NPs. For many NPs, the transition period is stressful and chaotic, dominated by uncertainty, fear of making mistakes, unpreparedness (Hart & Macnee, 2007) and adjusting to the expectations of colleagues (Lloyd Jones, 2005).

Transition defined

For the purpose of this study transition was defined as '*that confusing nowhere of in-betweenness… the way we come to terms with change*' (Bridges, 2001, p. 3). It represents movement, confusion, stages and a journey from a place of comfort and familiarity towards a place of new and unknown territory (MacLellan et al., 2015a). A universal attribute of transition is the notion of temporality with adjustments to roles, relationships and contexts.

Methods

The aim of this study was to explore the transition experiences of 10 newly endorsed nurse practitioners in Australia during their first year of practice.

Methodology and study design

A qualitative research design was used in this study. The methodology was a modified version of Carspecken's (1996) five stage critical ethnography and focused ethnography (Wall, 2015). Face to face interviews with new NPs were conducted. Interviews were recorded verbatim, transcribed by a confidential transcriptionist and analysed thematically.

Critical ethnography

Critical ethnography (CE) is used to explore injustices brought about through power imbalances in order to bring about emancipation (Hazelton & Rossiter, 2006). CE is overtly political; it seeks to expose hidden agendas, challenge oppressive assumptions, describe power relations, and critique the "*taken for granted*", (O'Reilly, 2009, p. 51). CE attempts to understand "what is" and "why" and "how" a situation has been structured by ideologies (Savage, 2006). Researchers who engage in CE seek to bring about a critical discourse by encouraging participants to express their concerns within a safe environment (Allen, Chapman, Francis, & O'Connor, 2008).

Critical ethnographers encourage honest communication and critical reflection during interviews to help uncover what is going on in a culture or subculture (Allen et al., 2008). They accept and value each participant's subjective experiences, ideas, intentions and emotions and they recognise the importance of interpreting findings within the study context (Brewer, 2005, p. 11; Wiersma & Jurs, 2005, pp. 202, 242, 244).

Focused ethnography

Focused ethnography (FE) is a variant of CE that explores cultures and sub-cultures within a discrete community or context, and where both participants and researchers have specific knowledge about an identified problem (Higginbottom, Pillay, & Boadu, 2013). It is a rigorous approach to studying a sub-culture when there is a defined research question, the researcher is familiar with the setting, and the opportunities for observation, a characteristic of ethnography, are limited (Wall, 2015). FE is characterised by limited field visits rather than an extensive period of observation. The researcher conducts multiple semi-structured in-depth interviews with participants over time (Higginbottom, 2011; Knoblauch, 2005) in order to enable thick description of the phenomenon of interest.

Ethical considerations

Ethical approval for the study was obtained from the university ethics committee; all participants provided informed consent.

Recruitment

An advertisement was placed on the Australian College of Nurse Practitioners [ACNP] website and NPs who were in their first year of practice were invited to contact the researcher. Purposeful sampling was used to ensure diversity in gender, age, clinical specialty and location of practice (Belgrave, Zablotsky, & Guadagno, 2002). Eight females and two males, from four Australian states, metropolitan, rural and remote regions, and a range of specialties, consented. Specialties included; primary and community health, chronic and complex care, emergency and aged care, rehabilitation, surgical and trauma /retrieval nursing.

Data collection and analysis

Data collection and analysis was informed by a modified four stage version of Carspecken's (1996) method and included:

Stage 1 – Building a Primary Perspective: Short periods of observation of NPs during practice were conducted in 2010–11 (Carspecken, 1996, pp. 44–53). The researcher observed and recorded field notes that captured the context of practice and interactions with members of the healthcare team. Consistent with FE, the period of observation was limited in duration and supported with in-depth interviews in the participants' setting. Phone interviews were conducted with the three participants located in remote locations. The face-to-face and phone interviews were audio-recorded and transcribed. Pseudonyms were used to maintain confidentiality and features that had the potential to identify individuals were deleted or de-identified.

During the interview the NPs experiences of their first 12 months were explored. They were invited to describe the strategies they used to negotiate their position and to critically reflect upon their experiences. Data collection included conversation with notations of body language; hesitations, silences, facial expressions and gestures (Kay, Evans, & Glass, 2015).

Stage 2 – Preliminary Reconstructive Analysis: This stage involved analysis of the first data set to reconstruct preliminary meanings (Carspecken, 1996, pp. 93–120). The researcher explored the participant's experiences, their beliefs, assumptions and values, as well as the power relationship and political forces that were shaping their experiences. At the same time, the researcher reflected on and recorded emergent ideas in a journal as an additional source of data and to ensure transparency and rigour (Holloway & Biley, 2011). Reflection is a method which is frequently adopted in critical research to ensure that the researcher's personal and professional values, beliefs and previous experiences do not influence analysis and findings (Jack, 2008; Mantzoukas, 2005; Rose & Glass, 2010).

The researcher (first author) has Master of Nursing (Nurse Practitioner) degree and was Principal Advisor to the Chief Nursing and Midwifery Officer (NSW) for the introduction of NPs more than a decade ago. She also convened an accredited Master of Nursing (Nurse Practitioner) program for seven years. These experiences meant that the researcher was not an 'outside observer' but someone who approached the study with prior knowledge about transition experiences. A reflective journal was therefore maintained to identify assumptions that might influence data analysis.

Stage 3 – Dialogical Data Generation: During this stage there was a degree of familiarity between researcher and participant. The discourse however, was led by the participants; they were encouraged to speak openly, and at length, about their experiences (Carspecken, 1996, pp. 154–164). The 10 participants were interviewed three to four times each over a period of nine to twelve months. Data collection ceased after 32 interviews of 50–60 min duration. Data saturation was achieved during this stage (Cleary, Horsfall, & Hayter, 2014).

The longitudinal design adopted for this study allowed early interpretations of the data to be verified with participants in later interviews (Whiffin, Bailey, Ellis-Hill, & Jarrett, 2014). It also captured shifts in attitudes, beliefs and perceptions and the process of change during the transition period (Flick, von Kardoff, & Steinke, 2008, p. 148).

Stage 4 – Conducting Systems Analysis: In this final stage, data from the 32 interviews were analysed by comparing and contrasting the participant's experiences to identify issues relating to power and politics at the individual and systems level (Carspecken, 1996, pp. 195–202). Deep immersion (Kay et al., 2015) was ensured with the transcripts, field notes and journal reflections being read, reread compared and contrasted for similarities, differences, patterns and themes. Once familiar with the data, significant elements were coded and categorised and clustered into themes (Burns & Grove, 2005, pp. 547–548). The final stage of this analytical process was to synthesise the information and verify the conclusions.

Consistent with critical ethnography and critical theory, understandings about power and politics were drawn from the writings of Foucault (1972, 1973, 1977) who has written extensively on the relationships between power, politics and knowledge. He argues that the relationships between three forms of our 'disciplinary' knowledge; technical, practical, and emancipatory (or knowledge relating to domination and power) (Habermas, as cited in Street, 1992)); overlap, support and mutually use each other. Of importance to this study is that "domination is found in each of these interrelated interests…[and that] these systems of relationships give different emphasis to power" (Street, 1992, p. 100). Discourses based on local knowledges are fragmented and discontinuous lending them to the risk of 'cooption'. Foucault argues (as cited in Street, 1992, p. 101) that power and knowledge are inseparable and interrelated; they imply one another; one cannot exist without the other. Power produces different forms of knowledge and people exercise power through knowledge. The exercise of power, through knowledge, is intentional, it is exercised by everyone at every level of society; it is not the just the remit of Government or States. Power therefore, can be productive as well as repressive and the "discipline" (as in institutional/hospital/health knowledge) is one way that power can be exercised and where the behaviour of individuals in society are regulated.

In this paper the main theme: the enemy within is described to highlight power, powerlessness and politics within nursing. Other findings are reported separately (MacLellan et al., 2015a, 2015b; MacLellan, Levett-Jones, & Higgins, 2015).

Findings

The transition experiences described by the 10 NPs were, in many respects, dominated by issues associated with power, powerlessness and politics. In a previous paper (MacLellan et al., 2015a), the power dynamic between NPs and their medical colleagues were discussed in detail. Somewhat surprisingly, and in contrast to a number of previous studies (Harvey, 2011; Turner et al., 2007), in that paper the NPs described many examples of collaborative, positive and productive working relationships between themselves and their medical colleagues. However, in the current paper, where the relationships between members of the nursing profession are explored, the "enemy within" is revealed.

According to the Oxford English Dictionary (2016) an enemy is defined as "a person who is actively opposed or hostile to someone or something".

In this study, there were many descriptions of overt and covert expressions of hostility and opposition, of supportive relationships and friendships lost and of adversaries instead of allies. The participants described nurses who were once colleagues who became formidable opponents; they described acts of horizontal violence such as passive aggressive, dismissive behaviours, obstruction and inertia which were evident at all levels of the organisation. While some balance is provided in the few positive examples of camaraderie between the NPs and other nurses, many NPs experienced the contrary.

Power and powerlessness

Power struggles, both overt and covert, were evident between nurses and the newly practising NPs, and between experienced and transitioning NPs. Indeed, the deliberate misuse of power was widespread.

For a number of the participants, their apparent lack of power stemmed from their perceived place within the hierarchy of the healthcare team, with many feeling they were accountable to and controlled by more senior and respected members of the team who exerted positional power:

> *Each individual group, pathology, radiology, emergency physicians; certainly pharmacy, still want to have a reasonable amount of say in what they think we can and can't do. It's just that unfortunately nurses are still at the bottom of that hierarchy system. Medical dominance is alive and well.* (Grace)

However, while recognising her subjugation and the hierarchical structures that dominated the organisation, Grace was nevertheless determined to assert herself and advocate for her role within the healthcare team:

> *You under-value where you are [as a NP]… you're actually a little bit lower. I don't know whether that's just a doctor-nurse thing that you've always been told that you're a little bit lower. Sometimes I get a bit frustrated with it, but I don't ever let it get the better of me, because I haven't worked this hard to improve myself, to have somebody else put me down.* (Grace)

For some participants, the knowledge held by others on the health care team was seen as a source of power; and their unwillingness to share knowledge was a misuse of power. Some of the participants who had naïvely expected other more senior NPs to be their allies and mentors to them in their new roles, observed how they deliberately withheld their knowledge, information and insights in a covert misuse of personal power:

> *Nurse practitioners are not getting off the ground because the other nurse practitioners rarely share their knowledge. Most are very secretive, protecting their own business, not wanting to share, not being open to communicate issues and helping each other through. The other nurse practitioners deliberately held information behind knowing that it could have helped me.* (Jill)

The following words capture the poignancy of this experience:

> *One of my colleagues said to me that the place wasn't big enough for two nurse practitioners and now I don't get told any information.* (Alison)

Some of the participants provided evocative accounts of how they had been deliberately oppressed, and their position undermined and sabotaged. While the motivation for these behaviours was not clear from the data, professional jealousy sometimes seemed evident:

> *I've been so oppressed … by boundaries. Some are necessary, some are not. Some are boundaries caused by oppressive people who try and sabotage your efforts to get where you want to be.* (Sue)

Some of the participants described the impact of context and how familiarity with the NP role influenced the degree of support or opposition they received from other nurses:

> *My colleagues here, they all are extremely supportive; they're a beautiful group of people. They see how I work day in and day out and there no reason for them to feel threatened and I'm very much a part of the team. But when I go to visiting sites where they don't know me personally, that when I get a lot of angst and lots of derogatory comments.* (Jessica)

Closely linked to the misuse of power were examples described by the participants where their ability to perform their role to the fullest capacity within their scope of practice was deliberately curtailed. Admittedly this may have been linked to the organisational needs at the time, but from the NP's perspective they often felt demeaned and undervalued:

> *When you look at nurse practitioners elsewhere and see what they're doing and they're intubating patients and they're putting in central lines and they're doing extra stuff, then we look at what we're doing and think I'm just putting a bandage on an ankle … it's demeaning. They're using me to get rid of the low-acuity patients but not allowing me to use my skills and knowledge and expertise.* (Grace)

For some of the participants the misuse of power seemed to stem from professional jealousy and the ubiquitous 'tall poppy syndrome':

> *I noticed there was a little bit of professional jealousy … just from some people . the snide remarks like, "I suppose you're going to tell us we're doing wrong" , that sort of stuff. You do get people that just don't understand what you're doing, or how you're doing it, or why you're doing it.* (Clare)
>
> *The clinical nurse consultant had dropped out of doing her nurse practitioner [study program]. So there's actually a lot of professional jealousy there and she is actually trying to undermine my practice, checking up, nasty comments, all these things I experience with her.* (Jill)

One of the challenges for the NPs in this particular study was that they were transitioning at a time of turmoil, with changing endorsement requirements and the move from state to national nursing registration. Many of the NPs were caught up in these political machinations and it became apparent that within these power struggles the NPs felt completely powerless to exert any influence over their employment status:

> *We finished our [NP] masters and then with the move to national registration all the goal posts changed. We had such trauma in submitting all our stuff and meeting the requirements. Then we met those requirements and we were endorsed to practice as NPs. But here we are eight months down the track and we still haven't had our positions validated. So we ended up going to the union saying, "Here we are, we've submitted. HR have given us approval". They said "you've got this letter and you should just automatically be approved". The health ministers were saying, "we've given the public service money so you can have these positions created … what's happening". Who knows … I mean, if you could find the cause of the problem you would do everything you could to sort it out.* (Clare)

During this time, government funding that had been promised for the employment of NPs, and which led to many of the

participants enroling in an NP master's program, was often not forthcoming, resulting in resentment, confusion and inertia at all levels of the organisation and nursing profession. Within these shifting and complex times the participants often felt disempowered and demoralised, with some resigning and a number deciding not to continue with the battle to become a NP:

> *At the end of the day there was no money there for this role to proceed. So we [the NPs] did all this work and then no job. But at that same time they put on a new Nurse Unit Manager (NUM). It was gut wrenching. I'd been there probably eight, nine years, I grew my career there … then it all fell apart.* (Michael)
>
> *They tap these nurses on the shoulder and say, "Go off and do your nurse practitioner program" and you can't help but wonder if they have thought it through? They can fluff you up and support your ego, but then they don't support you at the end of it [NP program].* (Clare)

In contrast to some of the negative experiences previously described, some of the participants persevered and were determined to succeed, despite the barriers to endorsement and employment, because of the support they received from other transitioning NPs:

> *I'm lucky that I've got a group of very dynamic people that are trailblazers and we get a lot of support from each other but … they really are no further advanced, even though there have been meetings with the union, the Minister of Health, our Nursing Director and General Manager, and they still haven't been approved or told what they're doing.* (Clare)

Politics

While the participants in this study often recognised the political manoeuvring that was occurring, they also felt ill prepared to step into the political foray. Indeed, a number chose to be 'apolitical', failing to recognise that politics is an inherent component of the role of a nursing leader:

> *I've never been good at the politics. I'm not into politics. It takes too much time . makes me tired. I can't stand the games.* (Emilie)

Some of the NPs in this study believed that being politically astute meant taking on a non-assertive approach and seeking not to 'rock the boat':

> *Management support is pretty good, so long as I tow the party line and don't create any waves. You just have to tread lightly and if you're prepared to be patient and not push the issue too far … it's because of the politics and the way that we work at the moment.* (Grace)
>
> *It's the politics. It's not about your knowledge. It's just getting through the whole bloody process and saying the right things.* (Jill)

One of the participants, who eventually resigned from her NP role due to burnout, recognised the relationship between the financial imperatives and political drivers, particularly for those working in rural areas. However, she felt powerless to negotiate with a largely hostile environment and with key decision-makers, either for the well-being of her patients or herself:

> *The health service wants "bang for their buck" and they don't have the money to put an NP at two sites, but it's very much needed. Currently [for me] it's a 500 kilometre round trip in one day. But I'm not able to negotiate . it's kind of overwhelming, like where do I start? There are so many people to see. I'm just kind of like ahh … I have to step back. I'm burnt out.* (Jessica)

One of the recurring frustrations expressed by the participants was that seemingly ill-informed decisions were being made by 'people in power' who had a significant impact on the role of NPs:

> *There's a lot of politics as well. Lots of management have few credentials behind their name. They're put into management positions managing other people who are very highly skilled and of course the highly skilled people are leaving.* (Jill)

Discussion

The findings from this study should be interpreted in light of the changing political landscape in Australia. At the time of the study, Australian state based registration authorities for health care professionals were moved to a single national system. With the changeover, there were many delays and much confusion for NPs seeking endorsement. In many respects, these NPs were powerless over the course of events during this period. At the same time, with changing governments in Australia, the much anticipated funding for existing and new NP positions was not forthcoming. As a financial commitment from organisations is crucial to the successful implementation of the NP role, government budget cuts to health caused health managers to reconsider supporting NP services (Raftery, 2013). The lack of funding resulted in 'turf wars' and a culture of competitiveness amongst nurses rather than cooperation, camaraderie and collaboration. Against this backdrop of political unrest and funding cuts, when allies and allegiances were most needed, many of the NPs encountered resistance from and undermining by the enemies within.

The findings from this paper demonstrate how many of the newly transitioning NPs felt disempowered, powerless and ill-prepared to negotiate the challenging political situations in which they found themselves.

In the case of this study, there were many exemplars which showed how health professionals; senior nursing leaders, other NPs, and allied health staff exercised their power by withholding or not sharing information or knowledge, being secretive, sabotaging efforts, directing the forms of behaviour expected of the new NP by setting boundaries, oversighting and scrutinising what they were doing, putting people down with words that demeaned them professionally, changing the goal posts by regulating when, where and how they might eventually be endorsed, if at all, or even what they should or should not say. Politics in this study, playing political games, treading warily or lightly around people were euphemisms for disciplinary power.

It seems apparent that for many of the NPs their educational preparation for their advanced practice role had paid insufficient attention to topics such as leadership, negotiation skills, and changing political climates. It is also apparent that the clinical contexts where these new NPs were being employed were sometimes unclear about type and degree of support that would be needed during the transition period. There seem to be an unmet assumption that these expert clinicians would be able to 'hit the ground running' and for this reason few were provided with formal mentorship or regular opportunities for clinical supervision. Instead, many of the NPs found themselves weighed down with unrealistic workplace expectations and with minimal support. Indeed, in some of the rural and remote areas the NPs were often the only highly qualified health professionals available, yet they were left to negotiate their positions against backlash of hostility and resistance.

This paper has identified that sectors of the nursing culture have covertly and overtly resisted the implementation and successful transition of NPs to practice. However, it should be acknowledged that there are also clinical contexts within which

NPs are highly regarded and supported as valuable members of the team.

In recognition of the importance and potential impact of NPs to the health Australian community, there is a need for strategies that support and facilitate their entry to the advanced practice role, so that rather than focus on power struggles and political machinations, they can direct their energy towards the provision of high quality patient care.

Optimising NPs experiences in this way is critical, but complex. There is a need for effective collaboration between and within and health services, policy makers and with education providers to ensure clear and feasible goals. In turn this should facilitate more effective interpersonal relationships between all stakeholders and enhanced clarity around the role, creating practice and learning environments that are cognisant of and responsive to the value added benefits of the NP role. NPs who are adequately prepared for the complexity and challenges inherent in contemporary clinical practice, including excellent negotiation skills should be also mindful of the tenacity and resilience required and the influence they themselves exert over their own transition experiences. This paper has identified that the realisation of these goals is not only possible but in some environments has already been accomplished.

Limitations of the study

The sample size of this study, whilst consistent with qualitative studies, may not reflect the experiences of all new NPs. Purposeful sampling was used in order to ensure representation from around Australia, including its many states, and metropolitan, rural, remote and regional areas. Sampling also ensured representation from a range of specialty areas and diversity in participants' demographic characteristics and clinical backgrounds was sought.

Conclusion

The impact of the political climate during the time of this study had an undeniable influence on many of the participants' transition experiences. Competition for the limited numbers of NP positions led to hostile nursing cultures and in some contexts a jostling for power, prestige and position. Rather than camaraderie, cooperation and collaboration many of the participants in this study described transition experiences where they felt besieged, undermined and alienated.

The findings reported in this paper illustrated the perceptions of a diverse group of NPs during their first year of transition set against a background of unfolding political events and changing economic imperatives in Australia. This study is important because it exposes a previously unexplored workforce issue that is having a serious impact on the recruitment and retention of new NPs. The transition experiences described by participants were fraught with alienation, undermining and hostility and in some contexts power struggles and political manoeuvring.

Ultimately, these issues may well impact the retention of NPs and consequently the quality of healthcare provided to marginalised clients in both metropolitan and rural communities in Australia. As such, listening to the voices of the participants in this study and attending to the needs of future NPs is imperative.

Conflict of interest

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