

Nurse practitioners leading the way: An exploratory qualitative study on the added value of nurse practitioners in outpatient care in the Netherlands

Enzio R. K. Boeijen, RN, MSc (Master's Student Nursing Science)^{1,2}, Jeroen W. B. Peters, PhD (Program Director & Researcher)³, & Anneke J. A. H. van Vught, PhD (Associate Professor)²

ABSTRACT

Background: Many Dutch nurse practitioners (NPs) work together with physicians and specialized nurses (SNs) in outpatient clinics, although the latter have questioned the added value of NPs in the outpatient clinic. Clarification of the distinction between and the added value of both nursing professions in relation to each other could lead to optimal use of the unique competencies of each type of nurse.

Purpose: To explore NPs' perspectives on their added value in relation to SNs in the outpatient clinic.

Methodological orientation: Data were analyzed by Braun and Clarke's thematic analysis. The CanMEDS competencies were used to identify the NPs' comments about their practice.

Sample: Twelve semi-structured interviews were conducted with NPs from two hospital settings.

Conclusions: The added value of NPs was most evident in: nursing leadership, integrating care and cure and performing an expert level of nursing expertise, and competencies in science. To optimize their roles, NPs and SNs need to make all team members aware of their unique competences and promote role clarification.

Implications for practice: This study provides barriers in barriers that influence optimal positioning of NPs within the interdisciplinary team, stresses the importance of discussion on the optimal skill mix within the interdisciplinary team, and describes the NPs' leadership role because this is the encompassing link between the main competencies of their practice. Addressing and overcoming these findings could improve the NPs' positioning and effective collaboration within (the outpatient clinic's) interprofessional teams.

Keywords: Interprofessional relations; leadership; nurse practitioners; nurse specialists; nurses; nursing; professional role; qualitative research.

Journal of the American Association of Nurse Practitioners 00 (2019) 1–9, © 2019 American Association of Nurse Practitioners

DOI# 10.1097/JXX.0000000000000307

Introduction

In 1998, the Dutch government decided that substitution of care within the nursing and medical workforces was needed to respond to the challenges in health care—such as the aging population, increased complexity of care, rising costs, and workforce shortages. Hence, nurse practitioners (NPs) were introduced as a substitution for

physicians, but the boundaries between NPs' and specialized nurses' (SNs) roles were not clearly defined. In practice, it is not clear who performs what and who is responsible for which tasks (Janssen, Wallenburg, & Bont, 2016). Many SNs feel that there is no clear distinction; NPs, on the contrary, are convinced that they “do different things” and that they “do things differently.”

Background

Specialized nurses are registered nurses with an associate degree and supplementary training in a specific field like neonatology or cardiology (European Qualifications Framework [EQF] levels 4–6). Nurse practitioners are registered nurses, who completed a 2-year master program (EQF level 7). This program focuses on the acquisition of advanced skills and knowledge, resulting in a specialization on a subarea and/or for a particular patient group (Tracy & O'Grady, 2019). A bachelor degree is required for entrance in

¹Clinical Health Sciences, Utrecht University, Utrecht, The Netherlands

²Faculty of Health and Social Studies, HAN University of Applied Sciences, Kapittelweg 33, Nijmegen 6503 GL, The Netherlands. Tel: +3124 351 10 80; E-mail: enzio.boeijen@han.nl

³Master Advanced Nursing Practice, HAN University of Applied Sciences, Nijmegen, The Netherlands

Received: 3 April 2019; **revised:** 9 July 2019; **accepted:** 11 July 2019

the program (EQF 6). The competencies that both NPs and SNs need to acquire are defined in accordance with the CanMEDS-system (Kappert & Hoop, 2019; Lambregts, Grotendorst, & Merwijk, 2015). Nurse practitioners function autonomously from physicians, at the intersection of care and cure, in contrast to SNs who predominantly practice care tasks. The NP profession is of greater complexity, that is, in clinical reasoning and clinical decision-making, and they have a greater degree of leadership in organizations and care environments (Janssen & Wallenburg, 2015; Kappert & Hoop, 2019; Tracy & O'Grady, 2019).

In this article, we purposely use the term "task sharing" instead of task substitution because it is a better representation of the interdisciplinary practice of physicians and NPs in the Netherlands. Task sharing is neither hierarchical nor confining and allows practices to expand or contract based on local health care needs (Institute of Medicine, 2011).

Numerous developments in entitlements and policy have strengthened the position of NPs in the Netherlands. In 2018, NPs obtained the legal right to independently select and carry out preserved medical procedures that used to be the domain of physicians, such as minor invasive procedures and prescription of medication (De Bruijn-Geraets et al., 2018). Initial evidence shows that Dutch NPs maintain and improve the quality and the organization of health care while retaining cost-effective care without increasing the demand for physicians (Kouwen & Brink, 2014; Laurant et al., 2009).

As the boundaries between NPs' and SNs' roles in the Netherlands are not clearly defined, an innovation dialogue with the involved health care professionals could help to overcome the lack of distinction between these professionals (Grol, Wensing, Eccles, & Daves, 2013; Janssen & Wallenburg, 2015) and aid clarification of the added value of the NPs' practices.

The study

Aims

To explore the views and perspectives of NPs on their added value in relation to SNs in the outpatient clinic, and to acquire a clear distinction within the nursing discipline in the outpatient clinic to increase job satisfaction.

Research question

What are the perspectives of NPs on their added value in relation to SNs practicing in the outpatient clinic in the Netherlands, based on the CanMEDS competences?

Design

A generic exploratory qualitative design was used because no previous research concerning this topic has been performed in the Netherlands. Generic explorative descriptions let interpretation emerge from the respondents' perspectives instead of established assumptions or methodology, whereby a complex and

detailed understanding of the phenomenon is obtained and linkages within it are explained (Caelli, Ray, & Mill, 2003; Creswell, 2013; Holloway & Wheeler, 2010).

Sample

A purposive sample (Polit & Beck, 2012) of NPs was recruited from two hospitals in two urban areas in the central Netherlands: one university hospital and one clinical teaching hospital. The composition of the sample reflected a variety of medical specialties, ages, and degree of work experience as SN and NP. To ensure that participants could distinguish the crucial factors in the NPs' and SNs' practices, three eligibility criteria for NPs were used:

- (1) ≥ 2 years of postgraduate working experience as a NP;
- (2) ≥ 2 years of working experience as a SN; and
- (3) Nurse practitioner specialization is equal to their specialization as a SN.

Candidate participants were proposed by experts in the field, and others were identified using the snowballing method. They were sent an email including an introductory letter and invitation to participate. Those who agreed to participate were contacted by telephone to ensure they met all inclusion criteria and to plan an interview.

Data collection

Data were collected through individual face-to-face interviews in which the interviewer used a peer-reviewed, semi-structured interview guide. The initial interview guide topics were based on the authors' experiences and the nursing CanMEDS model as described by Kappert & Hoop (2019) and Lambregts et al. (2015). Pilot testing with one NP did not necessitate changes in the interview guide topics. Still, the research team continuously adapted the interview guide in response to the emerging data (Braun & Clarke, 2006). Interviews were conducted at the respondents' work environments from March to June 2017. The interviews lasted approximately 50 min and were audio-recorded. The interviewer (E.R.K.B.) asked open questions, encouraging respondents to openly convey their perspectives and experiences. Respondents were asked to reflect on their professional development from SN to NP and to compare the roles and practices of NPs and SNs. Important perspectives and data analysis ideas were documented in field notes written directly after an interview. The field notes informed the data analysis parallel to the interview transcripts (Braun & Clarke, 2006; Creswell, 2013).

Ethical considerations

The institutional review board confirmed that the Medical Research Involving Human Subjects Act did not apply (file number ACPO 49.11/16). Written informed consent from the respondents was obtained before interviewing. None

refused to provide consent or withdrew from the study. The first author anonymized all information that might be used to identify respondents or their working practice and assigned a random respondent number.

Data analysis

To elicit the underlying meaning of respondents' perspectives, Braun and Clarke's (2006) six-phase thematic analysis was performed. Data were analyzed inductively to ensure that the data fully directed the analysis process (Braun & Clarke, 2006). Analysis started with verbatim transcription of the audio recordings (Holloway & Wheeler, 2010). The first author started the first thematic analysis step after four interviews had been held. The next eight interviews were conducted concurrently with the data analysis process, which informed further data collection with confirmative and divergent data. The first author reread all transcripts to identify meaningful fragments and generated initial codes by collating meaningful fragments. Themes were formed by analyzing the relationships between codes, collating related codes, and combining codes into potential themes. To review and define the themes, the first author (E.R.K.B.) and the second author (A.J.A.H.v.V.) reread the entire coded data set, refined the coding and themes, and described the essence of each theme. The themes were reviewed until meaning saturation was achieved (Hennink, Kaiser, & Marconi, 2010). NVivo software (version 11; QRS International) was used during the analysis process. A database of codes, themes, and quotes was collated in Microsoft Word and was revised during the final two phases of the analysis process.

Rigor

The interviewer (E.R.K.B.) had been trained in interviewing for qualitative research. Before the study, he had no professional relationship with any of the respondents. The study PI (A.J.A.H.v.V.) listened to the recordings of the first three interviews and provided recommendations to improve the interview technique, which enriched the data collection. To enhance the reliability of the findings, the field notes were reviewed and discussed by all members of the research team (Creswell, 2013). One independent researcher and A. J. A. H. van Vught coded five transcripts independently from the first author. Coding decisions were compared and reflected on until intercoder agreement was achieved (Creswell, 2013). To challenge and complement the data analysis, every phase outcome was cross-checked with A. J. A. H. van Vught and an expert in the field (J.W.B.P.) (Braun & Clarke, 2006). To ensure that we were fully guided by the data, we first completed all six data analysis phases and next related the final themes to the CanMEDS model. Because the Dutch NP and SN professional profiles are based on the CanMEDS competences (Lambregts et al., 2015), we used the CanMEDS

model to classify the NPs' comments about their practices. The COREQ checklist criteria served to ensure explicit and comprehensive reporting; these criteria have been set to promote explicit and comprehensive reporting of qualitative studies (Tong, Sainsbury, & Craig, 2007). For outcome clarification and reassessment of the study interpretations, a panel of experts reviewed the findings and interpretations.

Findings

Twelve NPs were interviewed. After the first 10 interviews, no new themes or nuances emerged. Two more interviews were conducted to ensure that meaning saturation had been reached. No repeat interviews were carried out. Ten NPs were women; the mean working experience as a NP was 8 years (range, 3–13 years); the mean working experience as a SN was 12 years (range, 2–30 years); and the specialty populations ranged widely (Table 1).

Respondents reflected on their professional development by comparing their working practice as a NP to that as a SN. They perceived that as a NP, they dispose of expanded and additional skills and attitude toward health care than as a SN and perform significantly different roles and tasks. They stressed that NPs and SNs differ in various competences and focus on different care levels. Analysis revealed three main themes linked to the added value of NPs in relation to that of SNs: (1) Nursing Leadership; (2) Clinical Expertise; and (3) Science.

Theme 1: Nursing leadership

Besides their responsibilities in the direct clinical care, respondents were of the opinion that they operate on a strategic level by directing and coordinating the integrated care for their specialty population. In comparison, SNs conduct only direct patient care within the outpatient clinic.

"Most tasks [...] are performed by SNs. I assist them and educate them on this subject, but do not perform those tasks myself anymore. I do point out, however, when errors are made or changes need to be implemented. So, it's more the coordinating aspect that I'm focused on, rather than the content." (R08—site 1)

Additionally, the respondents exert greater influence in organizational decisions as a NP than as a SN. They believed that this could be ascribed to expert knowledge and experience regarding the own specialty population and knowledge of organizational structure and culture. They also perform these activities on a larger scale than they did as a SN, on a regional, national, or international level. Herein, they are a better advocate for the patient and the nursing profession than they were as a SN. Respondents described themselves as the leaders of the nursing discipline, for example, by setting up and developing a complete care chain for their specialty populations,

Table 1. Baseline characteristics of the study population (N = 12)

ID	Sex	Age	Experience as NP (years)	Experience as SN (years)	Hospital Setting ^a	Registered Specialty ^b	Specialty Population (Specialization)
R01	f	52	10	3	1	4	Chronic cardiac failure (cardiology)
R02	m	49	10	16	2	3	Breast cancer (oncology)
R03	f	65	12	15	1	3	Palliative care (palliative care)
R04	f	44	5	20	2	3	Breast cancer (surgery)
R05	f	52	12	20	1	3	Lung cancer (pulmonary oncology)
R06	f	53	4	4	1	4	Pituitary & adrenal gland (endocrinology)
R07	f	58	13	7	2	3	Cardiac failure (cardiology)
R08	f	52	8	5	1	4	COPD & asthma (pulmonology & pulmonary rehabilitation)
R09	f	43	5	14	1	3	Bone tumor (orthopedics)
R10	m	47	5	2	1	5	HIV & suicide attempter (psychiatry)
R11	f	56	5	30	1	3	Pediatric HIV & humoral immunodeficiency (immunology & infectious diseases)
R12	f	34	3	5	1	3	Pediatric acute lymphocytic leukemia (pediatric-oncology)

Note: f = female; m = male; NP = nurse practitioner; SN = specialized nurse.

^aHospital setting site identifier: site 1: university hospital; site 2: top clinical teaching hospital.

^bThe Dutch Professional Nurse Practitioner Organisation (V&VN VS) registers practicing nurse practitioners in one of five specialties: 1: Preventative care for somatic conditions; 2: Acute care for somatic conditions; 3: Intensive care for somatic conditions; 4: Chronical care for somatic conditions; 5: Mental health care.

transcending the outpatient clinic. Still, they could not invest enough time in specialty nursing tasks and strategic and leadership activities because the working practice was excessively focused on medical practice.

“Because I was the first NP in the field of immunology in the Netherlands, I felt quite responsible to start creating a network in the Netherlands [...] I do notice that you are called to account on a whole different set of skills [...] Now I have become more daring [...] Because I feel I have to do it, because I am a NP now.” (R11—site 1)

As a NP, respondents routinely attend international conferences, where they share newly acquired knowledge more often, and on a larger scale. Education is included in their NP role, on a more advanced level than in their SN role, by providing education and developing curriculums for SNs, NPs, or physicians.

“I see a big difference in terms of professionalization, in that SNs tend to stay within their organization and sometimes visit a national congress, whereas NPs often attend international congresses and have international contacts [...] NPs are the leaders and the educators [...] So there is a big difference there too, because instead of taking up something from courses and congresses, you now actually bring something to the table.” (R05—site 1)

The respondents in this study perceived the NP practice as a value-added complement to both care and cure. One respondent underlined that the added value of the NP is a dynamic phenomenon: “It’s not like you complete the education and then stand still, definitely not as a NP. At a certain point it becomes like an oil spill: at first the difference is not that big but the difference gets bigger and bigger.” (R06—site 1).

Theme 2: Clinical expertise

According to the respondents, their added value in “clinical expertise” as a NP encompasses integration of care and cure, improving continuity of care and improving interprofessional communication. Providing care and cure as an integrated entity and being an expert in nursing were the aspects they most frequently mentioned in this context. The participant quoted below refers to the value-adding competencies as eliminating for the “gray area”. Additionally, physicians sometimes ask NPs for advice regarding a specific health care domain, considering them more skilled in that domain.

“There’s a gap between the nurses and the physicians. NPs can, in addition to a variety of tasks for which they use their basic nursing skills, take on the job responsibilities of a physician, and adequately combine the two. I think that has the potential to eliminate a very large grey area that used to be here [...] These NPs can perform a rather practical role that is difficult for a physician to take on [...] And as a SN you’re simply not trained well enough for that.” (R12—site 1)

Respondents perceived that their added value over SNs and physicians lies in expert knowledge and skills in care (nursing domain), integrated with expanded knowledge in cure (medical domain), resulting in a more holistic view toward health care.

“Because that’s where I think the NP differentiates from the SN or medical domain. They [SNs/physicians] only focus on a specific part. One on care, the other on cure and these come perfectly together in the NP role. That’s when you [as a NP] get the holistic picture of a patient and I think that defines the added value.” (R05—site 1)

Respondents experienced more autonomy in their scope of practice as a NP, which they ascribed to the education received in the Master of Advanced Nursing Practice (MANP) program and to legal entitlements. They work more autonomously than they did as a SN and therefore make more decisions without consulting a physician.

“I combine the nursing and medical processes, using clinical reasoning, in which I integrate the two, where I engage in a treatment relationship with patients and see them autonomously. And in case of doubt, I can always request supervision. But I definitely did not do that type of work before I became a NP [...] The experience you have gained as a nurse, you take that development with you as a NP, in which many medical tasks [...] are added to that.” (R05—site 1)

Respondents perceived the NP role as the best suited to fulfill the coordinating practitioner role in outpatient care. They universally felt that employment of NPs instead of SNs or physicians in the coordinating practitioner role results in greater continuity of care for both patients and professionals. Respondents described that patients more often visit the same care provider when NPs fulfill the coordinating practitioner role, which contributes to more continuity in health care.

“The difference I notice as a NP is that you’re in more of a coordinating role, safeguarding the continuity of patient care. I think that as a SN you’re in more of an observing role [...] but as a NP I’m contact person for all parties involved with the patient and I’m the person who’s up to date, and directing everybody [...] in both the nursing and the medical domain.” (R12—site 1)

Additionally, respondents noted that patients do discuss certain life issues that are linked with something medical with them as a NP, which they would not have discussed with them as SN, and that patients discuss these issues more comfortably with them than with a physician.

“I think that especially for things like problems with medication, problems with sexuality, those are definitely issues which patients talk more comfortably about with me than with a surgeon. And it’s often linked with something medical like therapy adherence, changing or adjusting medication; that’s something a SN can’t do.” (R04—site 2)

Respondents perceived that functioning as a contact person for all professionals involved in the patient’s care process improves the communication and alignment between everyone. They ascribed this to their expanded knowledge in the medical and nursing domains and their advanced communicative skills. As a NP, respondents felt a better interlocutor with other health care professionals than when they were a SN—especially with physicians.

“I think it’s because the NP function slowly became known, but also because of the know-how that I have gained, because of my role development, because you’re lifted to a higher level [...] you exude that [as a NP]. It makes that you are considered a serious interlocutor and that you’re asked to join in on many occasions.” (R07—site 2)

Still, an important barrier for some NPs to having added value as a NP was the lack of understanding and support from physicians and SNs. This attitude negatively

influences practicing the value-adding role of the NP. For example, in the following case, where the physician considered the NP's care as inferior and refused to work together with her.

"Yes, on an equivalent and acceptable level for them [physicians], because that's how it works with some physicians. They do not want to consult with a 'nurse.' They won't." (R07—site 2)

Theme 3: Science

Respondents described that their added value in "Science" encompasses improvement of the quality of care, performing and participating in scientific research, and implementing research into nursing practice. Respondents perceived that as a NP they should apply their critical attitude, expanded scientific knowledge, and systematic thinking for scientific research and innovations. As a NP, they feel better educated to prioritize, initiate, and coordinate quality improvement than as a SN.

"I think that the SN could definitely do that [quality improvement projects], but taking the lead, the initiative and taking things to the next level is hard. Because they don't have the tools for it that you get when learning to be a NP [...] that transcendent thinking and seeing the bigger picture, that to me is a difference between NPs and SNs." (R09—site 1)

As an NP, the respondents initiate, design, and coordinate scientific research much more than they did as a SN. They incorporate the medical and nursing domains in these scientific research projects. Therefore, their participation promotes the inclusion of nursing-relevant outcomes in scientific research. This in turn promotes the establishment of evidence-based practice (EBP) relevant to nursing care.

"Well, we simply weren't as active in that field back then [as SN]. We did do scientific research, but it was medical research. Now [as NP] we do nursing-based research or projects to improve the nursing healthcare outcomes. We have managed to put that on the agenda, so that the cardiologists see as well that it's important." (R01—site 1)

Furthermore, as a NP, respondents more actively implement research findings into daily practice. They ascribe this to their expanded scientific knowledge and skills regarding the evaluation and assessment of professional literature. Respondents perceived that incorporation of EBP and scientific research in their working practice results in improvement of patient care. Still, the outpatient clinical practice did not always allow them to

invest enough time to underpin the nursing domain with scientific research or EBP.

"In addition to that, as a NP you're also trained in other competence areas, scientific research, so you're much more engrained with the notion of evidence-based working and thinking [...] that as a result you won't act without having a scientific substantiation for your actions. This has a positive impact on patient care [...]. Acquiring evidence-based care." (R05—site 1)

Respondents reported that they self-steer their ongoing learning process more than they did as a SN. They more consciously and actively research their working practice when they encounter a problem because they want to learn and keep up-to-date regarding their specialty population. Additionally, NPs reported that they more critically reflect on their working practices than they did as a SN. Supported by their professional organization, they obtain feedback from supervision and interdisciplinary reviewing in a structured way. Herein, NPs dare to be in a vulnerable position because they consider this an invaluable addition to their learning process, contrary to when they were SN.

"The education [MANP] ensures that you gain a vast basic knowledge and that it's easier to find your way to specific information, and that has become easier all of a sudden. You share the experience, which is a major advantage as well, you stay in contact with the NPs with whom you have done several years of interdisciplinary reviewing, and you get tips in that area as well. You enter a different network, feeding your knowledge, pulling you out of isolation." (R06—site 1)

Discussion

This study describes NPs' perspectives on their added value in outpatient care in the Netherlands. The interviewees emphasized that the added value of the NP profession in relation to the SN profession lies in the combined practice of care and cure as one entity, and an additional set of competences, such as incorporating scientific knowledge in daily practice and developing the care chain for the specialty population. Nurse practitioners work more autonomously, implement a more holistic way of practice compared with SNs, and in many outpatient clinics perform the role of coordinating practitioner. Specialized nurses perform a case manager role; however, they are not entitled to perform this role autonomously. Nurse practitioners' added value is driven by their competencies in nursing leadership and lies in patient care tasks and responsibilities, and in leading innovation of health care practices. All interviewed NPs enacted leadership and applied "Clinical Expertise" and "Science" competences to direct and coordinate other

health care professionals, initiate innovations, and implement EBP in nursing and medical practice. Moreover, the nursing leadership role was described as the all-encompassing link between the main competencies in practice.

The main finding that emerged from this study was that NPs are of added value to the nursing and medical practice in outpatient care in the Netherlands. The fact that NPs practice a different task and role confirms the differentiation between NPs and SNs as described by Tracy & O'Grady (2019) and the new Dutch NP-professional-competency-framework (Kappert & Hoop, 2019). Nurse practitioners encompass all competencies from the advanced practice nursing (APN) role and blend them into daily practice, which distinguishes them NP from both the SN and the physician. Nurse practitioners perform tasks that were previously performed by physicians only. They are not substitutes but rather autonomous professionals with added value for patient care, who closely collaborate with SNs and physicians to improve quality of care (Janssen et al., 2016; Tracy & O'Grady, 2019). Furthermore, they have been described as occupying a key leadership position of influence for clinical and professional development (Delamaire & Lafortune, 2010). They actively evolve the NP role and advance their specialty by improving patient care quality and safety and sustaining the NP role (Hurlock-Chorostecki, Forchuk, Orchard, Soeren, & Reeves, 2014). The NPs in this study led the way in adding value to and developing the clinical nursing practice by enacting APN tasks such as initiating quality improvement projects or initiating scientific research. Participants also demonstrated the benefits of their education by continuously steering their learning process as NP, actively researching problems in working practice, and critically reflecting on their provided care. This also contributed to the developments in the three main themes found in this study (Kappert & Hoop, 2019; Melnyk, Gallagher-Ford, Long, & Fineout-Overholt, 2014; Tracy & O'Grady, 2019).

We have also identified barriers for NPs to enact their advanced level of nursing to the full extent. One is the lack of time to do so. Nurse practitioners are all too often focused on medical practice instead of integrated care and cure on an advanced nursing level. The interviewees confirmed they spent much time on medical practice, which restricted the opportunities to implement their APN activities. Elliott, Begley, Shaef, and Higgins (2016) describe that a strong focus on clinical caseload limits the time available for leadership activities, including research. Nurse practitioners were introduced in the Netherlands for physician substitution (Laurant et al., 2009), but medically driven configurations are not the best use of APN skills (Kappert & Hoop, 2019; Tracy & O'Grady, 2019). Still, the combination of APN and medical practice provides part of the added value of NPs. A better

balance between the NPs' activities in nursing and medical practice is needed to fully use their value-adding competencies. The second barrier we identified was a lack of support and understanding from other professional disciplines. The lack of support severely obstructed some NPs' autonomy in patient care because the APN role requires autonomy and authority to be fully enacted (Tracy & O'Grady, 2019). Lack of support from physicians continues to be a problem for NPs and results in inefficient use of NP time and expertise (Hurlock-Chorostecki et al., 2014). To gain more support for NPs and to promote effective collaboration between NPs, SNs, and physicians, it is imperative that the roles and scope of practice of all team members are clear and well-understood (Van der Biezen, Wensing, Poghosyan, Van der Burgt, & Laurant, 2017). Nurse practitioners should start addressing the optimal skill mix because SNs and physicians need to recognize that the NPs role is embedded in the nursing discipline and is not the junior practice of medicine (Tracy & O'Grady, 2019). Hurlock-Chorostecki et al. (2014) described the support from hospital leaders, physicians, and NP peers as a key to success and underlined that those should recognize the added value of the NP role. Constraints of NPs' APN role enactment inhibits NPs to match changing patient and team needs, risking stagnation of practice and worsening care quality in the current culture of rapid change.

Health care managers and directors have a key role in enabling NPs to act as leaders and innovators. As Elliott, Begley, Shaef, and Higgins (2016) suggested, they need to act as "leadership brokers" to provide opportunities for NPs to work on a strategic level and afford NPs with positions of authority—both within and external to the organization. Nurse practitioners need these opportunities to enact their leadership activities in the medical and the nursing domains, which constitute a major part of the added value of the NP. Health care managers and NPs should foster task sharing within their interprofessional teams, for example, on coordinating the care process, functioning as first point of contact, and providing care and cure as an integrated entity (Kappert & Hoop, 2019). Participants reported that these tasks are difficult for SNs and physicians to take on because SNs lack the knowledge on the biomedical model and physicians lack time and expertise on adopting the biopsychosocial model. That is why the NP has an additional value in high-quality care (van Dusseldorp et al., 2018). Task sharing supports team members to continuously work together and match the patient populations' health care demands to their team members' expertise (Institute of Medicine, 2011), which helps team members to adopt a role in which they excel.

Further research could elucidate the roles and scopes of practice of all team members (Van der Biezen et al., 2017). Exploring team members' perspectives on the NPs

role, and the conditions to promote clarity and effective collaboration within their interprofessional team, could initiate and support better understanding of the NPs role. To further validate our findings, further ethnographic research should describe the NPs practice, whether NPs do what they say they do in practice, and how they do it.

Limitations of the study

Although the interviewees were purposefully sampled, the results from this study cannot be generalized because of the small sample size and the sampling from one geographical region in the Netherlands. Because multiple respondents reported that any SN who has become NP belongs to the top-level of SNs and therefore possesses part of the crucial APN perspectives and capabilities necessary for becoming a NP, the study findings likely underestimate the differences between the complete populations of NPs and SNs and their practices in outpatient clinics. To saturate the findings of this study or to add new elements to the theory, subsequent research should include a larger population who practice in different care settings, should include the perspectives of all health care professionals working with NPs and address professionals' needs to overcome barriers for the implementation of the added value of NPs.

Conclusions

This study provides a meaningful and novel insight into NPs' perspectives on their added value in outpatient care in the Netherlands. The added value is most evident in leadership activities and tasks on a strategic level beyond direct patient care, such as integrating care and cure, acting as nursing experts, and implementing knowledge from scientific research. Furthermore, the limited time for leadership activities as a result of medicalized practices seems to be the predominant factor that could restrict enactment of the NP's advanced role. A clear regulatory scope of practice for all nursing disciplines could optimize the utilization of NPs in the Netherlands. To further optimize their practice, NPs need to proactively make all team members aware of their unique competences, promote clarification of the roles of NPs and SNs, and prevent medicalized practice for themselves. Identification of all barriers and possible facilitators can be the catalyst for even higher quality of outpatient health care. Additional research is needed to further validate the findings in this study and should therefore address clarification of roles and scope of practice. This clarification should include the perspectives of all health care professionals in the NPs' team and address professionals' needs to overcome barriers toward implementation of the added value of NPs.

Authors' contributions: All authors met the criteria for authorship. E. R. K. Boeijen, J. W. B. Peters, and A. J. A. H. van

Vught formulated the study. E. R. K. Boeijen carried out the data collection. E. R. K. Boeijen and A. J. A. H. van Vught carried out the data analysis, and all authors contributed to writing of the manuscript. All authors contributed to interpretation of the results, drafting the manuscript, and revising the text critically for its intellectual content. E. R. K. Boeijen and A. J. A. H. van Vught had full access to all the data in the study and can take responsibility for the integrity of the data and data analysis. All those entitled to authorship are listed as authors. All authors have approved the final manuscript and agreed with publication.

Competing interests: The authors report no conflicts of interest.

References

- Boeije, H. (2010). *Analysis in qualitative research*. London, United Kingdom: SAGE Publications, Inc.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Caelli, K., Ray, L., & Mill, J. (2003). "Clear as mud." Towards a greater clarity in generic qualitative research. *Int J Qualitative Methods*, 2, 1–23.
- Creswell, J. (2008). *Qualitative inquiry & research design: Choosing among five approaches* (3th ed.). Thousand Oakes, United States: SAGE Publications, Inc.
- De Bruijn-Geraers, D. P., van Eijk-Hustings, Y. J. L., Bessems-Beks, M. C. M., Essers, B. A. B., Dirksen, C. D., & Vrijhoef, J. H. M. (2018). National mixed methods evaluation of the effects of removing legal barriers to full practice authority of Dutch nurse practitioners and physician assistants. *BMJ Open*, 8, e019962.
- Delamair, M., & Lafortune, G. (2010). *Nurses in advanced roles: A description and evaluation of experiences in 12 developed countries* (Vol. 54). Organisation for Economic Co-operation and Development (OECD).
- van Dusseldorp, L., Groot, M., Adriaansen, M., van Vught, A., Vissers, K., & Peters, J. (2018). What does the nurse practitioner mean to you? A patient-oriented qualitative study in oncological/palliative care. *J Clin Nurs*, 28, 3–4.
- Elliott, N., Begley, C., Sheaf, G., & Higgins, A. (2016). Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review. *International Journal of Nursing Studies*, 60, 24–45.
- Grol, R., Wensing, M., Eccles, M., & Daves, D. (2013). *Improving patient care: The implementation of change in health care* (2nd ed.). Oxford, United Kingdom: Wiley-Blackwell.
- Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2010). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research*, 27, 591–608.
- Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Wiley-Blackwell.
- Hurlock-Chorostecki, C., Forchuk, C., Orchard, C., van Soeren, M., & Reeves, S. (2014). Labour saver or building a cohesive interprofessional team? The role of the nurse practitioner within hospitals. *Journal of Interprofessional Care*, 28, 260–266.
- Institute of Medicine. (2011). *Preparing for the future of HIV/AIDS in Africa: A shared responsibility*. Washington, DC: The National Academies Press.
- Janssen, M., Wallenburg, I., & de Bont, A. (2016). Carving out a place for new healthcare professions—An ethnographic study into job crafting. In H. Albach, H. Meffert, A. Pinkwart, R. Reichwald, & W. von Eiff (Eds.). *Boundaryless hospital: Rethink and redefine health care management* (pp. 119–141). Berlin, Germany: Springer.
- Janssen, M., & Wallenburg, I. (2015). Reconfiguring health workforce through mundane care: How new professional roles transform institutionalized healthcare practices. *BMC Health Services Research*, 16, 637.

- Kappert, J., & de Hoop, I. (Eds). (2019). *Nurse practitioner professional competency framework*. Utrecht, the Netherlands: V&VN.
- Kouwen, A. J., & van den Brink, G. T. W. J. (2014). *Task reallocation and cost prices: Research of obstacles concerning substitution*. Report from Radboud University Medical Center to the Dutch Ministry of Health, Welfare and Sport.
- Lambregts, J., Grotendorst, A., & van Merwijk, C. (Eds). (2015). *Bachelor of nursing 2020*. Houten, the Netherlands: Bohn Stafleu van Loghum.
- Laurant, M., Harmsen, M., Wollersheim, H., Grol, R., Faber, M., & Sibbald, B. (2009). The impact of nonphysician clinicians: Do they improve the quality and cost-effectiveness of health care services? *Medical Care Research and Review*, 66(6 suppl), 36S–89S.
- Melnyk, B. M., Gallagher-Ford, L., Long, L. E., & Fineout-Overholt, E. (2014). The establishment of evidence-based practice competencies for practicing registered nurses and advanced practice nurses in real-world clinical settings: Proficiencies to improve healthcare quality, reliability, patient outcomes, and costs. *Worldviews on Evidence-Based Nursing*, 11, 5–15.
- Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Wolters Kluwer Health; Lippincott Williams & Wilkins.
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19, 349–357.
- Tracy, M. F., & O'Grady, ET. (2019). *Hamric and Hansons advanced practice nursing: An integrative approach* (6th ed.) (pp. 61–79). St. Louis, MO: Elsevier.
- Van der Biezen, M., Wensing, M., Poghosyan, L., van der Burgt, R., & Laurant, M. (2017). Collaboration in teams with nurse practitioners and general practitioners during out-of-hours and implications for patient care; a qualitative study. *BMC Health Services Research*, 17, 589.