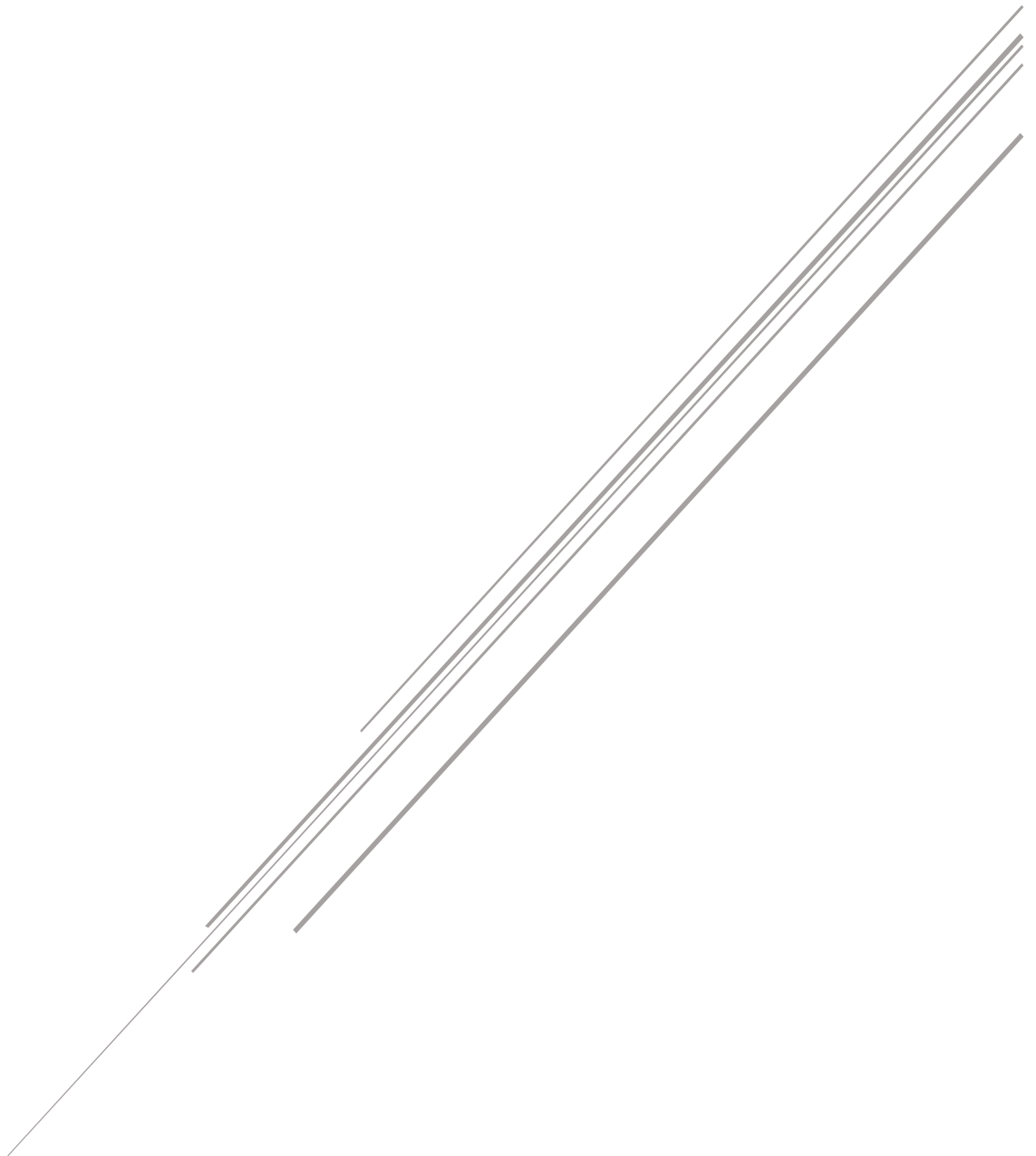


EXPLORING THE IDENTITY OF THE CERTIFIED WOUND OSTOMY CONTINENCE NURSE IN INDUSTRY:

An Interpretive Analysis of Professional Ecology



Doctoral Degree by Examination and Thesis, 2018
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Summary

This qualitative study is an investigation of the culture of nurse specialists who are certified in wound, ostomy and continence care, have practiced their specialty at the bedside, and who are now employed in industry by medical device manufacturers or distributors in the USA. It is framed within the context of the larger professional nursing society with a focus on ecology, defined as an approach to understanding identity and role within their socially constructed environment (Hughes, 2009).

These nurses are situated within a complex environment that is not well understood by those outside of their group. This study examines the cultural knowledge of the members and how they are establishing a new boundary of practice. It is about understanding the identity and the emerging role of this group of nurse specialists and how they perceive their reception by and their impact on the wider field of nurse specialists in this area of expertise. An examination of the literature demonstrated no documented evidence examining these nurse specialists. A purposive sample of Certified Wound Ostomy Continence Nurses (CWOCNs) who now work in industry in the United States was selected from my professional network, to conduct two methods of data collection; one focus group (n=7) and a series of six semi-structured, in-depth, individual follow up interviews. Audio and visual recording of the focus group and audio recording of each interview provided the raw data; all data was transcribed verbatim. Immersion into the data facilitated thematic coding that evolved through multiple iterations of interpretative analysis as a reflexive process (Srivastava, 2009). This qualitative study was guided by Symbolic Interactionism, to explore and describe the identity and the role of a group of nurse specialists. In the process of understanding identity, key findings emerged as themes of identity, role, boundary work and human ecology, rich with subthemes that indicate future implications for nursing.

Statements

Except where stated indicated by specific reference, the work submitted is the result of the candidate's own investigation and the views expressed are those of the candidate.

Candidate's Name _____

Date Monday, December 18, 2017 / Final Submission on Tuesday, 3rd of July, 2018

Declaration that no portion of the work presented has been submitted in substance for any other degree or award at this or any other University or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

Candidate's Name _____

Date Monday, December 18, 2017 / Final Submission on Tuesday, 3rd of July, 2018

Dedication

This work is dedicated to the following individuals who have impacted my journey.

... to Dr. Katie Featherstone, my supervisor, my teacher and my mentor, from whom I have learned the most valuable lessons along this winding road;

... to Dr. Jane Harden, a constant champion throughout my journey;

... to the love of my life, my husband Steve, for his constant support, encouragement and words of wisdom;

... to my parents who instilled in me the desire and the compelling drive to always be the best possible person I could be ...

... and finally, to all of the participants in my study, who I am honored to call my friends and colleagues.

Without each of their stories, this study would not have been possible.

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Introduction

This introduction tells a story about what to expect in this nursing research study. It briefly answers the questions of who, what, where, when and why this study was performed. Conducted in fulfillment of my Professional Nursing Doctorate, this study completes an academic requirement and achieves a professional milestone for this investigator.

Who is this study about?

This qualitative study is an investigation of nurse specialists, Certified Wound Ostomy and Continence Nurses (CWOCNs), who have practiced their specialty at the bedside, and who are now employed in industry by medical device manufacturers or distributors in the United States of America (USA). It seeks to explore, describe and understand the identity and the role of this group of nurses, with a focus on ecology, defined as an approach to understanding identity and role within their socially constructed environment (Hughes, 2009).

What is this study about?

This study is about understanding the identity and the emerging role of this group of nurse specialists and how they perceive the boundary work that they are performing. This qualitative study was originally envisioned as an ethnography guided by Symbolic Interactionism, to explore and describe the identity and the role of a group of nurse specialists. Due to methodological appropriateness, as the project developed, the study evolved over time to become a more broadly based interpretative qualitative study that yielded interrelated conceptual patterns.

Where does this study take place?

This study was conducted in the United States. The data collection took place in several metropolitan cities on the East Coast beginning in 2014 through 2015.

Why do this study?

This study arises out of my personal journey as a CWOCN who has worked in industry for over two decades. As an insider of this group, I lived through and continue to live the experience of a CWOCN working in industry. It was my intent to perform research and document evidence about the identity

and the role of this group of nurses. As Everett Hughes suggested, who better to investigate and document a profession, than one who is a member of that organization. In fact, documenting of the story of work is essential to the professionalization of a group. Hughes also recommended life experiences as a source for investigation.

The impact value of performing this study lies primarily as it is a vehicle to open communication, encourage dialogue and engage healthcare professionals in collaborative reciprocity with one another. The greater sociological purpose is to facilitate new ways of contextualizing how and why nurses' work is performed. This author feels a need to raise awareness of and give a voice to the nurses who are working in industry. What is known personally to the investigator, what is familiar, has fuelled this author's intention to broaden the awareness of and perspective on this work, to share this evidence with a wider segment of this population of nurses. This research is a way to move beyond relevance to self and explore a small sample of colleagues. The very acknowledgment of familiarity provides challenges of being an insider. Completion of this study has become not only a professional goal of this author, but essentially has come to symbolize my contribution to my professional organization. Exploring and documenting on expansion of the scope of practice normalizes work being done and exposes the value of a unique nursing skill set. It also provides evidence on the future of nursing as we seek to lead the way to providing reliable quality healthcare.

Review of the Literature

Chapter One

This literature review is organized in five primary sections and is further divided into subsections, to provide clarity for organization and understanding. An introduction at the beginning of each section guides the reader on the aim and the content of each section. This entire chapter is informed by the emergent themes from the interpretive analysis of this study. It starts with establishing a foundation for the review, with an examination of the literature surrounding the specialty of the WOC Nurse and the Society as it is nested within the larger body of nursing. The second section reviews literature on the concept of identity as an emergent theme of the study, beginning by framing identity within the tradition of society and theory of social interaction and proceeding to explore the identity of nursing. Section Three leads with a focus on the emergent theme of role by contextualizing the literature within the social tradition and examining the social mechanisms and professionalisation of role sets. Literature on the emergent theme of boundary work is the topic of Section Four, once again, positioning it within the social tradition and embracing the concept of human geography and then narrowing the scope to focus on the boundary work of nursing. The fifth and final section of the literature review is meant to bring cohesion to the chapter by reviewing the theory of nursing work with a focus on professionalisation, emotional labour and the emergence of new nursing roles.

Section One: Literature Examining WOCN as a Specialty within Nursing

This first section of the literature review is an introduction to frame the evidence about the Wound Ostomy Continence Nurse (WOCN) and to situate the WOCN within the larger community of nurses. Its purpose is to identify and examine the evidence on what is already known about the professional identity of the Certified Wound Ostomy Continence Nurse in Industry (CWOCNII) and to determine the knowledge base associated with employment of nurse specialists in industry. This section is structured in three parts to show evidence of changing roles of nurses within the United States, evidence surrounding the WOCN specialty and concluding with a systematic search of the literature by practice settings and focus areas of the WOCN specialty.

The changing roles of Nurses in Healthcare: the USA context

This subsection examines the current status of the role of nursing within the United States and frames the discussion for exploration of the role of nurse participants in this study. It is important to understand the wider context of how nurses influence healthcare systems and the way that their roles have changed with a context of their rising consciousness of their identity and their potential to impact outcomes of healthcare delivery. One of the most noteworthy documents to make an impact on the professional practice of nursing in the USA is the Institute of Medicine's (IOM) report on The Future of Nursing: Leading Change, Advancing Health (2011, p. S-1). It begins with the following

The United States has the opportunity to transform its health care system to provide seamless, affordable, quality care that is accessible to all, patient centered, and evidence based and leads to improved health outcomes. Achieving this transformation will require remodeling many aspects of the health care system. This is especially true for the nursing profession, the largest segment of the health care workforce. This report offers recommendations that collectively serve as a blueprint to (1) ensure that nurses can practice to the full extent of their education and training, (2) improve nursing education, (3) provide opportunities for nurses to assume leadership positions and to serve as full partners in health care

redesign and improvement efforts, and (4) improve data collection for workforce planning and policy making.

The report, a collaboration between the Robert Wood Johnson Foundation (RWJF) and the IOM, examines the complex challenges of healthcare delivery and proposes solutions associated with enhancing the role of nursing, the largest segment of workforce in the United States. It focuses on the leadership potential of nursing to address the challenges of healthcare delivery and to create solutions across the continuum of care. The recommendations call for the field of nursing to be instrumental in identifying opportunities and driving improvement by seeking new roles to have an impact and improve care.

Specifically, the report calls for nurses to 1) practice to the full extent of their education and training; 2) achieve higher levels of education and training that promote academic progression; 3) to be full partners with other healthcare professionals in the redesign of healthcare and 4) to engage in workforce planning and policy making with improved infrastructure for data collection information storage (Institute of Medicine, Committee on the Robert Wood Johnson Foundation, Future of Nursing and Robert Wood Johnson Foundation, 2011, p. S-3).

These key messages imply that nursing should be innovative and that nurses strategically position themselves in ways that increase their scope of practice and span disciplinary boundaries to support the transformation of the healthcare system (Institute of Medicine, Committee on the Robert Wood Johnson Foundation, Future of Nursing and Robert Wood Johnson Foundation, 2011, p. S-3).

Leadership is essential to this strategic positioning and to enable interdisciplinary partnerships, to impact the healthcare system not only at the bedside but beyond, extending to education, research and public policy.

Recommendation 2 of the Future of Nursing Report (2011) specifically states that health care organizations must engage with nurses to work with developers and manufacturers in the design, development, purchase, implementation and evaluation of medical and health devices and health information technology products (Institute of Medicine, Committee on the Robert Wood Johnson

Foundation, Future of Nursing and Robert Wood Johnson Foundation, 2011, p. S-9). This recommendation is aimed at expanding opportunities for nurses to work collaboratively in leadership roles across disciplines.

An immediate response by the American Nursing Association (ANA) to the IOM report (2011) was the creation of the 'Future of Nursing: Campaign of Action (the Campaign)' to oversee the journey to advance these recommendations (National Academies of Sciences, Engineering, and Medicine, 2016, p. 2). This infrastructure was put in place to coordinate efforts at the national level with those at the state level; The Center to Champion Nursing in America (CCNA) is the national body that collaborates with the state Action Coalitions. A task force was convened (2014) to assess progress and published a report (National Academies of Sciences, Engineering, and Medicine, 2016). The report incorporated three themes for the future evolution of nursing; broadening the coalition, promoting diversity and improving data collection and analysis (National Academies of Sciences, Engineering, and Medicine, 2016, p. 4). The context of change in health care during that time was and continues to be framed by what has been named the "Triple Aim" of improved patient experience, improved public health, while also achieving lower costs (National Academies of Sciences, Engineering, and Medicine, 2016, p. 3).

In response, eight states have made legislative changes to grant nurse practitioners full practice and prescriptive authority. On a federal level, The Centers for Medicare and Medicaid Services (CMS) issued a ruling to allow advanced practice nurses to practice to their full scope, which includes prescriptive privileges. Recommendation 4 of the IOM Report (Institute of Medicine, Committee on the Robert Wood Johnson Foundation, Future of Nursing and Robert Wood Johnson Foundation, 2011, p. S-10), calls to increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020, while Recommendation 5 calls to double the number of nurses with a doctorate by 2020 (Institute of Medicine, Committee on the Robert Wood Johnson Foundation, Future of Nursing and Robert Wood Johnson Foundation, 2011, p. S-11). All levels of Baccalaureate enrollment have increased, including entry-level, accelerated baccalaureate and baccalaureate completion enrollment to bachelor of science in nursing (BSN) (National Academies of Sciences, Engineering, and Medicine, 2016, p. 6). Doctoral program enrollment has more than doubled since 2010 and enrollment in PhD programs has increased by 15 percent (National Academies of Sciences, Engineering, and Medicine,

2016, p. 7). In addition, transition to practice models of training and residencies are being implemented to ease the transition to practice from academia to clinical practice with the goal of improving retention, expanding competencies and improving patient outcomes.

Although this programme of implementation in response to the IOM report (2011) is too recent to detect any significant change in the diversity of nursing, early indications of its impact are mixed. Based upon a comparative survey of 1000 hospitals, the representation of nurses in leadership positions as board members shows a decrease from 6 to 5 percent from 2011 through 2014, while the percentage of physicians remained the same at 20 percent (National Academies of Sciences, Engineering, and Medicine, 2016, p. 12). One positive action has been the creation of Nurses on Boards Coalition (NOBC) by the American Nurses Association (ANA). NOBC has been effective in both traditional and new media communication, reaching out with a Speakers' Bureau and online to communicate and give voice to the potential for nurses to be engaged as leaders in the wider community beyond direct caregiving, based upon their unique skill set and expertise.

Specific acknowledgement of progress within individual states is noted as above, however, key challenges remain. Greater focus and effort are needed to rectify the discrepancy between effectiveness of state efforts, the continued lack of diversity among the nursing workforce, the lack of nursing influence as board members in collaborative initiatives and a data deficit in each area that impacts the ability to accurately evaluate and gauge the current status and the progress to achieve these goals (National Academies of Sciences, Engineering, and Medicine, 2016, p. 16).

The next subsection focusses on the emergence and identity of one nursing specialty, Wound Ostomy Continence Nursing Society. It begins with the history of the specialty and includes their scope of practice, the regulation, accreditation and demographical distribution, with an examination of the stratification of the role.

The Wound Ostomy Continence Nursing Specialty

Nursing is a wide field with many different specialisms and the focus of this second subsection is to identify and describe the emergence of the Wound Ostomy Continence Nursing as a specialism and field, and to position it within the larger culture of nursing and the development of the profession. This

subsection will reflect on the origin of the specialty, its historical legacy as it evolved from the identified needs of a specific patient population. The initially targeted patient population included individuals who require ostomy surgery to create a diversion of the gastrointestinal or genitourinary system. The target population later expanded to encompass a thriving triad of nursing specialties that now includes skin and wound care, continence care and foot and nail care. We start with a brief history of the WOCN specialty to position it within the larger nursing organization and to support the exploration of who they are and what they do. Scope of practice, regulation, accreditation and certification, demographics and membership associated with the specialty of WOCN are all reviewed.

History of the USA Wound Ostomy and Continence Nurse Specialism

The legacy of the WOCN specialism began in the mid-twentieth century in Ohio, when a dynamic ostomy patient, Norma Gill, who performed informal advocacy consultation with other ostomy patients met a colo-rectal surgeon, Dr. Rupert Turnbull from the Cleveland Clinic (Rizzo, 1997). Together they collaborated and began to build what became known as Enterostomal Therapy; the root of the name being a combination of entero (an opening into the abdomen) and stoma (opening), a term to describe the rehabilitative therapy and support of people with abdominal surgery resulting in ostomies. News of their partnership spread and a need was expressed by patients for replication of their model, a model of specialized rehabilitative care and support that was a collaborative relationship between the surgeon and the clinical expert in managing life with an ostomy (Curtin, 1982). The model evolved from the first School of Enterostomal Therapy (1961) when the initial requirement was to be an ostomate, to become a nursing specialty with multiple schools across the United States (Rizzo, 1997). What began as a role taken by an individual with an ostomy, evolved to become a role to be filled by a nurse with specialty training achieved through certification.

Significant milestones that marked the advancement of this new nursing specialty, included multiple iterations of its naming, to reflect a broadening scope of territory and practice, including the American Association of Enterostomal Therapists (AAET) (1968), the North American Association of Enterostomal Therapists (1969) and the International Association of Enterostomal Therapists (1971). The training programs began as stand-alone schools, usually affiliated with medical centers, that offered training programs which were a combination of classroom and bedside experience. As the

demand for training grew and nursing took more ownership, accredited nursing Schools offering this specialist training multiplied nationally, an annual national conference was initiated in 1969 and in 1974 the first Journal of WOCN was published, as the IAET Quarterly. The first set of bylaws were written (1972) and a code of ethics was adopted, and a formal job description and organizational objectives were published. By 1976, a decision was made by the membership to limit entrance to WOCN accredited educational programs to Registered Nurses. In 1978, the first National Board Certification Examination was founded, in response to a demand for validation of proficiency in the nursing specialty. The Enterostomal Therapy Nurse Certification Board (ETNCB) was incorporated to separate the certification process from the IAET and the Board of Directors. The following year, strategic planning was initiated along with accreditation of the continuing education process.

The organization that had its roots in patient needs related to ostomy care, took on additional specialties, Wound and Continence (1978) and most recently, Foot and Nail Care (2005). In 1992, at the House of Delegates during the Annual Conference, the organization changed its name to the Wound Ostomy and Continence Society to better reflect the specialties and the patients it serves. Over time, the Society took on the accoutrements of a professional organization and in the span of fifty-five years, their membership grew from a single group of one dozen individuals to a network of regional and affiliate groups with a national membership of greater than five thousand nurses.

Scope of Practice of the WOC Nurse

The Scope and Standards of Practice (2010) of the WOCN Society were written the same year that the Society received endorsement by the American Nurses Association (ANA) as a recognized specialty nursing practice. Importantly, the scope of practice defines the specialty and serves as a resource to be used as a guide when validating professional practice (National Nursing Staff Development Organization, 2010, p. 4). It provides an overview of the nursing organization and captures the legacy and evolution of the specialty along with the competencies that have been identified for each standard (National Nursing Staff Development Organization, 2010). It also evolves as a living document, to reflect changes in knowledge and within the environment of practice and the community at large. The scope of practice is determined by education, experience, practice setting and role (National Nursing Staff Development Organization, 2010, p. 4).

The specialty of WOCN is currently defined as a 'multi-faceted, evidence-based practice, which incorporates a unique body of knowledge to enable nurses to provide excellent care to persons with select disorders of the gastrointestinal, genitourinary, and integumentary systems' (National Nursing Staff Development Organization, 2010, p. 5). In 1982, the scope of practice was expanded to include wounds and continence and in 1985, the baccalaureate degree became the minimum educational threshold for admission to school and eligibility for certification.

Within practice environments, the roles taken within the specialism include clinical experts, educators, consultants, researchers and administrators and may be performed either directly or indirectly associated with healthcare consumers, however, always through the implementation of the wider nursing perspective and expertise. The Scope and Standards of Practice (2010, p. 14) identify practice settings across the continuum of acute care, outpatient care, home care, long term care, academia, administration, research and industry. However, according to self-reported member survey, only 2.99% of members currently practice in industry (WOCN, 2016).

Regulation of the Wound Ostomy and Continence Nurse (WOC Nurse)

With the writing of the first Bylaws (1972), the organization initially responded to reflect the need expressed by the members, and how to best serve the population of patients within their recognized specialties. Since then, a total of seventeen Articles constitute the Bylaws, most recently amended and restated in June 14, 2016. The Bylaws establish the name and purpose of the organization, the membership, Ethics and Discipline, the Board of Directors, the Officers and Council, geographical distribution of territories, standing committees, the financial structure and means of communication. Pertinent to this study, nurses within industry have a different status within the organisation. The Bylaws state that 'Full members who are employed by a commercial industry that provides products or services as defined in the WOCN policy are not eligible to serve on the Board of Directors of the National Society' (WOCN Bylaws, 2016, p. 2).

The professional documents of the Wound Ostomy and Continence Nurses Society (WOCN Society) include the Scope of Practice and Standards of Care for each of the specialty areas (Lawrence et al., 2010). This embodies the essential elements and expectations for nursing practice of this specialty nursing group. They identify the specialty roles of each focus area across the continuum of care. The WOCN Clinical Practice Guidelines Textbooks on wounds, ostomy and continence outline the knowledge base in wound care, ostomy and continence care and form the body of knowledge that each WOC Nurse obtains and is certified in by the WOCN Certification Board. A number of publications and educational resources related to each specialty and to public policy are available as resources for individual practitioners and by groups as recommendations for practice. These documents are housed online at the web space for the WOCN Society (www.wocn.org).

Accreditation and Certification

Accreditation of the Wound Ostomy and Continence Nursing Educational Programs (WOCNEPs) by the WOCN Society is a voluntary process and is based upon established criteria (National Nursing Staff Development Organization, 2010, p. 12). Accreditation is administered by the Accreditation Committee of the WOCN Society, and that Committee reports directly to the Board of Directors. The Wound Ostomy and Continence Nursing Certification Board (WOCNCB) is responsible for administration of the certification process and is distinct and completely independent from the WOCN Society. The Board meets accreditation standards of the National Council for Certifying Agencies and the Accreditation Board for Specialty Nursing Certification (WOCNCB, 2015).

Certification for WOC Nurses is voluntary and is a way to validate credentials and expertise. It is a sign to the larger community of nursing and beyond; that nurse holds a special knowledge base. A key priority is evolving and changing in response to consumer demands. The field of WOCN continues to grow to meet the needs of 'consumers', while integrating new knowledge (National Nursing Staff Development Organization, 2010, p. 19). In a world that is experiencing constant change and stimulating more complex challenges for care delivery, the field responds by expanding roles while demonstrating leadership in advocacy for patients and evidence-based care.

Territorial/Demographical Distribution of WOC Nurses

WOC Nurses currently practice in a variety of roles across the continuum of care that includes practice settings of acute care in hospitals, home care, long-term care within nursing homes, outpatient settings in clinics and acute long-term care. Roles within each of these settings are considered traditional since each of these are settings where care is directly administered to patients or residents. WOC Nurses are involved with patient care as experts offering direct hands on care and through indirect consultations with generalist nurses who perform bedside care with recommendations. The WOC Nurse also practices in non-traditional roles such as within industry.

WOCN Society Membership

Online surveys are distributed periodically through the WOCN Society as a way to collect data on the individuals who practice this nursing specialty. The most recent online survey (2016) was disseminated to 5,200 WOCN members, with a return of 1,305 usable forms, and a response rate of 25% (WOCN Society, 2016). These numbers reflect self-reported answers of the sample surveyed. All data was de-identified, submissions were anonymous and upon receipt, all questionnaires were assigned a confidential identification number. Performance indicators are reported based on median rather than means. This is a low response rate and the representativeness of the survey is documented at the introduction to the report. Gender is represented as female (95%) and male (5%). Age is represented in the survey as ranges with the largest number of individuals falling into the range of 50-59 (37.6%), followed by those of age 60 and above (23.3%) (WOCN Society, 2016, p. 7). Types of certification are shown to be Certified Wound Ostomy Continence Nurse (CWOCN) (58.7%), Certified Wound Ostomy Care Nurse (CWON) (26.4%), Certified Foot Care Nurse (CFCN) (12.2%) and Certified Wound Care Nurse (CWCN) (11.9%). Years of nursing experience is evenly distributed in ranges of years from 6-10 (15.5%) to 36-40 (14.7%). Years of Wound Ostomy and Continence Nursing experience takes a progressive decline from 5 or less (28.6%) to 36-40 (1.9%). Educational levels represented in the survey range from Bachelor's Degree (66%), to Master's Degree (29.8%) to PhD/Doctorate (2.3%) (WOCN Society, 2016).

Stratification of WOC Nurses by Level of Education

When considering educational background, it would appear that nurses with advanced degree preparation are more concentrated proportionally among those who are employed by industry. Among the sample of all respondents (1296), 2.5% of whom are employed in industry, the educational level is proportioned accordingly, 2.1% have a Bachelor's Degree, 2.9% have a Master's Degree and 6.7% have a PhD or Doctorate. Out of 384 respondents with a Master's Degree, 2.9% are employed by industry, while out of thirty respondents with a Doctorate, 6.7% are employed in industry (WOCN Society, 2016, p. 27).

Stratification of WOC Nurses by Practice Setting

The primary practice setting for all respondents (N=1,296) is distributed between ten settings, with industry claiming only 2.5% (WOCN Society, 2016, p. 10). Acute care was the primary setting (60%), with outpatient as second (17.8%), Home Care as third (10.4%) and Industry fourth (2.5%) (WOC Society, 2016, p. 10). The remaining practice settings include LTAC, Long-term, Consultant, MD Office, School/Academic and Rehabilitation Care, which account for a cumulative total of 1,193 individuals. Stratification by practice setting, based on all respondents, reveals that industry is the fourth practice setting in terms of numbers of WOC Nurses.

WOC Nurses working in Industry

Within the survey sample of 1,193 WOC Nurses, the small proportion of nurses who work in industry, are distributed across five roles in industry identified by care settings, with the majority working within long-term care. See the table below for the current survey on WOC Nurses in industry segmented by practice setting, 2016 WOC Nursing Salary & Productivity Survey (2016, p. 109).

Are you an industry nurse?	Acute Care	Home Care	Long-term	Outpatient	Long-term Acute Care
(N)	777	135	23	230	28
Yes	4.3%	6.7%	13.0%	8.7%	3.6%
No	95.8%	93.3%	87.0%	91.3%	96.4%

Stratification of WOC Nurses in Industry by Years of Nursing Experience

When surveying by number of years of nursing experience, a high proportion of the nurses who were within industry had mature levels of experience in practice. When asked the question, 'Are you an industry nurse?', of 150 nurses with 26 to 30 years of experience, 6.7% reported that they were in industry; of 153 nurses with 31 to 35 years of experience, 3.9% reported that they were in industry and of those with 36 to 40 years of experience (N=96), 4.7% reported that they were in industry (WOCN Society, 2016, p. 93). When examining detailed results on educational level by practice setting, for the sample of industry nurses (N=32) the total number of years of nursing experience, the median is 27.5 years and the average is 28.8 years (WOCN Society, 2016, p. 123). For that same sample, when examining the total number of years of wound, ostomy and continence experience, the median is 18.0 years and the average is 18.7 years (WOCN Society, 2016, p. 123).

Feelings of Role Satisfaction within WOC Nurses in Industry

The survey explored areas of role satisfaction. Examining the sub-sample of 29 Industry Nurses, 51% responded that "I am not dissatisfied" (WOCN Society, 2016, p. 127), or in a more positive light, 51% were satisfied. Regarding financial support by employer to attend WOCN Annual Conference, the group of industry nurses (32) responded 'Yes' at 84.4% with 100% coverage of conference registration. This was the highest of any group. Concerning other benefits offered by employers, the industry nurses (29) report that WOCN Membership dues are covered by their employers (89.7%) (WOCN Society, 2016, p. 134). These are the highest percentages of any sample. The educational benefits provided by employers such as payment of conference registration and membership dues contributed to the overall feelings of satisfaction.

Key characteristics of WOC nurses in industry

The demographic survey findings show that overall, the participants were primarily older, with a concentration in the fifth decade of life and overwhelmingly female and this was reflected in the group working in industry. Overall, those working in industry had higher levels of nursing experience and demonstrated a higher level of professional maturity, with those in industry distributed heavily between 25 to over 40 years. In contrast, their years of WOC nursing experience were less than their general nursing experience, and within industry the average ranges from 15 to 20 years. The

stratification of highest level of education is the Bachelor's degree with the Master's degree, the next highest. Industry is shown to be the fourth primary practice setting, preceded by acute care, outpatient and home care, while each practice setting is populated by a portion of nurses in industry, from 3.6% to 13.0%. This sample will be discussed in more detail within the Methods Chapter, which will show that the sample of study participants mirrors the characteristics of the survey respondents as documented above.

Up until this point, the literature cited has been primarily documents that are foundational to the WOCN Society, written by the members of the Society leadership, to frame their position within the larger nursing organization. The final part of this section will be an overview of the wider literature published by and about WOC Nurse practice. It offers the results of a systematic literature search that includes the findings of the literature search on the CWOCNII in addition to the findings on the CWOCN across other practice settings, beyond industry.

Systematic Search of the Literature

This third subsection now provides a systematic review of the literature on the WOCN specialty, organized around practice settings and focused areas of the nurse specialty. It begins with a search to find evidence of the practice of the CWOCN in a role within the context of industry. This literature search includes evidence generated from qualitative studies, quantitative studies and mixed methods. Databases searched included Medline, CINAHL and Scopus were used to initiate the search for journal articles. As a member of the WOCN Society, the investigator had access to full text database of the Journal of the Wound Ostomy Continence Nurse (JWOCN), the primary publication of the WOCN Society and full text publication of all member only resources.

The initial search was performed in PubMed/Medline using the keywords of "Wound Ostomy Continence Nurse", role, "specialties, nursing", combining them using Boolean logic with the result that yielded 39 citations. Adding the key word of 'industry' to the previous search yielded no results. In response, the time frame was expanded from ten to twenty years, because of the specificity of content and the need to throw a wider net and capture the previous name of the nurse specialists prior to 1992. Reviewing the abstracts of those 39 citations yielded one paper with a sample that included nurses employed in industry (Aronovitch, 1995).

Keywords were expanded:

Setting	Perspective	Intervention or Interest	Comparison	Evaluation
Industry; manufacturing; medical devices	Wound Ostomy Continenence Nurse; WOC Nurse; WOCN; ET Nurse	Role	Perspective	Subjective experience

In response to identifying this single paper on the practice of CWOCNs in industry, the search was broadened to identify the evidence associated with practice by care settings, specialty areas of focus and geographical locations around the world. Key search terms included WOCN, WOC Nurse and role. Filters applied were English only, limited by publication within 20 years. With an intent to organize the search, the first screening of the three key search terms was to add a term related to the context of care, first acute care and/or hospital, second home care, and then long-term care and/or nursing home. Next, the key search terms of WOCN, WOC Nurse and role were further screened by specialty practice; first by adding the term ostomy, followed by wound care and finally by continence care. The search yielded results that were unrestricted by location, so papers from various countries were identified randomly associated with context of care setting and specialty practice. Overall, these fourteen studies identified that the role of the WOCN is defined by clinical expertise, it is practiced across the context of all care settings and the role is implemented around the world in a variety of countries.

Finding of Literature review on CWOCN in Industry

Only one paper was found with a sample that included nurses employed in industry (Aronovitch, 1995). This qualitative descriptive study on career mobility of Enterostomal Therapy Nurses (ET Nurses), the former name of the WOC Nurses, engaged a sample of 117 ET Nurses in a self-report survey. The response rate was 54.3%, members of the study sample ranged from 29 to 58 years, while their duration of practice was in the range of 1.5 to 18 years. The themes identified through content analysis included consequences from the experience of being an ET Nurse, precipitating event resulted

in a career change, ET Nursing is a major demarcation in practice, perceives self to be currently practicing as an ET Nurse, career mobility, feelings regarding ET nursing experiences, self-directedness in professional growth and trajectory from clinical nursing to the business world (Aronovitch, 1995, p. 169). Nurses working within the medical device industry were among the study sample. Thirty themes were condensed to eight with identification of what the author called 'residual learning,' a transfer of specialist nursing skills from one career placement to the next (Aronovitch, 1995, p. 170). Residual learning was defined as knowledge gained from past education and experience. This concept will be an object for further exploration in this study.

Literature Across practice settings

This section reviews evidence on the practice of WOCNs across care settings. Fourteen studies examined the role of the WOCN within the areas of clinical expertise. They demonstrate that WOCN is practiced across the context of all care settings and the role is implemented within a range of countries. The first practice setting explored in this search is that of acute care, within the hospital, which is the most frequent place of employment for the CWOC Nurse. The physical location of the hospitals identified below are trauma centers and university medical centers. Depending upon the geography, the patient population varies, and the papers cited are a mix of methodologies including quality improvement initiatives and retrospective, descriptive, comparative studies. Importantly, overall these studies indicate that the role of the CWOCN is a driver for change and practice improvement that is often associated with improvement of quality outcomes.

Taggart (2012) used Donabedian's approach to quality of care, to describe structure, process and outcomes, of a quality improvement initiative to extend the expertise of the CWOC Nurse. A Skin Champion Team was implemented within a trauma medical center in the state of Illinois, with the objective of decreasing the incidence of pressure injuries. Driven by the fiscal consequences of the hospital-acquired condition of pressure injuries, her model was designed as a unit based vehicle to improve the incidence of pressure injuries (Taggart et al., 2012). Through a three-pronged unit-based initiative, the program included standardizing patient assessment, developing the WOCN Unit Champions and implementing a process for case analysis of the hospital-acquired pressure injury. Through an intervention of recruitment, education and innovative procedures, outcomes resulted in a

decrease in incidence from 7% to 4%. Their conclusion was that WOC Nursing can be a driver of change.

Using the National Database of Nursing Quality Indicators (NDNQI), a secondary retrospective comparative analysis design was performed with a three pronged goal, to describe the demographics of employed WOC Nurses in hospitals, to identify the rates of hospital-acquired conditions (HACs) (pressure injuries and catheter associated urinary tract infections) and to determine the effectiveness of improved quality outcomes that are associated with care by WOC Nursing (Boyle et al., 2017). The sample consisted of 928 NDNQI indicator hospitals that participated in the NDNQI RN Survey (2012) and hospital-acquired pressure injury (HAPI), catheter-associated urinary tract infection (CAUTI) and nurse staffing data during the period of 2012-2013. All analyses were at the hospital level and study procedures were reviewed and approved by the institutional review board at the University of Kansas Medical Center. There were three study samples. Sample 1 consisted of the cohort of 928 hospitals that participated in the 2012 NDNQI RN Survey. Sample 2 (n=674 hospitals) was a subset of Sample 1 that reported HAPI and staffing data. Sample 3 (n=494 hospitals) was also a subset of Sample 1 and reported CAUTI and staffing data. The study suggests that the involvement of Certified Wound Ostomy Continence Nurses (CWOCNs), Certified Wound Care Nurses (CWCNs) and Certified Wound Ostomy Nurses (CWONs) was a significant factor in determining the impact on improved quality outcomes related to a decrease in hospital-acquired pressure injuries in hospitals. However, the same was not found for outcomes related to catheter associated urinary tract infections. The authors recommend further research to examine the role of CWOCNs in continence care.

Home care is another practice setting that is part of the expanding scope of practice by CWOCNs. The evidence below identifies the ways in which CWOCNs are impacting the care of patients with wounds, ostomies and continence at home. These papers report on retrospective analysis of cost-effectiveness and construct an argument in support of roles in home care. They identify that the greater the direct involvement of CWOCNs in wound and ostomy care, the more efficient that care is, and healing times become shorter. The overall impact of the CWOCN is shown to be in promoting positive patient outcomes, developing care polices and treatment plans, while establishing standards of care.

A retrospective analysis of the cost-effectiveness and benefits of ET (WOC) Nursing driven resources for the treatment of wounds was undertaken in Canada, by the Canadian Association of ET Nursing to examine the role and the impact of ET Nursing in Canada. A multi-center retrospective chart audit of nursing care in Canada was implemented within four community nursing agencies and one specialty WOCN owned and operated nursing agency (Harris and Shannon, 2008). Quantitative analysis was performed to evaluate and compare outcomes, nursing cost and cost-effectiveness. Outcomes used to measure effectiveness of wound management were the time required for wound healing, the time required for the patient to be discharged and the conditions at discharge. All calculations were performed using SPSS. Kaplan-Meier survival analysis was used to measure healing trajectories. Three major conclusions were that the ET only care model provides more rapid wound healing times, the ET only model is more cost-effective and within the other four models, cost and wound healing outcomes were improved when ET nurses saw the patients on 50% of visits or more frequently. They concluded that the increased involvement of the WOC Nurse was inversely related to healing times, while there was a linear relationship with cost-effectiveness. The authors conclude that these specialty practice nurses deliver skilled care to patients with complex wounds and their study provides evidence to demonstrate their findings.

A descriptive argument was constructed on the value of the WOC Nurse as an expert to support quality outcomes in home care (Baker, 2001). The argument is built that the CWOCN is an asset to any home care agency that manages patients within the tri-specialty of wounds, ostomies and continence. Due to the increasing complexity of patients who are being cared for at home, the clinical expertise of the WOC Nurse can be leveraged to address the needs of these complex patients while inserting a degree of cost-effectiveness. The role of the CWOCN in home care is identified as three-pronged, as a patient advocate, as staff and patient educator and as expert clinician. By utilizing the CWOCN in these ways, they found that the home care agency could benefit through implementing the WOC Nurse in roles that define care maps and protocols that improve outcomes while reducing excessive cost. The conclusion is that the WOCN is a patient advocate who provide cost-effective care with the outcome of chronic wounds that heal more likely when cared for the CWOCN.

A retrospective descriptive study on the occurrence of medical device related pressure injuries (MDRPIs) investigated prevalence in three long-term acute care hospitals within the United States, by a team of three WOCNs (Arnold-Long et al., 2017). Data on both hospital acquired pressure injuries (HAPIs) and MDRPIs were collected over a one-year period. The proportion of HAPIs and MDRPIs at each facility was 38%, 50% and 47%. The most common medical devices that are the source for pressure injury are respiratory devices, splints and braces and various types of tubing. Despite the need for various medical devices, it is apparent that evidence-based practice considers how to use these devices safely with regard for their potential harm. The findings support the need to monitor MDRPI and to implement prevention strategies. The report of this descriptive study showcases the role of the CWOCN in research and the way that they contribute to the data collection and analysis of pressure injury incidence, in this case, the evidence associated with MDRPI.

Literature on CWOCN in the Tri-Specialty Areas

This next part is a review of the literature that identified focused areas of practice and yielded papers on each of the tri-specialty areas of care. Evidence was found examining WOCN clinical practice from a variety of countries including Japan, Brazil and Italy. Overall, these studies identified the role of the CWOCN as a facilitator of support groups of ostomy patients during recovery and in the role of advocacy across the tri-specialty. The evidence shows that regular contact with a CWOCN improved the quality of life for patients. The role of the CWOCN within research is identified as they contribute to evidence-based practice.

Ostomy

An early publication on ostomy support groups (Mowdy, 1998) addresses the role of the WOC Nurse. Mowdy writes about the application of WOCN clinical expertise to the support of individuals following surgical procedures that result in the creation of ostomies. She recommends peer support of ostomates to one another and identifies the WOC Nurse as the leader and facilitator of support groups.

In another study on ostomy care, a sample of 743 persons with ostomies were surveyed as part of an open-label, noncomparative, multicenter study (Erwin-Toth et al., 2012) using a Stoma-Quality of Life (QOL) questionnaire to measure health-related quality of life. The Dialogue Study was the approved study name for international use, based upon dialogues with the study participants. The aim of the Dialogue Study was to investigate the QOL associated with use of a particular type of ostomy pouching system combined with WOC Nursing intervention. They found that the combination of regular consultation with a WOC Nurse and the use of the pouching system improved peristomal skin condition as confirmed by WOC Nurse assessment and health-related QOL. The Dialogue Study positioned the CWOCN in the role as primary investigators of evidence related to QOL.

A cross-sectional study was conducted in Japan, to evaluate the relationship of the quality of sleep in individuals with a urostomy (Furukawa and Morioka, 2017). Engaging with the participants of an outpatient stoma clinic, who also attended a support group (N=86), data was collected using two Japanese versions of validated instruments on quality of life (QOL) and sleep quality; World Health Organization Quality of Life 26 (WHOQOL 26) and the Pittsburgh Sleep Quality Index (Furukawa and Morioka, 2017). The results showed that domain-specific scores of persons with a urostomy were significantly lower than those of age-matched population of individuals with no urostomy. The role of the CWOCN, as the primary investigator in this research study, positioned her to contribute evidence that demonstrated an association between the QOL of individuals with a urostomy and sleep disorders. The investigators call for more research to potentially generate nursing interventions to address these issues of QOL.

A group of WOC Nurses in Brazil also studied the QOL in ostomy patients, receiving outpatient care, using a descriptive, exploratory, cross-sectional study (Santos et al., 2016). They performed a secondary analysis of data collected from a primary study on a Portuguese version of the City of Hope QOL - Ostomy Questionnaire (COH-QOL-OQ). Using a convenience sample of 215, they used two instruments, the WHOQOL-Bref (generic) and the COH-QOL-OQ (disease specific) and analyzed data using χ^2 test and logistic regression. They found three factors to be associated with lower HRQOL scores; less than 12 months since surgery, lack of religious practice and lack of partner. The role that these nurses played in conducting this study in Brazil was clinically significant. The Portuguese

language version of the COH-QOL-OQ is the first condition-specific instrument to measure QOL in Brazilians having an ostomy (Santos et al., 2016, p. 161) and these WOCNs made a unique contribution to the evidence base by showing that the implementation of a condition-specific instrument as opposed to a generic instrument, made a difference in the findings.

The Association of Stoma Care Nurses issued a joint statement with the Italian Society of Surgery on preoperative stoma siting (Roveron et al., 2016). They used the existing position statement written jointly by the WOCN Society and the American Society of Colon & Rectal Surgeons as a template, to provide recommendation for both stoma siting and preoperative counseling. The scope of the position statement applies to all patients who are expected to have operative procedures which would result postoperatively in creation of stoma, with the goal of improving quality of life, outcomes and health care costs. This statement identifies the role of the WOCN in pre-operative consultation that includes stoma site marking for placement of stoma during surgery and pre-operative counseling, as clinically significant to the post-operative outcomes of the patient. Prevention of post-operative complications and a better adaptation to the ostomy surgery and self-management of the patient is impacted by the role of the WOCN, in the pre-operative care of the patient.

Continence

In a position paper on the role of WOCN in continence care (urinary, fecal and combined incontinence), incontinence is defined as a significant healthcare problem and the implications include quality of life and costs associated with intervention (WOCN Professional Practice Committee, 2009). The competencies of the continence nurse were reviewed, and the paper concludes that the WOCN is positioned with the skills to collaborate effectively across disciplines to support this patient group.

The appropriate use of absorbent underpads is the source of continuing clinical dilemma; whether the use of disposable versus reusable pads is associated with hospital acquired incontinence Associated Dermatitis (IAD) and hospital acquired pressure injuries (HAPIs). A randomized controlled trial using cluster randomization based in an inpatient care unit was conducted by a team of WOCNs to determine if there is a difference in occurrence of HAPIs and IAD in incontinent adults using disposable

versus reusable underpads and to compare length of stay (LOS) between the two groups (Francis et al., 2017). The sample consisted of 462 subjects, who were patients at a large metropolitan hospital in the United States. The use of disposable underpads resulted in lower occurrence of HAPIs and a shorter LOS, while rates of IAD were not affected. The findings of this nurse-initiated study suggest recommendations for the use of disposable absorbent underpads for pressure injury prevention. These evidence-based findings have implications for nursing care that may impact hospital wide prevention and the incidence of hospital acquired pressure injuries.

Wound Care

In fulfillment of a Master's thesis, a Heideggerian Hermeneutic Phenomenological study of WOC Nurses was conducted to explore the meaning of being a certified WOC Nurse who practices the specialty of wound care (Sylvia and Jones, 2010). Using unstructured interview process, six interviews were conducted and audio-taped, then transcribed verbatim by the primary investigator, a certified WOC Nurse with over 30 years of experience in wound care. Eight themes emerged to shed light on the sample of nurses who practice this specialty to provide evidence of a rich description of their experience in the care of patients with wounds. The themes include essence of practice, holistic approach, the dichotomy, art of wound care, growth in practice, allure of the challenge, acknowledging limits and being a role model (Sylvia and Jones, 2010). These themes offer insight to the roles each of the nurses described.

A scoping review of the literature by three WOCNs was performed to determine whether or not incremental positioning and weight shifts are effective in reducing hospital acquired pressure injuries in the population of critical care patients who are too unstable to turn (Krapfl et al., 2017). A total of 18 papers were included, but no evidence was found that supported incremental positioning. Based upon their expertise, the authors concluded that although there was a lack of supporting evidence, they recommended incremental positioning as a means of pressure injury prevention in critical care patients who are otherwise too unstable to fully turn. By expanding their search from turning and repositioning to explore early mobilization of patients and use of positioning devices, in the critical care population, they found a number of quality improvement activities that advocated slow incremental positioning and weight shifts that influence gravitational equilibrium as a way to improved patient

tolerance for turning. So, despite the paucity of evidence that demonstrates a direct association of positioning with hospital acquired pressure injuries, they used their role as experts to make a clinical recommendation for individualizing care to meet patient needs.

This first section of the literature review includes evidence on roles within various care settings, including acute care, home care and long-term care. An expanding body of evidence also exists written by and about the roles of the CWOCN within the focused areas of the tri-specialty practice of wound, ostomy and continence. The literature examining the CWOCN, identified a range of roles including advocacy, clinical expertise, research, education, policy maker, quality management, counseling and authorship. Regardless of the role, the underlying theme that is the foundation of the CWOCN role, is the clinical expertise evidenced by their specialist education and certification. The role of the CWOCN is directly associated with improved quality of care delivery and patient outcomes.

Importantly, this limited literature identifies a gap in examining and understanding the role of the WOC Nurses as they are employed within the medical device industry. There is very little documented evidence associated with roles that transfer their specialty expertise to other professional settings and places of employment such as in industry; those who are extending the frontier of the nursing profession.

In the next section, the primary theme of Identity will be explored. That is followed by a review of role, boundary work and the theory of nursing work, in the subsequent sections of this chapter. The intent is to clearly review each of the emerging themes separately, however, it became apparent that on a certain level, the themes also overlap, becoming blurred and woven together as rich stories. Any attempt to place them in neat silos seems artificial.

Section Two: Literature Examining the Identity of Nursing

The second section of the literature review provides a review of the evidence associated with the emergent theme of identity. It is organized into two subsections; this first subsection on identity in general as framed within the context of social interaction. It begins with an overview of how the theory of symbolic interactionism frames the body of literature on identity and contributes to the academic discussion within the context of industry. Literature on social front, relational identity and the dilemma of expectations surrounding identity is reviewed. It is followed by the second subsection focused on nursing and identity. That subsection is organized around professional identity and nursing, social identity and nursing, bodywork, ownership of nursing identity and concludes with the future of nursing identity.

Identity and the Tradition of Social Interaction

Any discussion of cultural identity must be set within the larger scope of the society in which the individual or the group of individuals reside. The literature on Symbolic Interactionism is relevant here because it is the theoretical framework that has been chosen for the interpretation of this study. The experience of the WOCNII is informed by the context of their professional environment and their identity is continually shaped through their social and professional interaction and the meanings that they associate with each interaction.

Blumer describes social interaction as making meaning of identity (Blumer, 1969). Drawing upon the work of George Herbert Mead, Blumer writes extensively on the process of human interaction, seeing it as always dynamic, constructing meaning through interpretation and thus actively contributing to the meaning of self through the social relations of experience. Identity and role are intimately associated through the empirical process of social relating, the reciprocity of acting while acknowledging and taking on the perspective of others during joint action. The significance of self-indication within the process of action is framed by the surrounding environment that sets the stage for human interaction, while the self actively assigns meaning through interpretation, rather than by accepting what appears (Blumer, 1969, p. 81). Acknowledging the self within the cyclic process of communication implies an element of being proactive within the context of each human interaction.

Communication with others includes the self as an actor or a participant within each loop of communication. In this approach, the self can be thought of as the internal gatekeeper integral to each active communication, processing meaning through interpretation. The self is actively participating in communication and mediates their responses through ongoing processes of interpretation.

The three premises of symbolic interactionism are rooted in human social interaction and revolve around the self; acknowledging that the self acts deliberately toward things in the world because of meaning that it processes through association with those things, meaning comes through social interaction between individuals and that meaning derives from interpretation (Blumer, 1969). The self is central to and processes all interpretative meaning, which may be considered as the output of that interaction, but always set within a context that impacts each interpretative encounter. With each social experience, each social interaction, the self changes as it incorporates new data, processes it interpretively and then acts out based on new internalized meanings. Each social interaction is a platform for evolving empirical experience and the self is instrumental as a participant in the cycle of social action. This concept signifies the potential for being self determined with each new encounter. Likewise, on another level, groups enact this process and engage in joint action (Blumer, 1969, p. 20). This is a key conceptual framework used to make sense of identity and how it is continuously evolving through a social circuit of communication between the individuals, who in this case are the subjects of this study. This is the value of this perspective for exploring the identity.

Like Blumer, Goffman addresses the interaction of face to face communication between individuals as the 'symmetry of the communication process' and using the language of drama, speaks of setting the stage for an 'information game' (Goffman, 1959, p. 8). His colorful language helps us to envision how social interaction is orchestrated. Reciprocity and symmetry or lack of symmetry, of the exchange, signals the attempt of individuals to consciously influence the way that the self is presented in social interaction, as a give-and-take with an awareness of the intent to affect meaning. The conscious effort to influence perception and project meaning lends credence to deliberateness of construction of identity. Goffman uses dramatological analogies in his descriptions of role performance and this will

be covered later in the section on role. As noted previously, identity and role are integral to one another and a discussion of one inevitably leads to implications for the other.

From the interactionist perspective, identity is socially constructed through a dialogue that works through and incorporates the world (McCall and Becker, 1990). Self and the society is derived from experience guided by a process that enables an individual to interpret meaning of social interaction in a 'nonautomatic' way (McCall and Becker, 1990, p. 3), by actively including the self as a participant in the flow of communications within the context of the immediate surroundings. The responses of others are considered and action is taken based upon what the individual notes within his world. The self processes meaning through interpretation of others responses and uses that to guide actions moving forward. The self is constructed over time, always changing, always evolving and acts with determined spontaneity. Depending upon the social interaction, joint lines of action may align for an enriched complexity of experience. 'Society is the process of Symbolic Interactionism' (McCall and Becker, 1990, p. 6). The fluidity of self may be conceived as autonomous in the sense that each social interaction perpetuates a self-directedness through an interpretative process, that is displayed as self, for others to see. The self has the choice of how to interpret meaning, how to act based upon that interpretation and how to represent self to others. This is a proactive cyclic process of making meaning of the world.

Self as Social Front

In his discussion paper on the study of the self-phenomenon, Zhao (2015) proposes a revised conception of the self, drawing on early writings to configure self and how the image of self is presented through social interaction. Drawing on the writings of Charles Cooley, William James and George Mead, Zhao proposes that the self as a social front is partly a product of the meanings that are interpreted from others (Zhao, 2015, p. 242).

Zhao posits that the social front may be considered as a mirror of personal identity because it is constructed through an interpretive process during social interaction (Zhao, 2015, p. 256). The way that an individual defines their self is partially dependent upon that person's interpretation of the way

he or she perceives what others think of him or her. This demonstrates the reciprocity of social interaction that can be broken down to a looped cycle; output of actions toward others within an environment, receipt of messages associated with actions, interpreted intake of meanings of those actions by self, and active output of responses, which trigger the ongoing cycle. Each cyclic loop of communication has the potential to alter or mold the social front, and in turn, the portrayed self. The context of the society within which an individual resides, frames the evolution of self and sets the stage for the individual to manipulate their social front with the intent to actively influence the way that others feel. In that sense, the individual is socially active in constructing the image of the self. A deliberateness of identity building is inherent within symbolic interactionism. Depending upon the interpretation, the mirror may or may not serve to promote resiliency in the face of others. Zhao proposes that to fully understand the self, an individual's attempts to influence the attitudes of others must be examined (Zhao, 2015, p. 256). Questions must be asked, as to what is it that individuals do to influence others, how do they act and are they always conscious of opportunities to mold others' perspectives.

As posited by Atkinson (Atkinson, 2015), the self is emergent out of the social interaction. In the tradition of symbolic interactionism, without the reciprocity of the social framework, the self lacks input of data to interpret and derive meaning. Without the social, the self remains unchanged, unresponsive and static. The human social encounter is the essence for the analysis of identity. Context of the interaction is the basis for analysis and reveals the fluidity and responsiveness of the self as an active participant in all things social.

Relational Identity

Much of the work on identity is related to the individual as a member of a larger group or organization, however, there is a growing body of work on identity that focuses on interpersonal relationships and how they impact identity and role within occupational settings (Sluss and Ashforth, 2007). Relational identity blends the identity of person-based identity with that of the role-based identity while integrating the interpersonal relational and offers a new framework of what is termed 'levels of self' (Sluss and Ashforth, 2007, p. 13). Sluss and Ashforth build on earlier work to define relational identity

and identification situated within a hierarchy and to construct a rich model of classification concluding with suggestions for future research.

Like symbolic interactionism, relational identity is constructed through a continuum of social interaction that integrates the identities of the personal, the role and their relational dimension within a feedback loop. It is a more robust version of identity that builds upon the consideration of both the personal and the role. Relational identity always considers the personal, as opposed to only the functional. Having relational identification may be thought of as a healthy 'oneness with the role-relationship' (Sluss and Ashforth, 2007, p. 16). Relational identity implies that personal and role co-habitate for a hardy sense of self.

Frequent contact between individuals increases personalization and minimizes likelihood of stereotypical interactions. The more that two individuals see each other and interact together, the more that they come to know one another personally as opposed to seeing each other as representative members of a larger group (Sluss and Ashforth, 2007, p. 16). This observation has implications for raising awareness and giving voice to who you are and what you do. Contact between individuals may initially evoke a role based identity but as time passes and individuals interact socially, their perception of one another may change and become person-based (Sluss and Ashforth, 2007, p. 17). Exposure to others and carving out opportunities for social interaction with others, increases personalization and may minimize marginalization. Increasing transparency of social interaction, may enhance authenticity and maximize social relations based on experience. Real world social experience breaks down stereotypes and permits opportunities for genuine relations.

Perspectives on role-relationships temper social identity theory and offer a more holistic perspective on workplace identity and identification (Sluss and Ashforth, 2007, p. 27). Individuals who are members of a group which is not widely known may initially experience perceived tension from others who see them as part of a collective that is not known conventionally. Frequency of social interaction may serve to transcend the role and personalize the relationships. The significance of this perspective

lies in the potential to foster personalization of social interactions with the intent to influence role expectations associated with the constructs of identity and role.

In their inductive analytical study, supported by a grant from the National Science Foundation (NSF), Kootnz and McCabe (2015), interviewed a sample of sixty-eight university students from Midwest University in the United States. The interviews consisted of open ended questions and each two-hour interview was recorded and transcribed verbatim. Analysis allowed for identification of patterns and yielded themes about how friendship can impact both identity and role. Their purpose was to add to the evidence on identity work by studying the element of friendship as an integral part of the social network that frames the construction of the self and the process of constructing self-identity through identity talk as 'friendship talk' (Kootnz Anthony and McCabe, 2015, p. 65). This has implications related to the importance of friends as a subset of others in boundary work and the way that identity is crafted within the framework of symbolic interaction. Much of the social communication that is between colleagues, is also between friends. That social reciprocity within the professional network, that occurs among individuals who also happen to be friends, is one vehicle for sustaining and maintaining resiliency of identity. Three strategies were identified as envisioning self, betterment distancing and situating with networks (Kootnz Anthony and McCabe, 2015). Creating identity is framed by social interaction with others, some of whom are friends, which may in turn, also offer a sense of resiliency. The next section is about the dilemmas that may be associated with identity development.

Dilemma of Expectations for Identity

Identity dilemmas are defined as possession of identities that conflict with one another and result in a loss of valued identities (Dunn and Creek, 2015, p. 261). When considering the work of identity, there always exists the potential for a discrepancy in the expectations of an individual or a group for another individual or group, at either the micro or macro level (Dunn and Creek, 2015). Discrepancy equates with the state of being incongruent and difficulties increase when the social scene involves stratification with implicit power and authority.

Dunn and Creek coin the term, 'lag', for the misalignment of expectations within groups (Dunn and Creek, 2015, p. 261), which becomes increasingly prevalent given the complexity of social interaction with the potential for intersecting cultural expectations. Negotiation may facilitate 'alignment' and

allow for a more congruent coming together within a complex social interaction (Dunn and Creek, 2015, p. 261), although empirically it may not be possible. Unmet expectations are a product of the relational work of constructing identity and may be conceptualized as a stigma (Dunn and Creek, 2015). Once again, expectations are more likely to be met if individuals or groups foster communication that increases exposure to one another and offers opportunities for social interaction. Misalignment of expectations in social interaction and the experience of identity dilemma is a challenge to maintaining a sense of feeling valued about self. Making the unknown known is part of constructing identity, taking responsibility for constructing social front in the face of cultural and intersecting expectations is a process that can mature with conscious effort and with time.

Using travelers accounts, a conceptual framework for the experience of identity was examined to describe 'the flayed self' or the incongruent images of self; the way that an individual perceives self as compared with the perceived image of self as reflected back from others (Husting, 2015, p. 215). The flayed self is described as the image one has of self that is unlike the perceived image reflected through interaction with others. That zone that occupies the space between the self and those reflected perceived images can be a source of tension. Husting describes a phenomenon that is displayed by travelers to foreign countries and cultures that are unfamiliar and do not support the contextual native identity. It is not so difficult to expand this conceptual framework of identity to terrain that is professionally unfamiliar. The analogy of travelers to foreign countries might be just as applicable to those who are traveling in new professional territory.

Husting draws an association between identity or who we are with location or position and where we are, drawing on the work of Tuan (1977), to relate the impact of place with sense of belonging. Using semi-structured interviews with twenty-two participants, journaling over four months from eleven of the twenty-two participants and supplemental travel blogs, an incompetent identity was described and used to create a map of the flayed self (Husting, 2015, p. 215). A sense of place as home is aligned with stability and familiarity, but it is the archive of memories and relationships that are reflected in home that are central to identity. Familiarity breeds comfort and home is associated with stability. Frequency of transparent social interactions and the act of making the unknown, a known entity, can impact the outcome of social interaction, by constructing a pattern of familiarity over time, that builds relationships where identity can thrive and be competent. Reflecting upon dilemmas that may be

associated with the construction of identity, next it is relevant to examine identity development within the context of the professional nurse.

Search strategy for Review of Nursing and Identity

The systematic search of the literature examining identity, was performed online through Library Search using Cardiff University Library Collections. It began with a broad scope using the key words of identity and social interaction, additional search terms were used to focus the search including nurse and further narrowing by adding professional development. Focusing the search included limiting publications to peer reviewed journals in English between the years of 2010 to 2017. The number of citations were screened to a total of 170. Each title was screened for relevance which brought the total number of citations down to 32 and upon a review of abstracts, the total number of relevant papers were seventeen. Additional papers were found by reviewing the reference lists of full text papers. As a member of the Society of Symbolic Interaction, the author has access to the archives of the International Journal of the Society for the Study of Symbolic Interaction. Books on social construction of identity and symbolic interactionism had been a continuing source of interest since early in the investigation, from authors such as Blumer, Goffman and Hughes. The relevance and the enduring contribution of these authors to the development of identity served as primary sources of literature, often referenced by authors in journal papers. Publications will be reviewed here beginning with broad, general topics in sociology, to a concentrated focus on nursing. This first section on identity is about the social construction of identity, the social front of a professional occupation.

Professional Identity and Nursing

In their theoretical discussion of professional identity Johnson et al (2012) cite the paucity of literature examining the construction of professional identity in nursing. They define a professional identity pathway that is life long and examine factors that contributes to the understanding of a nursing identity throughout the course of a nurse's career. Acknowledging that professional identities are constructed through socialization, the pathway begins prior to formal nursing education and then continues through educational experiences in formal teaching, training and clinical practice. Mentors provide further socialization and the transition to practice offers challenges as nurses adapt to changing technology and advances in the field of practice. The authors recommend the use of

longitudinal approaches to investigate how nurses develop a professional identity over time with a focus on the role of education.

Professional identity in nursing incorporates a level of expertise dependent upon and reflected in both education and experience. Gobet and Chassy (2008) have proposed a theory of expertise that combines the constructs of expertise and intuition with an emphasis on clinical perception and problem solving. Based upon the Template Theory (TempT) (Gobet and Chassy, 2008, p. 133), they propose that perceptual patterns, analytical thinking and long-term banking of templates, that are constructed over time, and socially integrated with recognizable patterns, trigger the development of clinical perception intuition associated with clinical areas of specialty. Varying levels of complexity of patterns enables acquisition of templates that may be linked by similarity and association. Template theory explains the development of expertise in domains such as science. Five key features of Template Theory as applied to nursing include rapid perception, lack of awareness of engaging the process, holistic understanding, intuition is normally correct and it can be colored by emotion (Gobet and Chassy, 2008, p. 134-135). While this theory has implications for education, it helps to explain the unique analytical skill exhibited by expert CWOCNs during wound assessment. Intuition is linked cognitively to expertise as part of professional identity.

Identity is multi-dimensional, complex and as the familiar and often used phrase '*the art and science of nursing*' implies, is a combination of perception that may be both objective and subjective.

Professional nursing identity may be an area for consideration within gray zones, respectful of the contextual complexity. As Tyreman posits, 'there is no identity in isolation; identity only has meaning in relation to a community that recognizes that identity and agrees on its meaning' (Tyreman, 2011, p. 114).

Social Identity and Nursing

The tradition of Symbolic Interactionism helps us to understand nursing, the influences on identity, public image, and the future challenge of healthcare leadership. Each of these papers addresses

nurses and nursing within the context of being social; the geography changes, but the identity is consistent.

Everett Hughes wrote extensively on the study of self within the context of work. Part III in a collection of papers (Hughes, 1971) looks at Work and Self and includes a paper on Nurse's Work. Hughes posits that when an occupation is on the journey to becoming professional, that group engages in the work of studying what it is that they do, how they do it and the larger scope of the organization within which they reside. At the request of the American Nurses Association (1951), Hughes wrote a commentary that was published in the American Journal of Nursing; that commentary acknowledges and praises nursing for the courage to address their work and examine their job.

He states that when nursing or any occupation initiates that process of self-examination, it must be done by framing it, identifying them from those who surround that group and differentiating the 'frontiers' on their edges (Hughes, 1971, p. 312). He describes that zone of their work, what makes them and what they do, different from others around them as the 'frontier' between nurses work and work that other people do (Hughes, 1971, p. 312). At the same time, he advises that by this act of establishing the geography of self within the context of frontiers, there is the potential for both cooperation and conflict. Hughes goes beyond the mechanical concerns related to the functionality of the jobs that nurses perform to the social framing of the job. Beyond the list of tasks that are done, Hughes asks what is the glue that bundles those tasks together that is key. Tasks change, and Hughes speaks to the re-sorting of tasks in the process of professionalization. Location and social context change on the frontier, but what designates and differentiates nursing skills as cohesive and that makes nursing a profession. That information comes from those who are immersed in the work experience, the nurses themselves (Hughes, 1971, p. 312). Jobs or social roles can be configured as part of the identity of the individual, with the most appropriate people to write these stories are those immersed in the performance.

Using symbolic interactionism as a theoretical framework in their analytical study of professional identity set in Sweden, professional identity was described as an experience and feeling of 'being a nurse' (Öhlén and Segesten, 1998, p. 722). Identity was described as an interpersonal phenomenon with both subjective and objective elements. Interviewees also echoed thoughts on the invisibility of nursing. 'We are doing a job. And we are doing a pretty good job, but we have been invisible. That has to do with identity.' (Öhlén and Segesten, 1998, p. 723). Speaking to the way they see themselves, the

subjective element, and the way that others see them, the objective element, congruence between the two was identified as the grounding for professional self-image. Invisibility limits the potential for congruence. To label these perceptions as subjective and objective is misleading, they both stem from social interaction and the perception of meaning through interpretation, by self. Terms were used in a blended way throughout this paper, which sometimes made it difficult to differentiate and follow the concepts.

As part of their work related to the Nurses of America (NOA) project, Buresh and Gordon (2006) identified a remarkable lack of nursing voice in the public world. In their reference to the legacy of nursing narrative over the years, their descriptive language shifted from speaking of invisibility and visibility to 'silence and voice' (Buresh and Gordon, 2006, p.4). Their label for what began as a template for nursing in the nineteenth century is the 'virtue script' (Buresh and Gordon, 2006, p.33). That script, emphasizing virtue as opposed to knowledge, has endured and contributes to the stereotypical image that is still perpetuated today. In order to construct a credible image of nursing identity in the public today, they advocate for nursing to give voice to the complexity of what they do as part of the larger scope of health care delivery. The lack of public presence is compounded by the problem of distorted symbolic representation about nursing. When stereotypes prevail, social interaction, the reciprocal synergistic communication begins in an unbalanced way when a public world is uninformed about the reality of nursing work. In order to tip the scales in their favor and to balance the professional playing field, nursing must become vocal to facilitate social interaction. They recommend that nursing present themselves boldly and lay claim to the agency of their special knowledge and skills. By engaging confidently in social interaction, deliberate communication about self with others may change the meanings that evolve from face to face interaction.

In their examination of how the public image of nursing may in turn, influence individuals self-concept and professional identity, Hoeve and colleagues (Hoeve et al., 2014) identified 18 relevant studies published between 1997 and 2010. Content analysis was conducted to systematically identify the main characteristics based on the terms public image, self-concept and professional identity. Themes identified include work environment, education and career choice, traditional values, culture and gender, caring and identity and performance (Hoeve et al., 2014, p. 298). They concluded that the

public image of nursing lacks clarity and perpetuates misconceptions about the essence of nursing, what nurses do and who they are. Here social front may be a synonym for public image. In response, they call for nurses to raise awareness, add clarity about their roles and to be bold in their social interaction and communication to deconstruct stereotypes. Inherent to their discussion is the responsibility of nurses to take up the challenge of voicing who they are, making transparent their skill sets and leadership potential. Public image, work environment, work values, education and culture are all factors that influence self-concept and professional identity. Implications for practice include addressing empowerment and identity in nursing curriculum, while seeking out visibility in leadership roles.

Body work

Somology may be defined within the practice of nursing as a 'composite perspective' that is complex, developed from what is regarded by nurses as clinically relevant, and is both person related and contextually bound (Lawler, 1991, p. 216). In her work on somology, Lawler (Lawler, 1991) discussed nursing's occupational identity and how it is processed within society, both internally and externally of the traditional patient care realm. Because of the historical invisibility of what it is that nurses do, their legacy of invisibility impacts the current and future status of their perceived occupational identity within the larger society. The importance of social interaction to the role that nurses' play and the significance that is derived from that interaction with others, underlies the lived experience of nursing.

Importantly, invisibility is linked to the nature of their interactions. The social interaction in which nurses engage with their patients involves doing things with and for others; that might be considered contextually inappropriate if done outside an environment of professional caregiving in medical facilities. If an individual did not require caregiving support, these activities would be done by the self and in private. The specifics of the activities that are performed as part of their role are associated with the body, bodily functions and other areas such as sexuality, that may be considered taboo. The nurses' identity is integral to their role and the functions that they perform. Therefore, when talking with others who are not in the field of health care, nurses have historically not shared much of their everyday experience. That has led to a lack of knowledge about the work that nurses do. Lack of knowledge and the unknown, stifle communication and understanding impede the reciprocity of

communication. Regarding the identity of nurses and their status in society, as Lawler states, 'Its meaning to others is integral to our own personal being' (Lawler, 1991, p. 226). For nurses, the social interaction regarding sharing of employment related topics is challenged when their identity is an unknown to others. The reciprocity and synergy of interaction poses a challenge to identity and is a reflection of the society that does not speak of the body or of the work that nurses do.

Embodiment of nursing practice is the topic of a discussion grounded in nursing and sociological texts (Draper, 2014). However, repositioning it as central to person-centered practice, from an area of neglect to one of informing both education and research is key. Like Lawler, Draper sees the body as central to not only practice, but to the construction of nurse identity, lending congruency to a person-centered approach. Here again, is the dichotomy between bodies of knowledge as subjective and objective, with suggestion that the objective or scientific medical model has eclipsed the embodied subjective way of knowing.

Interactionists have often left the body and physical experience out of the discussion of self (McCall and Becker, 1990, p. 12). The challenge is to insert somology into the exploration of nursing identity when that identity hinges on the problems of embracing the body. The question of how to talk about the practice of nursing has now extended beyond the bedside. How to elevate that argument to the next level, by accommodating nursing within a broader social domain beyond the bedside is a more complex endeavor and requires further investigation.

Ownership of Professional Nursing Identity

In her review of observational studies, Allen (2007) set out to identify bundles of activities that describe what it is that nurses actually do. What she found was that in fact, what nurses do is incongruent with the professed image of the hands on bedside carer who devotes time to emotional relationship building with patients. Rather than administer direct care and build relationships with patients, nurses have constructed a wider repertoire of skills that testify to the ability to navigate healthcare systems, to maintain functionality and drive quality in the midst of chaos and complexity. The actual process outcomes that compose their skill set have become the leadership tools that will enable them to more fully embrace their scope of practice. The discrepancy lies between what they do and the perception

of what it is that they are believed to do. Importantly it is these leadership qualities of nurses and their skills in facilitating the healthcare system that are not acknowledged or recognized as their actual practice. It is imperative that nursing acknowledge, give voice to these skill sets and own them as key aspects of their identity.

In contrast, Latimer (2003) poses an approach to structuring identity by examining how practice is associated with nurses' socialness. This is a fresh way of thinking about the 'occasions for nursing' (Latimer, 2003, p. 232). By invoking symbolic interactionism combined with terminology associated with performance of identity from Goffman, it is the broad recommendation related to how to go about nursing research (Latimer, 2003). Latimer (2003) suggests that one way to know about nurses' identity is to investigate identity within a broader scope of practice, to get 'inside nursing' (Latimer, 2003, p. 234), beyond the context of direct patient care, to investigate other social interaction.

Traditionally, patients are the materials for performance of nurse's identity, while the zone of performance is at the bedside. Examining identity must involve broadening the boundary of practice to investigate new relevant geography, new context to enable an understanding of who nurses are and what they do. The question becomes when the bedside is no longer relevant, and practice is expanded to other fields and areas of focus, what then becomes the material for performance and how is the new geography identified. Might that material be unique skill sets applied in new clinically relevant context that reflect the complexity of health care?

In a personal narrative on identity, Lindsay (Lindsay, 2006) reveals that being a nurse is something she reflects on daily, but looking back to her early training, she realizes that she experienced a dilemma in her identity. Her dilemma was associated with the role she was trained for and the role that she actually played. She felt that the expectations of her training were contextually incongruent with the role that she felt she had to perform as a nurse in a hospital. She felt that the role she was trained for was not a good predictor of the role she subsequently was expected to play. The expectations of her training were unmet and she felt tension by what she perceived to be incongruent expectations of the two social situations. In her case, she felt that physicians held a position of power and she was forced to interact with them in the hospital according to their expectations without regard for her own professional expectations. She felt that the relational identity between herself and her physician colleagues was incongruent within the context of a hierarchy that she perceived as dysfunctional.

Macintosh (2003) performed a grounded theory study to explore nurses' professional development, the problems that they experienced and how those problems were addressed. The sample of twenty-one participants included experienced registered nurses who were graduates of diploma education programs and had worked for several years before enrolling part-time in post basic nursing baccalaureate programs. They had each worked for between 3 to 34 years and lived and worked in both institutions and the community in one of three eastern Canadian provinces. Using open-ended interviews, Macintosh developed a social model of re-working professional identity, which she constructed as a process involving three stages; assuming adequacy, realizing practice and developing a reputation (MacIntosh, 2003, p. 730). Three contextual factors may influence the process; expectations, perceived status and supportiveness (MacIntosh, 2003, p. 738). Expectations factor into the broad scope of professionalization, while perceived status reflects how individuals feel they are perceived by others. The question arises, that if professional expectations are the basis of actions, do those expectations have an impact upon social interaction with others, and is there the capacity for consciously manipulating the outcome. If so, then that premise illustrates a responsibility of self for actively processing relations. Social interaction is integral to the process of constructing professional identity and constantly evolves, by the intent of those social individuals. The next and final subsection looks to the future of nursing identity, how it is framed for the future and what might be some considerations moving forward on the journey of professionalization.

The Future of Nursing Identity

The social identity of nursing is addressed in a commentary by Tzeng and Yin (2007) when they call for a revolution in the nursing community to engage in new language and terminology related to nursing. They see the potential for conflict that may arise due to the tension between the way that a nurse perceives self and the 'distorted' occupational identity that is often formed or demanded in clinical practice (Tzeng and Yin, 2007, p. 187). In response, they posit that change in terminology is one way to enhance the perceived professional image of nursing and as such they propose a new term, 'Nurstry', as a label to designate the occupational identity of nurses (Tzeng and Yin, 2007, p. 186). This is more rhetoric than substance, but fosters a dialogue on the relational identity of nurses.

As explored within this review of literature, identity and associated terminology is discussed and referred to in multiple ways, such as professional, relational, role-related, person-related. Concepts of

occupational identity, self-esteem, self-image and role are all related to professional identity (Öhlén and Segesten, 1998). In consideration of each dimension of the concept, social relations and social interaction frame each discussion. Regardless of the dimension, identity is not examined as an isolated or solitary concept, the social empirical world sets the stage for identity talk. Within the framework of symbolic interactionism, all identity is contingent on a social context.

Terms often lack clarity in published evidence, including self-concept, career, or occupational identity (Johnson et al., 2012). Slight nuances in terminology may be manifest depending upon the theoretical or conceptual framework. Lack of standardized definitions accepted by all fields of study may contribute to lack of clarity, yet this dilemma is inherent to investigation that is conducted and read by audiences with multiple perspectives and conceptual framework. Resolution lies within ensuring transparency of definitions built into each investigation. Johnson and colleagues present a professional identity pathway and define self-concept as the way we think and feel about ourselves, while professional identity is a component of overall identity and augmented by 'position within society' (Johnson et al., 2012, p. 563). Career and work may be selected to suit our self-concept, here intertwining the discussion of identity and role. Some nurses report transitioning their workplace in response to events in their professional lives (Johnson et al., 2012). Referring to socialization as integral to construction of professional identity, nurses' expectations may not be met and may foster feelings of tension in the face of incongruent expectations. In fact, those changes in expectations influence professional identities and may factor into legitimacy of new roles.

This section has laid a foundation for thinking about the evidence on the first emergent theme of identity. The review of the social construction of identity helps to inform how that body of literature is reflected in identity building for nurses. The clinical relevance of the evidence informs the data analysis of the emergent themes. The next section will examine the literature on the second emergent theme, Role.

Section Three: Literature Examining the Nursing Role

Section three of the literature review acknowledges the close relationship of identity and role. Much of the literature discussed both identity and role and due to lack of clarity or a blurring in the use of terminology, identity and role were in some cases used interchangeably. However, here, the literature has been separated between the two themes based upon the study and findings. The differentiating factor to locate evidence within role appears to be the relevance to the discussion of the professional facet of role, or the professional part played within the context of society. The first subsection is about the way that role in general is informed by social interaction. This is a review of the general concept of role in the tradition of social interaction and includes role sets, social mechanisms, professionalism and identification. The second subsection reviews literature that focuses on roles within the domain of nursing.

Role Informed by the Tradition of Social Interaction

The writings of Goffman provide substance for grounding our understandings of role, both the definition of role and the way that role is applied to an individual and groups. For Goffman, his conception of role is constructed around the perspective of the theatre, the analogy of a theatrical performance and his language employs dramaturgical references and analogies. Interaction is defined as the 'reciprocal influence of individuals upon one another's action' when face to face (Goffman, 1959, p. 15), while a performance is defined as 'all the activity of a given participant on a given occasion which serves to influence other participants' (Goffman, 1959, p. 15). Regarding the reciprocity of social interaction, Goffman describes the 'symmetry' of communication as a kind of 'information game' (Goffman, 1959, p. 8).

Three focal points are relevant to the investigation of role; expectations held by the person living a role, the role as a social front that is presented in social interaction and the 'rhetoric of training' associated with roles (Goffman, 1959, p. 46). An individual who possesses or embodies certain characteristics associated with a role and claims that role, has expectations for others to treat him or her with the value associated with that role. There is an associated moral obligation of society to attribute the associated value and meaning attached to a particular role to an individual who lays claim

to a role (Goffman, 1959). If during the course of social interaction, the person playing a role does not experience a valued response from others, then that is an occasion that may provoke feelings of tension for the individual and reveals an incongruity of expectations surrounding social interaction. Associated with each role is a social front, defined as 'the expressive equipment of a standard kind intentionally or unwittingly employed by an individual during performance of role' (Goffman, 1959, P. 22). A front may consist of a wide range of characteristics or qualities such as the setting surrounding it, the appearance, clothing, posture or manner of speaking associated with the role.

In the context of what that means for nursing, there may be expectations associated with a social front and for roles such as nursing, the front may be ambiguous due to the lack of visibility surrounding the role, for example bedside nursing or emerging roles such as nursing within industry. Some roles have a high degree of specificity regarding the 'rhetoric of training' (Goffman, 1959, p. 47). Qualifications, regulations, certifications and competencies may all be included as elements of that rhetoric, with the intent to create a boundary that sets that role or group, apart from others. Regarding nursing, that rhetoric may have layers of complexity or may vary substantially depending upon the educational background and training. This inconsistency of the rhetoric of training within nursing may be a source of confusion to others. The lack of visibility of nursing, combined with the complexity of nursing's rhetoric of training serve to contribute to a social front that may lack clarity for non-nurses. To gain insight into the ambiguity associated with social front, an investigation of roles, role sets, relationships and the social mechanisms, that frame the social front is essential to gain a level of transparency. When transparency is achieved, congruent expectations for social and professional interaction become possible.

Role Sets and Social Mechanisms

An individual performing a role in a single social status is like the hub of a wheel with an array of role relationships radiating outward and associated with that role. Any role carries with it a spectrum of relationships that influence the way in which roles are experienced by the occupant of the role. Role Set is defined as a 'complement of role-relationships in which persons are involved by virtue of occupying a particular social status' (Merton, 1996, p. 113). The way that a role set is engaged depends upon the social interaction of the self with others and is impacted by the legacy of the past and the current experience of socialization. The role set is the aggregate network of role relationships

associated with a role as a single social status, rather than relationships associated with multiple roles; that is an important distinction. In a demonstration of the complexity of social structure, each social status has a role set that is accompanied by a suite of role relationships that defines the network associated with that social status (Merton, 1996, p. 114).

Five social mechanisms are identified as determinants of how role sets affect the social structure (Merton, 1996, p. 116-121). These mechanisms include the relative importance of status, the varying degrees of power among the role set, the observability of role activities and conflicting demands and the mutual support of individual status-occupants. Social mechanisms are inherent to the social structure and influence the expectations of members of the role set. They impact how the individual performing the role or the status occupant, experiences and manages social interactions within the role set. Even if all social mechanisms are functioning the role set may still not be operating at a level that maintains a balance to facilitate efficiency (Merton, 1996, p. 122). Observability or visibility of a role is integral to the functionality of that role set, both in terms of the quality of the role set and the impact on social interaction. Sharing of status and role jurisdiction cannot be operationalized without visibility of the role. Balance, coping, tension and conflict are all potential outcomes that may be experienced by the status occupant, depending upon how expectations are perceived.

Roles and Professionalism

As was apparent in the literature on identity, language and terminology may influence role expectations and may be perceived as symbols that represent professional status. A characteristic aim of any occupation may be to turn itself into a profession (Hughes, 1971, p. xviii). Nursing is on a path to professionalization. There is a precedent for the evolution of professionalization, roles are examined by those who are living the experience (Hughes, 1971, p. 311). Descriptions of the roles performed, and the work done, are set within the context of the work and the surroundings of where it is executed. Investigation of organizations looks at work, not just as functional tasks but as the social roles that are performed and associated with expectations. These descriptions often reveal work being done on the periphery at the 'frontier' (Hughes, 1971, p. 312). Frontiers are described within the contextual interface on the periphery, by those who are pushing the boundary. As an occupation expands, the context of the role changes as the frontiers migrate. The roles and the individuals who perform roles are the essence of the identity of the profession.

Social Identification and role relationships

Social identification within an organization, may be defined as 'oneness with or belongingness to a group' (Ashforth and Mael, 1969, p. 34). Social Identification Theory (SIT) orders the social environment and is the topic of a paper by Ashforth and Mael (1969) as it applies to organizations. It enables individuals to be positioned in roles, geographically within that social environment. The frequency of references to geography and location in the discussion of role are sign posts of the concept of social ecology, an application of the concept of physical mapmaking in the earth sciences to society. They (Ashforth and Mael, 1969) posit that individuals tend to define themselves, their identities and their roles, using their position within their world as a reference point to various organizations. Identity and role are significant determinants of group affiliations within and between organizations and the boundaries that separate them.

Sluss and Ashforth (2007) suggest that identification of self is essentially based upon social interactions in role relationships, the reciprocity of meanings and comparisons between oneself and others. The definition of self is on three levels of identity; individual, interpersonal and collective. They equate SIT with interaction based upon group prototypes that tend to be depersonalizing as opposed to personal characteristics and they view roles within SIT in terms of expectations based on position within organizations (Sluss and Ashforth, 2007, p. 18). Relational identity and identification are grounded in person-based identity and role-based identity of each individual in a role relationship. A typology of relational identification is a composite of both individuals within the role set and may indicate either relational identification, ambivalent relational identification or relational disidentification (Sluss and Ashforth, 2007, p. 19). Relational identification may be considered as either particularized as in the context of between two individuals or more generalized (Sluss and Ashforth, 2007, p. 19). This concept of relational identification adds the potential for an element of personalization, a blend of the person and the role. Over time, with frequent contact and interaction, relationships may become more personal. Acknowledgement and recognition of interpersonal attraction and role transcendence also distinguish relational identity from social identity, providing for the transition from generalized to particularized and the closeness that may evolve in relationships over time with more frequent interaction (Sluss and Ashforth, 2007, p. 17). Sluss and Ashforth see the structural functionalists, those who advocate social identity theory and the symbolic interactionists as complementary, both yield

reciprocal interaction of individuals, systems, structure and process (Sluss and Ashforth, 2007, p. 12). Framed by symbolic interactionism, meaning of identity is always evolving through the social reciprocity of communication rather than expectations.

Role relationships that occur between a subgroup of an organization and that larger organization are affected by being nested within that larger organization. Social ecology and the pervasiveness of location are determinants of the functionality of social mechanisms. Nested groups are challenged to identify with each other, despite of and because of the position of one as a subgroup of the other (Ashforth and Mael, 1969, p. 30). Expectations may be experienced as congruent or incongruent depending upon the functionality of social mechanisms. Incongruent expectations are an output of dysfunctional social mechanisms, or at best mechanisms that are not fully optimized. Bias and conflict may exist if expectations of the nested group are incongruent with the larger organization. Social distancing, negative stereotypes may become contagious (Ashforth and Mael, 1969, p. 32). 'Wisdom is little more than the ability to remember the lessons of previous identities and integrity is the ability to integrate and abide by them' (Ashforth and Mael, 1969, p. 31). The very existence of groups paves the way for conflict and the authors call for future research on the boundary issues surrounding group insecurity and the tension expressed through groups' efforts for legitimacy (Ashforth and Mael, 1969).

Thus, for nursing, like other professions, roles are socially constructed and framed by the context of their everyday reality. Depending upon the visibility of their social front, the functionality of their social mechanisms impacts the expectations of others and influences the structural integrity of their role. At a micro level, relations between individuals may become more congruent over time with increased frequency of interaction. For nurses, increased professional interaction has the potential to clarify expectations and build more personal and functional relationships. For nurses in industry, the synergy of their role relationships is affected at a macro level by their geography of being nested as a subgroup of the WOCN Society. Being nested poses potential challenges to boundary work and may impact their efforts at legitimacy. Defining their role, effectively relating to their role set and establishing their boundary are all part of their professional project. Their unique space in a zone at the margin of their territorial practice, has expanded the scope of practice and they are processing a new role set that no longer incorporates the patient, but a new domain of others. The next section focuses on understandings of role and the body of evidence found in nursing.

Roles and Nursing

All of the evidence above on role and role sets, relationships and the functionality of the social mechanisms has implications for nursing. Now on to examine the evidence on how nursing is experiencing the work of self-examination of their role and how they are establishing their professional status and developing a social structure that facilitates growth.

Role tension was a key issue that emerged within a qualitative study examining job satisfaction among community health nurses. Designed to learn about how they experienced their roles and job satisfaction, Participant Action Research was conducted with six focus groups, content analysis was performed and three emergent themes were struggling for identity, valuing autonomy and seeking recognition (White and Kudless, 2008). The primary concerns of participants were centered around role issues; role strain, blurring and ambiguity. The participants expressed concern related to how others saw them and whether they were perceived as autonomous and independent practitioners by others. They felt tension within their role set. There was consensus on recommendations to address issues surrounding role that called for a nursing 'voice' within their system and this action was dependent upon the engagement of a nurse leader (White and Kudless, 2008, p. 1083). To achieve their goal, the action plan focused on development of a career ladder and recruitment of a Nurse Leaders. Role and the quality of the role set is of primary significance, with an overlap into boundary work, especially the implications of social interaction with blurring of roles and perceived ambiguity.

In a paper that addresses development of a new role, the clinical nurse leader, seven individuals offer their stories about their unique experiences as they were embedded within an organization as clinical nurse leaders (Poulin-Tabor et al., 2008). A major medical center and an academic university located nearby collaborated to construct the role and the appropriate training and didactic experience to prepare individuals for the role of the clinical nurse leader, over time. That clinical nurse leader role is engaged as clinician, outcomes manager, client advocate, educator, information manager, systems analyst, risk anticipator, team manager and lifelong learner. Despite the complexity of the role sets, system processes are identified, and multi-disciplinary approaches are taken that support collaboration with an emphasis on being patient centered. A background of clinical experience, an

educational program targeted to identified needs and a role immersion that facilitated relationships, all contributed to the success of the program. The cohort concluded that the implications of this role are that they can achieve a balance of evidence based practice and safe patient centered care. The flexibility and broad scope of the role is applicable to other practice settings beyond the hospital, given the full commitment of the organization. They envision this as a way to redefine their professional role to fill the needs of a complex healthcare system that they feel is in crisis (Poulin-Tabor et al., 2008).

In an examination of the premise of caregiving as the historical precedence of professional expertise, Allen examined the professional contributions that nursing is making in the health care environment (Allen, 2014). Forty nurses were purposively selected and shadowed as ethnographic interviews were conducted, for an average of eight hours with each participant. The purpose was to identify roles, twelve were initially identified. The typology of categories include process-based roles, service-based roles, nurse specialists and trouble-shooting roles (Allen, 2014, p. 132). Allen posits that organization be reinstated into the professional nursing mandate, which is appropriate because of the complexity of the skill set that is necessary to ensure high quality care.

Conducting intensive observation and interviews, as part of an ethnographic study set in a Canadian mental health unit in Canada, Salhani and Coulter (2009), investigated interprofessional relationships with a focus on the nurses' role in expansion of professional jurisdiction. The setting was one unit of a 368-bed urban psychiatric hospital. They address medical dominance, gender and the scope of nursing practice. Political strategies and struggles within the interprofessional work environment centered around issues of autonomy, interprofessional roles and program delivery. What they state began as a political analysis of power, ended with more questions than answers and revealed a struggle by nursing to increase collaboration within the mental health system in their unit.

Draper (2014) calls for a refocus of embodiment in nursing practice, which has been displaced by dominant scientific and medical ways of knowing about the body. Her discussion paper addresses what she calls the 'heart of nursing' (Draper, 2014, p. 2236). Reframing the Nursing role as embodied engagement to make meaning of experience based on touch, body boundaries and place (Draper,

2014, p. 2239). She concludes that the lived experience of embodiment in the role of nursing and the identity of nursing is increasingly important given the focus on outcomes measures and promoting higher standards of care.

This third section of the literature review includes evidence on nursing roles and reflects a variety of study methods from participant action research to testimonies of clinical stories, to ethnography, that are reflective of the importance of context to role performance. The ambiguity or clarity of role perception in nursing surfaces as impactful for role sets. A broad systems approach to the concept of role that focuses on engagement with others and embraces collaboration has implications for the functionality of role, whether the context is acute care, mental health or community care. Visibility of role and the commitment to ownership of role and the unique skill set that is nursing, enables role to be operationalized across practice settings. Relations among role sets may be optimized and more personalized with increased frequency of interaction. Being resilient and reaching out to others who may be unfamiliar with a new role because it is being performed in a new context, increases the likelihood of improved relations and a more functional social structure. Autonomy and power reside in role as a lived experience when the role occupant owns and makes transparent the skill set that enables social mechanisms to maximize relationships.

This section has laid a foundation for thinking about the evidence on the emergent theme of Role. The literature was reviewed on the general concept of Role and then, evidence was presented with a focus on Role in Nursing. The next section of the Literature Review will examine the literature on the emergent theme of Boundary Work.

Section Four: Literature Examining Boundary Work

Section Four of the literature review is organized around the literature on Boundary work. Due to the complexity and overlapping of the subjects, it becomes increasingly difficult to designate completely separate bodies of evidence. However, this review focuses on the social construction of boundaries and how they are created, the concept of space and place, boundary making and spanning, human ecology and the fluidity of boundaries, and the capital expenditure and concludes with literature associated with the significance of boundaries in nursing.

Boundaries and the work of constructing and maintaining them have a place in the making of a professional entity and influence the roles of individuals within it. Boundaries facilitate identities and roles and create visible bounded communities, places where individuals share membership and derive a sense of being distinguished from others. The boundary lines that distinguish an entity, imply perceived feelings of being inside and outside, while carving out a place that is home to some, while foreign to others. Boundaries are important to this study because of the experience of the CWOCN as role and identity is situated within the context of new professional territory. Reviewing the evidence on the work of establishing boundaries will inform this study.

Social Construction of Boundaries

Boundary work was originally proposed as a way to differentiate between the realm of science and non-science (Gieryn, 1983), was described in association with the public image or the social front, presented to others. Conceptualized as a way to frame the professional status of scientists, it became associated with the relative autonomy and perception of the in-group as opposed to those outside. Those who were designated to be within the newly established territory or place, were favored as scientists, as opposed to those situated exterior to the boundary who could not lay claim to the expectations of the ingroup. Within those bounded groups were claims to special knowledge and skills in addition to the regalia that symbolize that knowledge and do the work of maintaining the demarcation of the collective. Creating boundaries might be considered as a means to an end, that

end being professional autonomy with expansion and monopolization of authority (Gieryn, 1983, p. 789).

Application of the concept of maturity to boundary work adds a dimension of scale along a continuum (Montgomery and Oliver, 2007). Boundaries that are mature accomplish a goal of creating a domain of residence. Conducting two longitudinal case studies, Montgomery and Oliver (2007) yielded a model of networking to show the ways in which boundaries of social organizations are constructed. They propose a four-stage process model, drawing on Social Identity Theory. The model begins with social awareness. It moves to strategic efforts aimed at socially organizing and interacting with others, evolving from symbolic to defined social boundaries of membership in a domain, while eventually being concerned with the process of domain maintenance (Montgomery and Oliver, 2007, p. 665). This model offers a way to gauge the maturity of the boundary line and is a way to gain insight to the professionalization of the organization and its members. Boundaries may be conceptualized as multi-dimensional, fluid and malleable through social interaction. Without the demarcation of distinct boundaries, framed as both symbolic and social, activities such as boundary spanning would be a challenge and the case is made that without construction of boundaries, a social entity cannot exist (Montgomery and Oliver, 2007, p. 662).

Space and Place in Boundary Work

In any discussion of boundaries, the topic of spatial relations arises. The symbolism of place and space carry significant meaning in social interaction, where place may be associated with designated boundaries that are familiar, while space is perceived as strange, more abstract and less well defined (Tuan, 1977). The designated boundary between place and space is a zone that challenges the social mechanisms of differentiation along a continuum. That zone is structurally co-dependent and shares borders (Tuan, 1977, p. 6). Those individuals or collective groups who operate within that fluid zone may be engaging in risky business when boundary lines are drawn. Those who are working on the frontier of their profession may be those who are willing to take a risk. They may be individuals or communities who are able to thrive in the early phase of establishing a boundary, when boundaries are not mature (Montgomery and Oliver, 2007). Those lines beg for definition, establishment and maintenance, while sustainability is a constant for the future. The degree of demarcation between place and space may be examined in social interaction of individuals and groups and is relevant to

human ecology when investigating identity and role in boundary work (Tuan, 1977, p. 6). Mapping of territorial boundaries fluctuates to reflect an evolution of the perception of place and space. As those lines move, they symbolize a transfer of perceived balance of power based upon experience as individuals or groups expand to reflect a new frontier. Venturing beyond the security of place as home to the periphery where place becomes space means acting on courage and being willing to take a risk. That act of taking a risk conveys meaning about the individual or group who is actively living that experience, about their spatial consciousness (Tuan, 1977, p. 104). The individuals who choose to engage in roles that establish new boundaries have chosen to chart new territory while constructing new role expectations. Part of the work of establishing new boundaries is associated with constructing a social front for professional interaction. The construction of those new role expectations implies a responsibility to make them visible to others.

Boundary work and Boundary making

An expansion on the concept of boundary work is boundary making, blurring and maintenance, which are all ways of understanding the process of evolving boundaries (Liu, 2015). Establishing boundaries and maintaining them is part of the process model proposed by Montgomery and Oliver (2007), but blurring of boundaries is another dimension for consideration. As boundaries are configured along continuums; blurring implies a degree of ambiguity (Liu, 2015). It is proposed that making, blurring and maintenance are all elements of boundary evolution (Liu, 2015). Jurisdictional conflict may employ any of these mechanisms to legitimize professional space. Incorporated into the process of establishing and maintaining boundaries is the potential for blurring that can occur if the reciprocity of communication allows for overlapping of the specialty knowledge, skills or accoutrements of each entity. While constructing boundaries, there is a reciprocity and exchange of power and resources between individuals (Liu, 2015, p. 4).

Symbolic boundaries designate things, people, groups or objects into specific geographic locations that serve to selectively organize the environment according to the associated power (Lamont et al., 2015). There is some association between these designations and the accoutrements used to symbolize entry into professional organizations; all influence the social construction of identity and the way that relatedness of groups influences the perception of self. The early discourse (Gieryn, 1983) has been

generalized beyond the application to the field of science. The labor associated with Identity and role work embraces exploration of how and why groups differentiate themselves, relative to one another. In this revision of his earlier work (2001), Lamont speaks to the necessity of symbolic boundaries as a precursor to the more objective boundaries, while supporting the argument that they are co-dependent.

The domain of boundary work is multidimensional and encompasses not only the establishment of but also levels of ambiguity or clarity and the maintenance of boundaries, which is helpful to the discussion of the professional work of nurses in industry and beyond; indeed anywhere the context of practice is expanding to role sets that are on the margins of practice. Any discussion of expansion necessarily involves peripheral practice. Symbolic boundaries support the designation of a social front and make it visible to others outside of those in the periphery.

Boundary Spanners

Boundary spanners may be perceived as emerging leaders; being in a position of spanning boundaries and bringing collectives together through collaboration was perceived as being more positive, trusting and more likely to lead. Greater physical presence and face to face interaction in social relations did have a positive influence on the potential for leadership (Fleming and Waguespack, 2007). Echoing the findings of Sluss and Ashforth (2007), that frequency of contact and interaction increases the probability of personalization and decreases the tendency to stereotype, Fleming and Waguespack (2007) found that opportunities for increased visibility and face to face encounters did reflect positively on authenticity of interaction. Manipulation of social capital is one way of influencing boundary work.

Brokers, those who bridge the gap between disconnected others, occupy positions where they sit at the 'crossroads where knowledge and other resources flow' (Tasselli, 2015, p. 865). Since knowledge and reality are socially constructed, to be a broker infers a strategic positioning at the intersection of boundaries where connections can be built across networks. An individual who is able to broker and locate at strategic intersections, is perceived by both entities with trust. In his mixed methods study of knowledge transfer at the micro-level, Tasselli (2015) concludes that being an effective knowledge

broker depends upon a unique positioning, intra and interprofessionally, within social networks but is further facilitated by the perceived characteristics of the individual broker as being both motivated and legitimated. In his investigation of 148 professionals within a hospital in Italy, he found that brokers may be considered as mediators, trusted by both individuals or groups on either side of the knowledge gap. Social interactions by individuals who span boundaries are significant to the overall outcome of being able to make connections and act as a conduit of knowledge. The reciprocity of human and social currency flows when the social networks are optimized and the mutual give and take is framed within the context of trust.

Those who construct boundaries may perform in roles such as brokering or spanning and may be perceived with increased levels of trust and legitimacy, which has implications for nursing. Those who are active in bridging gaps between individuals and collectives are positioned as mediators to facilitate the reciprocity of social interaction and bodes well for nurses who are able to collaborate and act as conduits in educational roles and interprofessional collaboration. In nursing, these individuals are perceived as leaders.

Human Ecology and Geography

With an interest in boundaries, Hughes observed their fluidity and used the term human ecology as a way to investigate how groups thrive or diminish as manifested by boundaries (Hughes, 1971, p. xi). He employed a term used by geographers to refer to the way in which 'species compete for group survival in the absence of fixed boundaries' (Hughes, 1971, p. xi). 'Human ecology was to be a view of things that would keep on the lookout for the frontiers . . .' (Hughes, 1971, p. xvii).

The concept of fluidity and the way that boundaries evolve is applicable to nursing as roles expand the scope of practice. Evidence shows that terminology and language can be a powerful way to frame practice and applying language of geography and the concept of being a pioneer takes on meaning to the journey of nursing. Context and social structure are embedded in the evolution of role and identity in nursing. The following subsection examines the literature on boundaries as they are relevant to nursing.

Boundary Work within Nursing

This subsection reviews evidence of research associated with the boundary work performed by nursing. Observational studies on work bundles are explored while case studies are used to demonstrate how care pathways can be interpreted as facilitating communication for collaboration.

In her review of a decade of observational studies as a way to understand what it is that nurses do, Allen (2007) speaks to the work of brokering boundaries as one of the skill sets that nurses have become adept at. As integral to the bundles of work that nurses do, they are skillful in working through the flow of chaos in health care, being flexible, and facilitating boundaries as mediators.

Allen's qualitative case study of the development of a care pathway is designed around her consideration of a care pathway as a boundary object (Allen, 2009). She posits pathways as a boundary concept that loosely facilitates interaction and reciprocal communication interprofessionally. Pathways are framed as a space where intra and interprofessionals can come together, without compromising their individual identities, more or less a zone of neutrality. Her descriptor of the pathway as representative of a 'zone of agreement between social worlds' has the potential to bring together multiple stakeholders with conflicting agendas (Allen, 2009, p. 355). This model represents the complexity of the social worlds and the way that position, identity and role all co-mingle to facilitate action by professionals upon the same stage. Using this concept enables a contextual scene where stakeholders from distinct groups, representing their own worlds, can come together and negotiate collaboratively without perceiving a compromise of their own unique identities. While performing for a common goal, individuals from different social worlds can retain their unique identity while contributing to the overall goal. The participants were able to align their interests with manageable tension, span the boundaries that might otherwise separate them and do work that achieves a common goal of delivering a process for patient care.

Ethnography is implemented in a mental health unit in Canada to investigate boundary work and the political implications for nursing. Role transition is examined in the context of one ambiguous nursing service. Intensive observation and interviewing for political analysis, was conducted in a mental health

unit within an urban metropolitan hospital in Canada. It was performed with the intent to investigate the boundary work of nursing to extend their professional lines of authority as they negotiated the complex interprofessional dynamics of nursing and medicine (Salhani and Coulter, 2009). Issues with professional jurisdiction framed the way that intra and interprofessional conflict was experienced, with tension between medical and non-medical professionals but also within professional nursing structure. Tension was demonstrated as feelings of being marginalized and treated 'like an outsider' (Salhani and Coulter, 2009, p. 1226). The authors implemented a political analysis looking at roles through the lens of power struggles and the strategies used to establish jurisdiction as part of the nursing professional project. The significance of the struggle for power was led by elite nurses who were able to engage their nursing community in successful collaboration to organize and establish authority within their professional nursing boundaries. As they concluded, they offered up more questions than answers with their political analysis. What is significant is that the thought process on boundary work is engaged in by nursing and perception of how authority and power can be brokered through leadership.

Currie and colleagues performed a qualitative study examining nurses delivering genetic services (Currie et al., 2010). This work is highly relevant to the way that individuals and groups of individuals see themselves while at the same time, how they see the relations and the difference between themselves and others. The overlap to boundary work is conspicuous as this study was undertaken to examine role transition of nurses to a less boundaried position, one of increased ambiguity. Of interest, is a finding that movement into and out of traditional roles which are culturally conservative are associated with less tension while movement in and out of less bounded, novel roles may be associated with risk (Currie et al., 2010, p. 953). This finding poses a question into the relevance of what is considered traditional and the effect that the associated meaning of tradition has upon role transition. The question becomes how does the meaning of tradition impact the social mechanisms and the expectations surrounding roles. In the language of boundary work in nursing, what is considered traditional and the context of the role, impact the experience of the nursing professional structure. The perception of the social front by others and by those within the group, can affect perception of authority.

The evidence in this section illustrates the conceptualization of brokering boundaries and how it applies to nursing and the way that nursing skill sets support the social interaction of nursing and frame them as leaders for collaboration. Boundary work is applied to professional nursing roles associated with the context of power and how the dynamics of interprofessionalisation can be manipulated to impact the jurisdiction between nursing and medicine. A gap in the evidence surrounding the role illustrates the need for investigation. I identified the potential insulation of the cultural identity of this group (Merton, 1996). Hughes spoke of 'frontiers' as societies grow and establish new territory with connections to the old (Hughes, 2009, p. xvii). The space that these nurses are practicing in is a frontier and it is not yet established as a legitimate practice for a nurse, their social front in industry is hidden from other nurses (Goffman, 1959, 27). This study of their professional and personal experience set out to understand how these nurses see their role, their experience of career mobility, the contextual meaning of their role and their contribution within industry. The next and final section will review the literature on the theory of nursing work.

Section Five: Literature Examining the Theory of Nursing Work

This final section of the literature review will present literature associated with the theory of nursing work and will focus on professionalisation, the emotional labour involved with the work of nursing and the new roles being implemented and the implications for the future. It builds upon the literature previously presented in the earlier four sections and brings together a convergence of evidence that is relevant to the core of nursing work.

Professionalisation

Like other occupations as they mature along a continuum of professionalisation, the status of nursing is evolving. Several issues surrounding organization and jurisdiction of boundaries, internally and externally, complicate the issue of professionalisation, along with the complexities of the healthcare delivery system within the United States and globally. Inherent to the discussion are the historical roots of the profession, the implications of gender, relationships and interaction with other professions and the lack of clarity regarding regulation and hierarchy of the status of nursing.

When evaluating the status of professionalism, there is a call to take into consideration the place of practice, the setting where nursing is practiced with a special emphasis on nonhospital environments (Wall, 2013). Boundaries of jurisdiction are fluid as professionals test the markers and navigate in and out of new spaces. Roles are dependent upon the context of employment and inform the domain of professionalism, yet identity may transcend settings and be associated rather with a knowledge base or a skill set. The self-employed nurses interviewed described themselves as 'always a nurse, first and foremost a nurse' (Wall, 2013, p. 981). As one nurse so aptly described, 'It's not the tasks we do. It's how we inform the experience . . .' (Wall, 2013, p. 981).

Addressing legitimacy of nursing work and demarcation of boundaries, Pearson calls for a re-thinking of role boundaries with renewed relevance at this time of interprofessional healthcare reform (Pearson, 2003). Nursing work that has already been described as 'invisible' by Buresh and Gordon, is declared as being ambiguous by Pearson, who notes a professional obsession with defining exactly what falls into the definition of nurses' work. Framing an argument around the significance of nursing knowledge that informs experience as opposed to an enumeration of specific functional tasks, sheds light on the holistic nature of the body of work and nursing knowledge. Elements such as

coordination of care, managing the bureaucracy, leadership and clinical judgement are suggested as being some of those invisible attributes (Pearson, 2003).

In support of the argument for re-conceptualizing the profession, the term re-professionalisation has been coined (Law and Aranda, 2010). They posit that the ambiguity surrounding the role of nursing does a disservice to the profession by attempting to pigeon hole attributes of a role. The continuing rhetoric surrounding the hierarchy of nursing degrees, drives tensions surrounding boundaries and in light of the evolutionary nature of the profession, they suggest a provisional perspective and a post-nursing discourse (Law and Aranda, 2010).

Taking a very different stance, pursuing the logic of professionalism with a focus on either specialist or holistic expertise, highlights the status of functional tasks and whether those tasks are claimed or discarded within legitimate jurisdiction (Kessler et al., 2015). It appears that roles, boundaries and associated tasks are the building blocks of claims to professionalism, while scope of practice is perhaps best served by addressing knowledge base and skill set, which are very different.

A thought-provoking focus of interest is how the practices of reflection impact on the concept of professionalism in nursing. Professionalism is at its core, experiential and incorporates social interaction with others. '... in order to be a nurse, there needs to be another' (Binding et al., 2010, p. 593). Social interaction and being with others in context is integral to professionalism and to acknowledge others, reflection in and about the moment presents opportunity for more authentic engagement, enhancing professionalism. It is posited that reflection is a conceptual skill that impacts practice and as it is honed, it is a component of the expert skill set of a professional and indeed is a challenge to the model for nursing education (Binding et al., 2010).

A quantitative explorative cross-sectional study of 780 nurses from Slovenian hospitals identified values and competencies that contribute to evidence-based practice (Skela-Savič et al., 2017). They conclude that by strengthening professional values and knowledge base of competencies, there can be expansion of the potential for and implementation of evidence-based practice. In their self-reported sample, using previously developed scales, they found a gap between the traditional role played by the participants and the conceptual values and competencies of professionalism. A deficit of education and training related to professional values and competencies had an impact on evidence-based practice and professionalism. They posit that these findings are significant drivers for the education of nurses and for the nursing association within their country and have the potential to

expand everyday practice to reflect a professionalism that is currently under resourced (Skela-Savič et al., 2017). Thus, an investment in values and competencies may contribute to enhanced professionalisation.

This literature shows there are areas of contention and debate ongoing as nursing proceeds along the continuum of growth to professionalisation. Left sorely unaddressed in the literature is the risk of moving beyond the zone of patient interaction in nursing. The concept of engaging with others in the context beyond the zone of patient care is an extension of professionalism for nursing as boundaries are spanned and new geography is explored. Emotional labor and emotional intelligence as they relate to professionalism and role development will be reviewed in the next section.

Emotional Labor

This subsection will review literature on emotional labour and resilience, while also addressing emotional intelligence. Emotional labour was initially defined, associated with the airline industry, as the effort invested in managing one's own emotions and those of others with the implication that during worktime, those emotions are commodified (Hochschild, 2012). The term has been generalized to apply to service occupations, including healthcare and nursing and associated with the caring role (Riley and Weiss, 2016). Conceptualization of emotional labour has been modeled as both surface acting and deep acting, and may indicate the incongruence of feelings and expressed behaviors (Badolamenti et al., 2017). Emotional labour is associated with cognitive dissonance when the feelings differ from the outward facing expressions of behavior during social interactions (Delgado et al., 2017).

Emotional labour has been associated with three characteristics; face to face or voice contact, the production of an emotional state in another by a worker, and the regulation of emotional activities of workers (Gray, 2009). Emotional labour may also be categorized as being therapeutic, collegial and instrumental (Delgado et al., 2017). Regardless of the designation, emotional labour is about being social and cannot be experienced without others in social interaction. It is proposed that the legitimacy of emotional labour as an expert skill extends beyond the zone of patient interaction to the zone of professional interaction with colleagues and clients.

One literature review of emotional labour that included twenty-seven papers, used a narrative approach and found two main themes, emotional labour strategies and emotional labour antecedents

and consequences (Badolamenti et al., 2017). A prototypical model was adapted and identifies positive consequences of heightened well-being and personal growth, when strategies are effective (Vilelas and Diogo, 2014). Emotional labour was identified as a multidimensional, complex concept, representing a nursing competence to provide the best care and is often associated with the domain of caring in nursing, a concept that is difficult to quantify and may not be routinely acknowledged. In addition, emotional labour is difficult to quantify financially, the empirical cost of emotional labour is high and does eventually have an economic impact on care delivery if it results in outcomes such as nurse burnout. It is this financial accountability that may drive support of recognition and attention by organizations.

Nurses have a high awareness of the experience of emotional labour as a professional competence, but it has also become part of the invisible cloak that nursing is shrouded in with both positive and negative impact on resilience (Sawbridge and Hewison, 2013). Emotional labour is often associated with a gendered influence and invisibility (Gray and Smith, 2009). The ability to acknowledge emotional labour, and to engage skills competently in ways that positively impact on social interaction may be identified as a component of the expert skill set employed by nurses.

As service workers, nurses perform roles that involve significant emotional interaction within the zone of patient care, but there is evidence that emotional labour extends beyond that immediate zone to involve colleagues and co-workers (Riley and Weiss, 2016). An interesting point in the discussion comes with the differentiation between emotional work and emotional labour, but this may be an unnecessary distinction since it is the same skill set being employed. The term work is being associated with sourcing from within individual space without compensation, while the term labour is sourced from within an organization in exchange for payment. The context of framing for compensation is proposed as the distinguishing factor (Hochschild, 2012). The competencies associated with emotional labour are part of the skill set, it is the framing of contextual interaction that differs and adding a new term may add unnecessary complexity.

Recommendations by a 'think tank' called for systems to support nurses while acknowledging the impact of emotional labour on daily work experience (Sawbridge and Hewison, 2013). If nursing embraces the concept of a caring role, within and outside of the zone of patient care, and simultaneously embraces the premise that emotional labour is a competency within the skill set, it follows that training, education and systems of support should be structured to strengthen that

competency, especially in light of the reciprocal aspect of being able to appreciate the satisfaction associated with emotional labour (Riley and Weiss, 2016) (Karimi et al., 2014). If left unmanaged, emotional labour may be a source of stress and tension, while if acknowledged and cultivated, emotional labour can become a source of professional satisfaction and well-being.

Managing emotional labour and increasing competency in that skill set may involve several strategies. Concepts such as emotional intelligence, critical companionship, clinical empathy and being reflexive are each closely associated with emotional labour (Gray and Smith, 2009). To address the complexities of emotional labour, it becomes necessary to explore the ways that emotions are experienced on a scope that involves all members of the role set. Competency in emotional labour involves a social philosophy that is flexible and reflexive, to facilitate interaction that can respond to the complexities of healthcare delivery (Gray and Smith, 2009). Discussion surrounding exploration and management of emotional labour necessitates that emotional labour no longer be tacit, but rather that it be claimed among the competencies of the core nursing skill set and become a visible asset (Gray, 2009).

Resilience is recognized as a protective mechanism associated with emotional labour and can be developed and nurtured as a skill (Delgado et al., 2017). Defined in many ways, resilience may be considered as an energy force with both internal and external factors. Training and education on resilience building activities and interventions have the potential to impact on how emotional labour is experienced and training on both external and internal factors can promote resilience. Training on external factors may incorporate social networking, resources, role modeling and supports within the workplace, while training on internal factors focus on attributes such as sense of self, flexibility and adaptability (Delgado et al., 2017). Each approach to professional development seeks to achieve the goal of managing emotional labour in a positive way that enhances social and professional interaction. The result being that the negative effects of cognitive dissonance are minimized, and social congruence is maximized to yield emotional labour that is professionally healthy.

The emotional nature of nursing work is addressed by Kelly (Kelly et al., 2016), which recognises that nursing work has both an emotional and a physical aspect and that duality is experienced as social interaction within a zone of caring for the patient. When nursing is conceptualized as a profession that provides a service, the labour involved then is more easily conceived of as a commodity of social caring (Kelly et al., 2016, p. 112). The professionalism of that commodity is routed in the knowledge base

and expert skill set. The supportive effect of resilience is closely linked to nurses' health and the emotional aspect of nursing labour as roles are performed (Kelly et al., 2016, p. 114).

The literature shows that emotional labour is integral to the skill set and competencies of professionalisation. It is implicit that any service profession, including nursing, that interacts with others, claims as part of its skill set the attributes of resilience and the ability to engage confidently in social interaction through emotional labour. Maturing along the continuum of professionalisation leads to the expansion of roles and boundaries being explored. This next subsection of the theory of nursing work will review literature on the applicability of this discussion to new roles in nursing.

New Roles

As professions, including nursing, adapt to the changing healthcare environment, not only do the existing roles adapt, but new roles evolve to respond to emerging needs. These new roles are a result of individuals and collectives of individuals who begin to interact with others in new ways to fill those emerging needs. The journey along a continuum of professionalisation demonstrates not only the adaptation of existing roles, but also the development of new roles. A growing body of nursing literature addresses the diversity of new roles and how they are a response to the complexity of healthcare.

One of the new roles is categorized as a clinical nurse leader, who is described as a point of care coordinator (Lammon et al., 2010). The skill set of the clinical nurse leader is described as incorporating leadership, risk analysis, outcomes analysis, and quality management, while driving evidence-based practice. The clinical nurse leader has a graduate level of education and combined with core competencies, that role is responsible for clinical decision making within an interdisciplinary environment. In response to demands of increasing diverse patient population, the clinical nurse leader role is seen as a champion of cultural competence and human diversity (Lammon et al., 2010). It is and continues to be a process of integration for this new role. Acceptance by organizations and nested within the larger nursing society of which it is a part is strategic, hinges on education and is a collaboration between academia and the practice setting.

Acceptance of these new roles within the larger professional collective is a slow process and exemplifies emotional labour. Although the need for these professionals may exist, the role is not necessarily viewed as a solution. Emotional labour is part of the equation for face to face interaction,

while the approach with colleagues is collaborative to achieve a good fit for interprofessional harmony. A qualitative descriptive study of twenty-four new clinical nurse leaders found that clarity surrounding the role was strategically important to their integration into an existing organization, while internal organizational support was key to maintaining the role and their working relationships with colleagues (Moore and Leahy, 2012). Taking a cue from a wider professional lens, marketing of the role with a heightened awareness of the work done, paved the way to set expectations and gain acceptance.

A case study of the implementation of a new nurse practitioner role identified similar findings to those about clinical nurse leaders, and detailed three concepts that impacted on how a role is implemented; the intention, those involved and acceptance by others (Sangster-Gormley et al., 2013). Once again, competencies associated in domains related to emotional labour are found to be clinically significant. Relational identity, the association of increased exposure to a new role, and heightened awareness of that role by others, can influence the perception of value by others, if there is a foundation of authenticity and transparency. Building and strengthening relationships also support the social mechanisms that enable members of role sets to know and appreciate competency. Face to face interaction in a new zone of practice aids the contextual perception of roles; strategies, antecedents and consequences are linked.

A qualitative study of the role of community matrons in England engaged with healthcare professionals, patients and caregivers to explore the factors that influenced how the role was embedded within the community (Randall et al., 2015). In this study the invisibility of the role within the community was one factor that effected how the role was embedded and supported the need for strategic pre-planning. Another key factor was the clarity or lack of clarity surrounding the introduction of the role. It also demonstrated how the role involved spanning the boundaries of other professionals in the community to identify a gap and fill a need. Embedding a new role is an evolving process over time that necessitates executing the competencies of emotional labour, to achieve a level of professionalisation.

In line with the previously noted IOM Report (2010) and the changing face of healthcare legislation in the United States, the focus of care has expanded from simply providing care to managing health, leadership demanded change (Berg and Dickow, 2014). The Nurse Role Exploration Project, in addition to addressing education and practice, also reconceptualized the roles for registered nurses in response to identifying gaps in provision (Berg and Dickow, 2014). Strategies for success included

engaging stakeholders, convening advisory panels and seeking funding to ensure responsible solutions. The field of nursing has acknowledged that competently engaging with other professionals also meant implementing their expert skill set including emotional labour, in order to lead to roles beyond direct patient care. This journey on the continuum of professionalisation continues to lead to new roles in care coordination, academia, informatics, community centered care and primary care partnerships. To do this, it meant strategizing and delivering a unifying message that was visible and clearly communicated, not only within nursing but to others who are connected within these new role sets.

From an international perspective, new roles have been met with mixed results, at least partly in response to the way that these roles are introduced to the larger healthcare community. Investigation of jurisdictional establishment and legitimacy, case studies within the NHS Acute Hospital Trusts, found that standards and statutory regulation needs to be accompanied by an examination of how new jurisdictional boundaries come about and how they are established, implying the process is instrumental and needs to be better understood and critiqued (Maxwell et al., 2013). Themes that emerged included relationships, support for new roles, personal characteristics and receptivity to change, along with professional, specialty, organization and relational identity. Competency in the skill set associated with social identity as referenced earlier, impacts on role implementation, as an evolving process. Setting the stage with social mechanisms that introduce and guide expectations, monitor engagement and continually seek a balance with stakeholders is critically important to establishing social congruence. Identity and role, emotional labour, intelligence, the art and science of performance all impact perception of legitimacy.

Upon review of the literature on the theory of nurse work, it becomes apparent that this profession is on a complex journey of professionalisation. There is a growing body of evidence that supports an evolution along a continuum of maturity. Continued examination is warranted, in order to consider the ambiguity and lack of clarity with both internal and external facing of nursing. Taking ownership of what is our unique knowledge base and expert skill set, making calculated decisions as to strategic paths forward and promoting nursing as a leadership force, are all steps to be taken as part of the journey of professionalisation. As with any living maturing collective, change is slow and requires significant commitment, dedication and passion. Examining self can be an excruciating task, as expressed by a participant later in this study, but it yields a bounty of experience.

This literature review has provided a foundation for this study by examining the literature on WOCN as a nursing specialty, identity, role, boundary work and the theory of nursing work. Each concept has been considered in a broad sense and in a way that is focused and relevant to nursing. These concepts are all emergent themes within this study and the evidence on conceptual background will support and shed light on the methodology, the analysis of findings, the discussion and the implications for the future. The second chapter will present the methodology of this study.

Methodology

Chapter Two

This chapter is about the methodology, the methods conducted and the rationale for implementing methodology in this study.

This qualitative study is an investigation of the culture of nurse specialists who are certified in wound, ostomy and continence care, have practiced their specialty at the bedside, and who are now employed in industry by medical device manufacturers or distributors in the USA. It is framed within the context of the larger professional nursing society with a focus on ecology, defined as an approach to understanding identity and role within their socially constructed environment (Hughes, 2009).

These nurses are situated within a complex environment that is not well understood by those outside of their group. This study examines the cultural knowledge of the members and how they are establishing a new boundary of practice. It is about understanding the identity and the emerging role of this group of nurse specialists and how they perceive their reception by and their impact on the wider field of nurse specialists in this area of expertise. An examination of the literature demonstrated no documented evidence examining these nurse specialists. A purposive sample of Certified Wound Ostomy Continence Nurses (CWOcNs) who now work in industry in the United States was selected from my professional network, to conduct two methods of data collection; one focus group (n=7) and a series of six semi-structured, in-depth, individual follow up interviews. Audio and visual recording of the focus group and audio recording of each interview provided the raw data; all data was transcribed verbatim. Immersion into the data facilitated thematic coding that evolved through multiple iterations of interpretative analysis as a reflexive process (Srivastava and Hopwood, 2009). This qualitative study was originally envisioned as an ethnography guided by Symbolic Interactionism, to explore and describe the identity and the role of a group of nurse specialists. Due to methodological challenges as the project developed, it evolved over time to become a more broadly based interpretative qualitative study that yielded interrelated conceptual patterns.

Aims and Objectives

The aim of this study was to understand the professional identity of this emerging sub-culture of nursing specialists. As an insider, I decided to study my own professional group, because there is a lack

of documented evidence. This investigation aims to fill the gap in the evidence base of this nursing specialty, understand the impact of this emerging role within the institution of nursing and within the medical device industry and provide a platform for nurses to speak about their experiences in a safe environment. My aim is to understand the identity of these nurses, to understand their role and how they are integrating their professional role within the world of industry (Hughes, 2009, 314).

The aims of this study were to:

- Fill a gap in the evidence base of this nursing specialty;
- Identify the knowledge that is brought to this new role;
- Establish and understand this role within nursing;
- Define the professional boundary of this culture of nurses working within medical device industry (Hughes, 1971);
- Provide a platform for the CWOCNII to speak out in a safe environment while exemplifying a model for the future of nursing in industry.

Research Question

This study of CWOCNs employed in industry and their professional and personal experience sets out to understand how these nurses see their role, their experience of career mobility, the contextual meaning of their role and their contribution within industry. The findings of this research will inform understandings of their identity and the boundaries of their role in their practice setting. The investigation involves a series of probing questions to inform understandings of cultural experience through in-depth interviews and a focus group:

- What is the skill set, that is brought to industry?
- What is the contextual meaning and contribution of the role within the medical device industry?
- What is the territorial boundary of this new nursing geography?
- What is the professional ecology of this new geography?
- What is the experience of career mobility to a new geographical practice?

These are all integral questions surrounding the identity of this nursing culture. The answers lie within the subjective experience of the participants.

Overview/Rationale for a Qualitative approach

Methodology provides the rationale for why a researcher makes design choices (Kramer-Kile, 2012). A spectrum of choices is available when selecting a methodology. Initially the choice was the broad selection between qualitative and quantitative research methods. Qualitative research was the clear choice for me, easily distinguished by my chosen framework and the way the approach lends itself to my aim and my research questions.

Methodological coherence speaks to being sensitive to how data and the conceptual framework relate to the original research question (Kramer-Kile, 2012). Being coherent may lead a researcher to rethink the methodology originally chosen, which is what I have done. 'Emergent design' describes how researchers make ongoing decisions about design based on a learning curve as a study progresses (Polit & Beck, 2012, p. 487). What began as ethnography moved to interpretative qualitative research.

The interpretative approach is my overarching framework and the approach that I have used. Positioned here within the United States, broad interpretative qualitative research is now focusing on timely empirically relevant cases linked to research experience (Flick, 2009). It recognized the importance of embracing the subjective meaning of my participants with a broad interpretative lens on their social identity while being true to the aim of my research, a rich description of their culture and the knowledge they have constructed in their new terrain of practice. Within this interpretative qualitative research approach, my role as a reflexive investigator as an instrument of research is recognized, while maintaining a focus on the social experience and meaning of my participants (Creswell, 2007). I found that the interpretivist approach accommodated me by accepting my involvement as an instrument in the research process. Qualitative Interpretative approaches are inductive and begin with participants but allow for the researchers' interpretation (Scotland, 2012). Hybridization or the pragmatic use of methods as opposed to a more rigid prescribing way of implementing methods is evident in the interpretivist approach (Flick, 2009, p. 459). Following the choice of qualitative interpretative approach, a number of options were open to me.

Interpretivism

Interpretive qualitative approach recognizes self-reflective nature of research and the role of the researcher as interpreter of the data (Creswell, 2007). Exploring and describing a professional identity and role within the broad qualitative interpretive tradition is chosen as the most appropriate way to

accomplish the goal and the objectives of this study. I think of myself as a key instrument in this interpretive inquiry.

As put forth by Schwandt (1994, p. 119), interpretativism may take a number of approaches: interpretative anthropology, interpretive interactionism, or a version of symbolic interactionism. Interpretative anthropology as viewed by Geertz is more rooted in hermeneutical phenomenology and employed by anthropologists. Interpretative anthropology is often associated with grounded theory with more of a focus on the individual (Streubert and Carpenter, 2011). What I do find helpful is Geertz's use of thick description when referring to the cultural output of research in this tradition (Geertz, 1973). For me it is helpful to think about the goals of my research framed as thick and rich. Denzin begins with a Symbolic Interactionist approach with his Interpretative Interactionism or Interpretive Ethnography, but takes on a postmodern perspective with a focus on critique and marginalized cultures while anchored to ethnography (Flick, 2009; Denzin, 1997). I made the decision early on to reject the view of my participants as marginalized.

Theoretical Framework: symbolic interactionism

Symbolic Interactionism informs this qualitative study (Denzin & Lincoln, 1994, p. 10). Three guiding principles of symbolic interactionism frame this study: first, individuals act toward 'things' based upon the subjective meanings associated with them; second, these meanings are derived from social interaction and thirdly, these meanings are a result of interpretation (Blumer, 1969, p. 2). These principles help me to gain insight into cultural knowledge (Spradley & McCurdy, 1972).

The interpretivist approach that works well for my study is Symbolic Interactionism as put forth by Herbert Blumer who was greatly influenced by G.H. Mead. The salient aspect of symbolic interactionism is that the individuals of a culture act proactively rather than reactively. Those actions are contextually driven by the social circumstances of their micro and macro environment. Interpretation is inherent throughout the process of making meaning. The aspect of the individual as a social being, interacting with others, yet distinctly experiencing self-interaction is relevant. Finally, symbolic interactionism advocates going directly back to the social world being studied. Direct examination of the empirical world is relevant as is familiarity with that world, as I have described being a member of the nurse group being studied. The implications of the approach of symbolic interactionism involves four central concepts: people, the association of people in a process, the social acts both individual and collective and the complex interlinkages of act that make up an organization

(Blumer, 1969, p. 50). This conceptual premise provides a way to integrate the human experience within the social context as a way to facilitate my investigation.

Symbolic interactionism and its application within this study

The theoretical lens of Symbolic Interactionism frames the approach to investigating the identity and the role of participants (Emerson, 2011). The cultural identity of these nurse specialists is the knowledge that they share and that knowledge consists of all the elements within their world (Spradley & McCurdy, 1975). Part of the work of describing a culture is identification of those elements that make up their world, the meanings and symbols attached to them, and the complex way that they are organized within their environment (Emerson, 2011). That is the essence of my study, to understand the cultural knowledge of this group as evidenced by their stories about what is meaningful to them (Blumer, 1969).

To explore this culture, it is important to focus on the social experience of these participants, how they interact with each other within their network and how they make sense of their interactions with others outside of their culture. The way that people see themselves is a product of actions and interactions within their social environment (Bryman, 2008). Engaging with CWOCNIIIs is a way to learn about and understand how they see the people, the things, the events in their environment; and the meanings that are associated with them.

In carrying out this research, I had to constantly be aware that although I am an insider, this is not my story, it is the story of my participants. I acknowledge the differences that exist between my own perspective as an insider and theirs, while being aware of the critical nature of representing their stories of reality (Sandelowski, 2006, p. 10) (Denzin and Lincoln, 1994, p. 10). Today, more than ever, researchers are studying their own culture (Pellatt, 2003, p. 31). There is no substitute for familiarity with those being studied (Blumer, 1969, p. 39). However, through the conceptual framework of symbolic interactionism, the cultural identity of CWOCNIIIs is grounded in the empirical world of their experience and informs the interpretive analysis.

Methods

Exploration of the social group is not bound to any specific set of techniques (Blumer, 1969). The guiding principle is to 'get a clearer picture of what is going on in the area of social life' (Blumer, 1969, p. 41). The techniques may include direct observation, one on one interviews, documentation such a

letters and diaries, examination of public records, group discussions, case studies, panel discussions and use of conversations. While Blumer (1969) posits that it is not necessary to follow a pre-established protocol of techniques, he does state that exploration and inspection should include interpretative analysis along with descriptive analysis.

Focus group and In-depth Interviews

The methods or the specific means of doing the research that I chose, are the focus group and a series of semi-structured in-depth, one on one interviews. By choosing two different methods, I solicited data from a group of multiple individuals and from single participants and added the element of triangulation of data (Fontana and Frey, 1994). The two methods of data collection I used are generated in very different contexts and those contexts had significant impact on the outcomes and the quality of the data that I collected (Rubin and Rubin, 1995). Both methods are speech events to solicit data by setting a scene for guided conversations, but each is very different based upon the setting, the social context, the participants and the general approach to the speech event (Rubin and Rubin, 1995). The use of the focus group was a way to observe social interaction that would otherwise not be accessible, and interviews provided an opportunity to directly interact with the participants to engage in inquiry about the meaning of their role and identity.

Rationale and Sequence of Methods

In consideration of which technique to implement first and how they fit together, I made the choice to perform the Focus Group first, for three reasons. First, by gathering data within a focus group and experiencing what the group was expressing, I would then be able to learn from the group and enrich my approach to the one on one interviews that followed. The descriptive and interpretive analysis of the focus group informed the one on one interviews. I found that I did not wish to begin the interviews until I had completed a draft of analysis of the focus group. The second reason had to do with logistical planning. The best place to stage the focus group was just prior to the National Annual Conference which was scheduled in May 2014. Because each of the participants attended the conference, by scheduling the focus group on the afternoon prior to the Keynote Address, I could ensure the chance for highest attendance. Third, it offered me the opportunity to begin data collection with a panel of seven individuals as a springboard to produce significant volume of data and participant response.

Because of their inherently different approaches I will describe the theory and rationale of each technique separately along with their application to practice. Then I will address the descriptive and interpretative analysis of each method separately, to clearly distinguish how each method contributed to the overall findings related to the cultural knowledge of the participants. Documented textual data obtained from multiple methods maximizes the efforts in the field and enriches the stories of these participants and the construction of a unique interpretation of their culture (Atkinson et al., 2003). The goal was to understand the complexity of their world and by using two techniques, it was my intent to obtain a broader and more a richer description through triangulation (Fontana and Frey, 1994).

Overview of The Focus Group

Focus groups derive from two distinct traditions (Thorne, 2016). The first is related to academia, they were originally conducted to facilitate social change in South America and used to foster social reform (Thorne, 2016). The second finds its roots in North America within industry and used in market research. Focus groups were and are still used as integral components of data collection in marketing and media. The one thing that these traditions share is using focus groups as an approach that is interested in understanding group dynamics, to engage socially and to shed light on shared social perspectives (Thorne, 2016). Their essence is exploration of the social component of content, as opposed to the individual perspective.

A focus group is an event that engages individuals in discussion in an attempt to access information through group interaction (Polit & Beck, 2012). When focus groups are convened, the participants are invited to come together to discuss a topic of concern to an investigator. Those who are invited to participate may or may not know each other previously and probably did not have the opportunity to build a rapport (Rubin and Rubin, 1995). Depending upon the mix of personalities, participants may or may not be inclined to speak out due to the nature of the group setting and the fact that they may be in the presence of strangers. The output of the focus group tends to be pragmatic, due to the interaction and the overall need to sample multiple opinions from within the focus group (Flick, 2009).

More recently, in qualitative research, focus groups are used to bring individuals together who may be members of a homogenous group, to discuss an experience that they have or are sharing together (Polit and Beck, 2012) (Rubin and Rubin, 1995). The dynamics of the group provide for data that can be found within an interactive social setting (Flick, 2009). Beginning from an interactionist point of view (Flick, 2009), the focus group creates a social situation that allows participants to engage with one

another in a give and take flow with members feeding off one another to reveal an expanded discourse that might not have been an outcome of a one on one interview (Fontana and Frey, 1994). In the same vein, the opinions generated tend to represent diversity along a continuum. The focus group allows for individuals to 'spark off' one another, in a way triggering thoughts that otherwise might not have been expressed outside of that social context (Rubin and Rubin, 1995, p. 140). Within the context of this group setting, patterns and meanings may be observed from the social interaction and may be considered one of the strengths of this method (Bryman, 2008).

The focus group does yield rich data with a level of complexity that arises out of the social interaction and poses analytical challenges unique to the context of the setting, which will be discussed in the analysis section. As an approach, the focus group contrasts with and serves to complement the in-depth interviewing that engages with individuals in the context of a one on one experience.

Rationale for Use of Focus Group

My rationale for choosing a focus group was to gather individuals together, who otherwise would not have the opportunity to be all together at one time. I realized that it offered several benefits related to the process of data collection. By bringing together the focus group, I had created the opportunity to exclusively be a participant observer. I could capture the social interaction among the group while being able to observe the social dynamics. Although it was an event designed for my study, it set the scene to accomplish the goal of creating a performance stage for data collection.

The focus group was an artificial event engineered to allow me the opportunity to observe participants as a group, their behavior, their dialogue, and most importantly their social interaction with one another. I planned it to enable 'the here and now' for these participants (Berger and Luckman, 1966, p. 22) that would provide them a socially constructed cultural scene to share their stories and to interact with one another (Spradley and McCurdy, 1972).

Although the focus group was an artificial situation that I purposefully planned and not a natural occurrence, it had value as a contextual event for observation. It was appropriate in the sense that without it, the participants would not have had the chance to exchange ideas and thoughts. For the participants, this focus group was a community experience (Spradley and McCurdy, 1975). It was an engineered social situation, that was designed to be a cultural scene (Spradley and McCurdy, 1972, p. 27). Although it was not a 'natural laboratory' (Geertz, 1973, p. 22), it offered me an opportunity for fieldwork experience.

This event allowed for the social interaction between participants within a group setting, that would not happen unless intentionally planned. The event itself was intentionally created, but the communication that was facilitated is a product of the reciprocal influence of the individuals' face to face interaction (Goffman, 1959, p. 15). The comments, the feedback, the responses happened within the context of the focus group setting and provided important data. Because they work for various companies, some of which are competitors, the chance for them to commune together exclusively, does not happen. The focus group was a social setting engineered to allow a narrative exchange of social interaction; thoughts, feelings and opinions (Spradley and McCurdy, 1972). They came to the event to share and to hear what each other had to say. What they lack routinely is the situational context to be able to share as a group, they were provided that venue. This group is representative of a culture that is building a shared legacy of practice, defying physical separation in space, while sustaining a resilience that supports their professional bond.

Implementation of Focus Group

One focus group of seven individuals was carried out during the annual conference of the WOCN Society (2014, Nashville, TN). It was scheduled to last one hour from the time of introduction to closure; the video captured 75 minutes of activity. All logistical planning was performed approximately six months prior to the event. Working together with my professional organization (WOCN Society), I secured a function room for the event the afternoon prior to the Keynote Session of the Annual Conference.

A number of variables need to be addressed by the researcher during the planning phase of the focus group. Logistics include all arrangements for location and functions associated with the physical environment where the focus group will take place. Engaging a function room, planning any refreshments and notifying participants of the event are all details to be considered and acted upon. The associated tasks may be performed by the investigator or otherwise arranged and delegated to others. Regardless, of who performs the tasks, the investigator is responsible for addressing each of the logistical details. The researcher must manage the technical expertise required to capture the event as audio/visual recordings. Audio and visual equipment is placed so that all recordings are captured in good quality and preserved with back up. The investigator must think about how to introduce the topic and guide the participants through the hour or more of the discussion (Bryman, 2008). This process may be likened to the action of a conductor who facilitates an orchestration. The need exists to ensure that an even flow of communication ensues with engagement of all participants

in a way that permits all participants to offer responses, while steering the conversation away from more dominant members to others who may not be as assertive (Fontana and Frey, 1994). These details may be addressed by arranging for the technical assistance to perform the tasks or they may be handled directly by the researcher. Logistical planning is a complex task and requires much forethought.

Facilitator

During a focus group, the researcher who acts as facilitator may be distracted from the focus of what is happening during the event, due to multiple logistical demands (Rubin and Rubin, 1995). I chose to engage a professional facilitator to conduct the focus group for several reasons. I had no active role on the day of the event, other than to be an observer and a hostess. By not taking on the role of facilitation, I gave myself permission to disengage from those responsibilities and to be vested in being an observer for that event. The person I engaged as the facilitator was a professional and her expertise was known to me through previous business engagements. I sought her out because I knew that she was an expert in facilitation and she was skilled in interviewing of health care professionals. During a series of meetings, she was fully informed about the study, the questions, the objectives and the aim and I shared with her the Interview Guide (Appendix) I was preparing, to customize the flow for optimal dialogue. Even though I chose not to be the facilitator, I still retained the full responsibility for every facet of preparation and design to maximize the effectiveness of the event.

The participants all agreed to be video recorded for analysis of narrative and visual imagery. For security I engaged a professional for audio-visual taping of the event from beginning to end. Backup of the recording was done with two iPads and a laptop, in addition to the video recorder. By engaging a professional, I felt comfortable with knowing that multiple backup systems were in place and I felt confident that my data would be securely captured. The output recording was used for transcription and visual review.

Participants

The participants were all selected from my professional network of Certified Wound Ostomy Continence Nurses who currently work within industry. My inclusion criteria stated that prior to making the transition to industry, they had each worked at the bedside doing patient care within their specialty area. They each must have spent at least two years employed by industry, either a manufacturer or a distributor of medical devices. Certification in at least one of the three specialty

focus areas of wounds, ostomies or continence was requisite. To become certified, a registered nurse must have an undergraduate degree in nursing. The participants were approached by me, face to face, at professional meetings and conferences. I explained about my study and the word soon spread of my research. Individuals approached me to volunteer. I was able to select key participants who have access to what is happening and are willing to engage (Thorne, 2016).

The participants are summarized in the table below according to specific demographic variables. Each individual has been given a pseudonym to protect identity. The participants are mature individuals and range in age from forty-six to sixty-six, spanning a total of 20 years. Their years of experience in their specialty of wound, ostomy or continence care range from twelve to twenty-five years, with a combined total of 140 years. Their duration of time spent employed in industry ranges from two years to twenty years, with a combined total of eighty years. Geographically, they are from the northeast, the mid-west and primarily the south of the USA.

<i>Focus Group</i>	<i>Participant Name</i>	<i>Age</i>	<i>Years in Specialty/Industry</i>	<i>Geography</i>
<i>1</i>	<i>Iona</i>	<i>66</i>	<i>25/20</i>	<i>Alabama</i>
<i>2</i>	<i>Beth</i>	<i>62</i>	<i>25/12</i>	<i>New Jersey</i>
<i>3</i>	<i>Cate</i>	<i>67</i>	<i>15/9</i>	<i>Nebraska</i>
<i>4</i>	<i>Dora</i>	<i>46</i>	<i>20/2</i>	<i>Florida</i>
<i>5</i>	<i>Edith</i>	<i>54</i>	<i>12/9</i>	<i>Georgia</i>
<i>6</i>	<i>Fay</i>	<i>57</i>	<i>23/17</i>	<i>South Carolina</i>
<i>7</i>	<i>Gwen</i>	<i>58</i>	<i>20/11</i>	<i>Florida</i>

Running the Focus Group

The participants directly interacted with one another, in addition to responding to the facilitator. There was a level of rapport among the participants, before they even came together. Because they were purposefully chosen as members of an intimate professional community of nurses, they were all acquainted and some were friends. There was a sense of comradery among them, so they were likely to be comfortable with one another. This technique was well suited to gather individuals together to discuss a shared experience, their role and identity working in industry.

As I observed the communication flow the process became like ‘an information game’ (Goffman, 1959, p. 8), with one participant responding to another and a third or fourth member jumping into the dialogue. The focus group offered the participants a stage to share stories, opinions, knowledge and aspirations in a way that they are rarely able to do. Their experience of coming together from different companies to dialogue about who they are and what they do rarely occurs. Created as a forum for observation, the focus group had implications for myself and the group beyond that single event.

Investigator Journaling of Focus Group

During the focus group, I was free to write notes on the event, since my role was to observe. I did not have the burden of leading the group, so I could focus on observation (Sanjek, 1990). This set of notes was kept as an electronic journal of the focus group. This journal includes notes on the themes I identified, that I termed jottings, with observations and notes on comments made by the participants and the emotions in the room (Emerson et al., 2011). I also had a debriefing of the focus group with my facilitator and videographer, immediately following the focus group and I took notes during this session (Kvale, 2007). My field notes assisted me to frame the context of the event while offering me an opportunity for reflexivity.

During my writing my notes helped me to get back into the moment of the event. They were an important source during the writing process and I used them to recapture the nuance of a sequence, I found them valuable. They were a resource of both my immediate reactions and my thoughtful recollections and each time that I reviewed them, they offered me a fresh perspective on the event.

The preparation for and the implementation of the focus group informed my next phase of data collection. The collaborative work that I did to guide my facilitator prior to the focus group was helpful to me as I thought about and processed what needed to be done to meet the challenge of interviewing. The early analysis of the focus group data informed and helped me to refine the Interview Guide for the interviews. Being an observer of the focus group, I was able to gain the perspective of having experienced the social interaction that occurred among the participants, to see how the questions were responded to and to listen to the give and take among the participants. I was able to then sit back and reflect on the flow of dialogue, and to think about how I could use that experience to benefit the next phase of interviewing.

Overview of In-depth interviews

Creswell (2007) writes of interviewing in a prescriptive fashion as a series of steps, while Polit and Beck (2012) describe it as a data collection method in which an interviewer asks a respondent a question. Mishler offers a definition of interviewing 'as a discourse between speakers . . . in which the meanings of questions and responses are contextually grounded and jointly constructed by the interviewer and the respondent' (Mishler, 2009, p. 33, 34). He proposes four components that I have used to conceptualize my in-depth interviews. Interviews are speech events; their discourse is constructed jointly by interviewer and responder; analysis and interpretation are based on a theory of discourse and meaning; and the meanings of questions and answers are contextually grounded (Mishler, 2009, p. ix). Interviewing builds upon conversational skills, but when those skills are used within a qualitative research setting they are considered tools of data collection and go beyond simple conversation to a way of thinking and acting aligned with the qualitative research philosophy of listening to understand (Mishler, 1986). Hughes (2009) thought of interviews as a conversation, a major tool of social research (Hughes, 1971, p. xii). One element stands out, they are narrative events that involve at least two individuals.

The intent of a semi-structured in-depth, face to face, one on one interview is an approach used to collect rich data in a way that is flexible yet focused on a particular phenomenon (Polit and Beck, 2012). In a qualitative in-depth, semi-structured interview, the participants are encouraged to talk about a specific area of interest and to share what they have to say in their own frame of reference (Polit and Beck, 2012). Although an interview guide or protocol may be implemented, open questions are used to elicit what individuals think based on information or knowledge that they have acquired through experience (Flick, 2009). Qualitative interviewing is structured to elicit detailed descriptions, integrate multiple perspectives and describe a process (Weiss, 1994, p. 9). Weiss (1994) advocates that the aim of research should guide the selection of the method. The aim of my research was to seek answers to questions that can only be found through listening to the stories of my participants. The participants must be given the opportunity to share those stories in a safe and welcoming environment. Therefore, by implementing a series of in-depth interviews I could provide the platform for them to do that.

The intent of the interview event is to set the stage for the participant to feel free to tell their stories and to facilitate an understanding of those stories by the engaged interviewer. A level of trust in the

interviewer and rapport between the interviewer and the participant may frame the event for success (Fontana and Frey, 1994). A benefit of being an insider is that I entered those interviews feeling confident that I already had a strong sense of trust and rapport with each of my participants. Although typically qualitative interviewing happens between an investigator and a participant who are strangers and previously unknown to one another, in this study each of the participants and I are familiar with one another and we have a pre-established level of rapport, as acquaintances, colleagues and friends. This relationship impacts the quality of the interview and implies issues related to familiarity (Rubin and Rubin, 1995). I address the problem of familiarity later in the section on analysis, but for now, my relationship with my participants did provide me with a level of comfort going into and during the interviews. It afforded me a level of rapport with my participants that enabled me to engage with them in what I believe was a trusting exchange. In-depth interviewing was chosen as the appropriate method to capture the depth of data that I needed to collect from my participants in order to learn about their identity and their role.

Overview of Interview Topic Guide

As part of the preparation for my qualitative interviews, I designed an interview guide (See Appendix). Guides are defined loosely and can be individualized to fit a researcher's need (Bryman, 2008). The Guide is a tool to assist with the topical direction of conversation during interaction with my participants and to influence the depth of the conversation (Rubin and Rubin, 1995). Intended to be used in a flexible way, guides may be as simple as a bulleted list of focus areas across the series of interview events. The questions themselves were not intended to be specifically asked in a route fashion, but meant to act as a trigger to cover areas of interest related to my overall research purpose (Bryman, 2008).

As preparation for data collection, I spent approximately two months compiling my Interview guide, with the goal of offering myself guidance during the data collection. The process served to familiarize me with ways to influence the flow of conversation. The Guide was structured with high level questions about role and identity that sought to address differing levels of complexity by using main, probing and follow up questions (Rubin and Rubin, 1995). The questions were written broadly and open ended so that the participants could take a direction of their own choosing in their responses (Keele, 2011). I sequenced the questions so that the series of interviews might flow in a similar pattern. For example, I began with an introductory question related to telling me about how they came to the practice of nursing. Keeping in mind the aim of the study, the prepared list of questions

was meant to direct my focus while aligning the flow of conversation, yet accommodating the responses of the participants (Mishler, 1986). The main questions were an introduction to the topic of identity and role while the probes guided the depth of query, leading the participants deeper. Those probes were used at my discretion to get at more rich data and to gently direct the conversational flow to full exposure and closure on an experience. My use of probing was a way to gently exert power to collect the data I needed to tell their stories (Manias and Street, 2001). The follow up questions clarified and sometimes exposed unexpected empirical evidence for greater insight (Rubin and Rubin, 1995).

The descriptive and interpretative analysis of the focus group helped me to approach my in-depth interviews with a broad sense about some of the concepts that had already become apparent. My immersion in the data from the focus group had yielded themes, patterns and attributes about the participants that I had identified, deconstructed and constructed through my researcher's lens. My analysis of individual participants and cross analysis of all participants together had yielded rich data that informed my data collection moving forward. I felt more aware and more confident in going forward with the in-depth interviews based on my focus group experience. My initial experience with the focus group prepared me to engage one on one with my participants and to develop my Guide for the next phase of data collection.

Implementation of Interview Topic Guide

Initially when I set out to develop the Guide, I envisioned it as a way to add to my level of confidence during dialogue with participants, but I found that by the time the interviews began, and I implemented the Guide, I was so familiar with the line of inquiry that it primarily served as an aid to bolster my self-confidence by managing the unexpected nervous challenge of my first interview. After that first interview, my level of nervousness decreased significantly, and my confidence rose. I never felt totally secure, because I was constantly aware of the familiarity factor and I attempted to be ready at every step to be surprised. I found that the probing and follow up happened almost naturally and came from my own instinctive need to know how they felt. The Guide acted more as a check list to ensure that primary areas of focus were addressed. In hindsight, I found the real value to be in the actual activity of constructing the Guide, the thought process that went into the design was the most significant thing to me. It served as more of a memory prompting exercise (Bryman, 2008, p. 695).

Organization of the In-Depth Interviews

For the six participants who accepted, dates were set following the first draft of the descriptive and interpretive analysis of the focus group and scheduled via electronic communication. Each interview was to last approximately one hour. Three interviews were carried out during a national wound healing conference in the spring of 2015 at a hotel in San Antonio, Texas. Two interviews were carried out during the Annual meeting of the WOCN Society (2015) also in San Antonio, Texas. Since the participant for my final interview was not attending conference, that interview was planned at a mutually convenient location for both myself and the participant at a restaurant half the distance between our homes. Organization of the interviews included selecting the most appropriate space to conduct them, a neutral space that was comfortable for participants and for myself. I decided that the space needed to be logistically under my control so that I could provide a quiet, safe space for my participants, which would enable the best audio quality for taping (Bryman, 2008). The first five interviews were conducted in my hotel suite, to ensure maximum level of privacy and confidentiality, while the final one was held at a restaurant which did offer a workable solution. Although not as private as the hotel suite, the restaurant was neutral space and we were seated out of the main flow of customers.

Participants

The participants are summarized in the table below according to specific demographic variables and each individual has been given a pseudonym to protect her identity. I address their representativeness in the section below on sampling, but the group chosen is similar to and reflects the wider population of WOC Nurses in industry. As the table demonstrates, the group is mature with decades of experience in their specialty and at least five years of employment working for either a manufacturer or a distributor of medical devices. The participants range in age from forty-two to sixty-five, spanning a range of twenty-three years. Their years of experience in their specialty of wound, ostomy or continence care range from sixteen to thirty-eight years, with a combined total of one hundred forty-five years. Their duration of time spent employed in industry ranges from five years to twenty years, with a combined total of over fifty-eight years. Geographically, they are from the northeast, the mid-Atlantic, the south and the northern mid-west, as indicated in the table below.

<i>Interview #</i>	<i>Participant Name</i>	<i>Age</i>	<i>Years in Specialty/Industry</i>	<i>Geography</i>
1	Lolly	62	23/3.5	Connecticut
2	Jane	65	20/12	North Carolina
3	Candice	57	16/5	Florida
4	Edith	42	20/8	Colorado
5	Lara	56	28/10	Minnesota
6	Gwen	65	38/20	Virginia

Implementation of In-Depth Interviews - What happened

By the time that I scheduled my first interview, I had already transcribed the data from my focus group and completed the descriptive and interpretive data analysis. I had identified categories and concepts that had emerged from the focus group. The Interview Guide was used as a tool for prompting me, to ensure that primary areas of focus were covered (Bryman, 2008). As the interviewer, I saw my role as having responsibility to impart a sequenced order to the discussion, as opposed to allowing chaos and to set the stage for the event (Bryman, 2008). However, overall the interviews were loosely structured and although I introduced topics, the flow of the dialogue was determined to an extent by the responses of the participants (Rubin and Rubin, 1995, p. 159). Depending upon their responses, I probed to clarify and dig deeper for my understanding of what they were telling me.

Each participant dialogue was audio recorded in *Sound Note*, an application for the iPad and with *Recorder*, an application for iPhone, as a secondary back up recording. I found that I experienced some tension due to the need to manage the logistics of recording, but I had planned it well in advance and felt as secure as I possibly could be by my preparation. Before initiating each interview, I inquired as to whether there were any questions or concerns and verbally confirmed that the participants agreed to be audio-taped. I could take limited electronic note taking using the application, although my primary focus was on the actual interview exchange. I found it difficult to multi-task and take notes while keeping my attention in the moment and listening intently to what they were saying. I did not want to miss the opportunity to probe and to follow up because I knew that I only had one moment in time to capture their story. I could and did go back to listening to the audio tapes multiple times, but I only had one chance to engage with them and I was very aware of that.

By engaging with my participants in a way that encouraged a conversational flow, I believe this helped to facilitate their sharing of personal stories. I felt as if the rapport we shared fostered a heightened awareness of my part in that social situation (Mishler, 1986). In turn, I feel as if that rapport enabled a conversational flow and ultimately led to stories that yielded abundantly rich data.

Investigator Journaling of Interviews

During the in-depth interviews, because I engaged directly with each participant I did not have the luxury of time to take detailed notes. However, I attempted to take at least a minimum of notes to capture my subjective responses to the dialogue that included thoughts on voice modulation and body language (Emerson et al., 2011). Unlike with the focus group, I did not have the video to re-engage with and to observe at will. For the interviews, I had only my audio recordings to listen to. Therefore, I felt that the notes were significant data. The process of note taking during interviews was more challenging because of the need to multi-task. I felt that my primary attention was to the moment and the participant who was speaking.

Multiple tiers of notes were compiled over time; some notes in anticipation of event(s), some simultaneously during the event and others written retrospectively. I had not recognized how time would alter and impact the quantify of my note taking. Although I had read the theories on field notes (Bryman, 2008) (Polit and Beck, 2012), I had failed to fully comprehend how I would capture time sensitive notes along a continuum. Notes such as those captured at the time of transcription, written simultaneously with the events and retrospectively, were retained as Thoughts on Transcription, one document for each data collection event. An electronic journal in One Note was used to reflect intermittently on the writing process and the fleeting thoughts, comments and observations chronicled along the course of writing.

Each document, Thoughts on Transcription, was a collection of my recollections that included the way I felt going into each interview, my thoughts surrounding various responses by the participants to probing questions and my descriptions of how I guided the discussion. Sometimes I commented on an opportunity that I had taken to probe deeper and sometimes I acknowledged that I may have only skimmed the surface and missed a chance to explore deeper. Overall, I had achieved six documents, one associated with each interview, to record my reflections and I used them to help identify some themes related to identity and role.

Sampling

Sampling can be a complex process and is approached very differently by qualitative and quantitative researchers (Polit and Hungler, 1999). This section on sampling includes the approach to sample selection and size, representativeness and purposive sample rationales. Unlike quantitative studies which may have the intent to generalize beyond the sample, the aim of this study is to describe and understand in depth a culture of nurse specialists. Given that this is a study of cultural identity, it becomes very important to select individuals who are living the cultural experience and are willing to share it in depth (Keele, 2011). Therefore, the selection process has a definite purpose, it is non-random, and it is purposive and stems from my desire to engage with participants who have experienced the transition from hands on nursing to work within industry (Bryam, 2008). I was aiming for an intimate sample who knows a lot about the experience of this culture (Rubin and Rubin, 1995). There is no intent to generalize beyond this culture and the selection of individuals is designed to access that population who is actively experiencing the culture.

Approach to Sample Selection

When I began my search to identify a sample, I chose to call the individuals whom I sought out participants, rather than subjects. The terminology used to reference members of the sample, reflects on the philosophical framework of the study (Thorne, 2016, loc. 1651)). The term participant acknowledges the value of their contribution as key informants. The individuals who gave of their time and shared their stories intimately with me were more than subjects, they were and continue to be my colleagues and peers. They were participants who actively contributed their stories and shared experiences with me, as part of the study process (Streubert and Carpenter, 2011, p. 28). Without their willingness to participate, there would be no study.

My initial participants were chosen from a group of individuals who volunteered to participate. Through the course of dialogue with CWOCNIIIs, I spoke about my study, my goal, my purpose and shared that I was interested in engaging with nurses who had made the transition to industry. The word spread and soon I was being approached by volunteers who expressed a desire to participate. Proceeding more quickly than anticipated, I found that it was not necessary to actively recruit because individuals were approaching me and requesting to participate. I experienced the snowball effect (Streubert and Carpenter, 2011, p. 297). There is a sense of community among us, word spread, and I could then select the optimal participants based upon my inclusion criteria.

Sample Size

Sample size for a qualitative study is not defined by established criteria, but rather by the purpose of the study, the participants engaged and the type of sampling that is chosen. The number may be as small as ten individuals (Polit and Hungler, 1999, p. 299). It is difficult to estimate the size of the wider pool of individuals who make up all Wound Ostomy and Continence Nurses in industry with certainty, because there is no formal identification process as a group; I estimate it to be approximately on hundred. For my study, I recruited seven individuals to participate in my focus group, while a total of six individuals were chosen to participate in in-depth face to face interviews. This size sample of thirteen was an appropriate number to speak for the larger group, as a proportion of the larger group of which they belong, which at that time I estimated to be in the range of approximately eighty to one hundred. I chose the participants to be representative of the wider pool.

Representativeness of Participants

Nurses who transition to industry usually have at least several years of clinical bedside expertise and some level of expertise in their specialty area, as demonstrated by professional certification. Their foundation of clinical experience in direct patient care and their specialty certification facilitates their credibility and enables their connection to the nursing community still at the bedside. Historically, they have usually demonstrated some administrative or leadership experience, prior to the transition to industry. They have their certification in at least one specialty area of wound care, ostomy care and/or incontinence care, since that certification is an acknowledged credential and valued for credibility. They are educated with at least an undergraduate college degree. Based upon my personal and professional experience, they are also individuals who are fearless to speak out and exhibit a passion for their chosen work and for quality care.

Striving for representativeness, I chose participants based upon their experience and their professional background and educational preparation (Rubin and Rubin, 1995), as I outlined above. Overall, those individuals who comprise the sample are mature, with a solid foundation of clinical nursing experience, a dedication to the profession of nursing and they are leaders in their area of expertise. The sample of participants was chosen from the pool of my professional network of CWOCNII, a group I am intimately familiar with, both professionally and personally. My aim was to have this study sample represent the larger group of Certified Wound Ostomy and Continence Nurses who work in industry. In turn, that group is a subset of the wider pool of Certified Wound Ostomy and Continence Nurses.

Certification requires that all Wound Ostomy and Continence Nurses who apply have a Bachelor's Degree, several years of bedside nursing experience and can pass a standardized examination in the area of their specialty. Therefore, those basic requirements became a part of my inclusion criteria. Acknowledging that each individual has their own unique perspective that they bring to the study sample, the inclusion and exclusion criteria offers no guarantee of bias deficit, but represents an ideal goal of the best effort to identify key informants (Thorne, 2016).

Purposive Sampling

Purposive sampling is a sampling technique which is designed to identify a subpopulation of the larger group it represents in a way that is most like that larger group in respect to the experience and in the context, that is being investigated (Thorne, 2016). Purposive sampling and the criteria for selection defines the logic with which I have chosen to represent my study group (Thorne, 2016). Purposive sampling was determined by setting inclusion criteria based upon the characteristics and the quality of the data needed for the study (Polit and Hungler, 1999). The aim was to select individuals who would be representative of the larger group of Wound Ostomy and Continence Nurses who work in industry, being fully aware that representativeness is a complex task and acknowledging that those chosen will reflect a perspective on the identity and role played by the participants. These key individuals will each have experienced the inclusion criteria that have been identified. That criteria included certification by the Wound Ostomy Continence Nursing Certification Board for at least 3 years in all or one of the specialties of wound, ostomy, continence and employment by a medical device manufacturer or distributor for at least 2 years. Initially my intent was to also include academic preparation at the Masters level, but that criteria would have narrowed participant choice and greatly impacted selection of the sample size. Use of purposive sampling will engage a sample that is knowledgeable about the experience of being employed within industry and is willing to share their experiences (Streubert and Carpenter, 2011).

It is crucial to engage nurse specialists who are grounded in clinical practice and then moved to industry, so they will have experienced the transition and be able to reflect on the context of both work environments (Streubert and Carpenter, 2011). By excluding those with less than two years in industry, I specifically eliminated individuals with less experience in that work environment and included those who have had the opportunity to make the transition and have lived through the initial changes in life style. I made the decision to recruit those who have had enough time in industry to

begin to at least make sense of it. One of the participants was relatively new to industry having only worked there for two years. She was vocal and expressed herself freely throughout the focus group, so her stories were included as part of the data.

Recruitment of Participants

Each participant was contacted via email with a message that introduced the concept of the study and offered a broad outline, including the research question, the aims and the objectives of the study. Each potential participant was asked to respond to a query about whether they would be interested in participation, with a 'yes' or 'no' and advised to forward any questions or concerns that they might have. All of those who expressed interest were sent an Informed Consent (Appendix) electronically; they kept a copy for themselves and responded to me with a signed copy. They were each given the opportunity to voice concerns and to ask questions. Voluntary participation was clearly stated and a desire to withdraw would be accepted at any time. All communication was documented in email, while all documents were filed electronically.

The participants were recruited for the focus group first and when that option was filled, they were offered the opportunity for an interview. All available slots were filled within two months and all logistics were managed in One Note. In the end, I had to turn away some potential candidates. Over the course of my study, five additional colleagues who currently work in industry and fit my inclusion criteria voiced a desire to participate, but my selection was already complete, by the time that they expressed interest.

Data Analysis

This section on data analysis will include literature on use of field notes and approaches to data analysis of both focus groups and one on one interviews. Denzin writes of the 'triple threat of representation, legitimation and praxis' (Denzin 1997, p. 3). He links that triple threat with the creation of 'social text' (Denzin, 1997, p. 3) and advocates rethinking the process of interpretation. He refers to going into 'arenas' of experience that may or may not be familiar and attempting to make sense of 'turning-points' in their lives (Denzin, 1997, p. 92).

As Sally Thorne posits, an interpretivist approach is an alternative approach that is being applied to generate knowledge by identifying concepts and themes within the complex discipline that is nursing (Thorne, 2016). An inductive process of analysis facilitates the pursuit of knowledge within the

context of the empirical world of social interaction, while negotiating a credible path to new evidence through inductive analysis. Because my study explores an area of new investigation, the process is inductive and begins from data collection that is specific, through organization and analysis of the data that is collected, to the more general concepts and themes that are constructed (Elo and Kyngas, 2008). Inductive analysis is complex and evolves through iteration as new understanding emerges. Throughout the process of making sense, there are periods which may be experienced as chaotic, when immersed in analysis. Flick speaks broadly to qualitative research at the 'crossroads between art and method' (Flick, 2009, p. 465) and refers to the researcher's attitude and their link to reflexivity (Flick, 2009, p.462).

My participants, as a subset of the larger group of Certified WOCN's in industry, derive meaning of their experience through interpretation of their surroundings. As investigator, I observe and derive meaning of their interpreted experience through my own subsequent interpretation. I will present each of these iterations as stages of analysis in the process of telling their stories. Immersion in the data, identification of specific themes, leads to deconstructing and reconstructing overall concepts and finally merging them to present.

Field Notes

A significant portion of my data collected while in the field, consists of what I label as my fieldnotes. These notes are my own personal reflection on what I was observing, my personal reactions, opinions and comments on details about what was happening in my field of observation (Emerson et al., 2011). They are moments that I captured during the data collection process; my filtered and selected responses as the researcher, to the researched (Flick, 2009). As Sanjek (1990, Xii) so aptly notes, 'unlike historians, anthropologists create their own documents.' I captured my responses, my gut reactions to what was said, with a range of emotions. I captured my own feelings of anticipation, some anxieties and concerns over impending events such as my scheduled inquiries for data collections. These notes allowed me a place to vent and offered insights into the way I observed, they complemented the actual transcripts of my participants. In the face of vast quantities of data, it becomes imperative to record one's own reactions to the process of collection over time, preferably simultaneously or soon thereafter (Byram, 2008). My fieldnotes helped me to come to terms with the filters of my perception, my perspective on my research, essentially a window on my own reflection (Cudmore and Sondermeyer, 2007).

Responses, reactions and comments on details during data collection are vital to complement observation. Details into what was not spoken was noted during data collection events. Voice inflections, intonations, pauses, body language were all details captured in notes. With all of the stimuli during observation it is easy to be distracted and being centered on the purpose of my research helped to focus my note taking (Bryam, 2008). Documentation of my fieldwork included a journal, analytical memos, jottings, mindmaps, marginal comments in transcripts and visual imagery. I tried to take notes to some extent simultaneously in the field during observation, or as soon as possible following the event. Most of my notes were taken electronically on my iPad using SoundNote application with the occasional pencil and paper sketching (Flick, 2009). Expanded notes written up within a day or two following the events were also performed electronically and filed on my laptop. Taken all together with the transcripts, the fieldnotes added to the richness and depth of the observations and added to the quality of the data organization and processing (Flick, 2009).

Approaches to Analysis

Each speech event yielded volumes of audio and audiovisual data that initially required transcription. Following transcription, data first had to be managed, sorted, organized and categorized and broken down to the simplest units (Polit and Beck, 2012). Although analysis begins at the time of collection, managing the data was the initial challenge. As those units were made sense of, the analysis proceeded by assembling them together in a meaningful pattern. What began as reduction yielded a constructive outcome through an iterative process of induction that seemed to be fluid, changing over time with successive reviews and deeper immersion (Polit and Beck, 2012) (Elo and Kyngas, 2008). Because each method of data collection was so contextually different, I will discuss each one separately. My perspective as a practitioner, researcher and my relationship to the participants and their professional work is integral to the process (Streubert, 2011, 183).

Focus Group Analysis

Management of data begins with the process of transcription which is labour intensive and requires attention to detail (Polit and Beck, 2012). Although I briefly considered employing a transcriptionist, I decided that the action of transcribing verbatim would help me to become more immersed in the data (Bryman, 2008). Initially I intended to complete data collection in less than one year, but the transcription and analysis of the focus group took far longer than I anticipated. The source was the videotape and verbatim transcription of the focus group yielded over fourteen thousand words. The

impact of context readily became apparent to me when faced with the problem of transcription of my seven participants who are all engaged in a complex flow of dialogue (Bryman, 2008). The individual voices had to be identified and followed as seven threads of dialogue, each associated with an individual. The fact that I am an insider and friends with each of them, impacted the ease of my identification of each voice (Rubin and Rubin, 1995). Because I know them and their voices, it made the work of singling out each voice much easier, as compared to the same situation, if they were strangers to me. Because of my choice to videotape the cultural event, having the video gave me a source of confirmation regarding the identity of each voice.

Another challenge was to capture not only the spoken words, but the intonation and modulation of each voice. As I transcribed I used comments in parentheses to describe the way that their words were expressed. I also captured pauses in their speech and times when there were interruptions to the flow of conversation. My fieldnotes embedded within the transcripts added value to the meaning by integrating what was left unsaid with what was said in the text (Bryman, 2008). I found that all those practices during my transcription positively influenced my ability to describe and interpret the data, later on. The act of transcription and the organization of data helped to make me more familiar with it and acted as a springboard for my analysis (Polit and Beck, 2012).

Descriptive Analysis of Focus Group

One issue with analysis of focus groups is whether to be concerned with individual content analysis or analysis across individuals as a group (Polit and Beck, 2012). I chose to reduce the whole event to seven individual components first. Then, when the transcription of each of the seven participants was complete, I began to immerse into the data, reading and rereading, to see the similarities, the commonalities and search for concepts until that process was exhausted (Polit and Beck, 2012). A major component of the across individual activity was the social interaction between participants. The cultural scene of this focus group became a logistical challenge for me to make sense of (Spradley and McCurdy, 1972). At times, it seemed overwhelming to me and I found myself listening multiple times to some of the same bits of conversation. My approach was initially to perform individual analysis of each participant, but I followed that with comparative analysis across the group of participants to account for the social interaction (Polit and Beck, 2012). It seemed to me to yield the most value, to identify the individual contributions and then to work toward analysis of the entire group, as informed by each individual.

Initially, upon reading about software package options for thematic coding, I considered implementing such software, but I made the decision for manual method of theming due to greater opportunity for immersion (Bryman, 2008, p. 565). This being my first foray into such research, I wanted to experience the full impact of the process of discovering themes. I had read about software packaged programs for coding that break down the data and sort it into manageable categories, but I decided to experience the entire process manually. I determined that for me, it would be a learning experience to take a large volume of narrative text and sort it to smaller units, categorizing them into similar and differing categories (Polit and Beck, 2012). Use of the Similarity and Contrasting Principle was helpful to me during analysis (Spradley and McCurdy, 1972, p. 562). The aim was to construct a descriptive analysis that would be true to the dialogue of the seven person focus group and would be an authentic representation of their stories.

Interpretive Analysis of Focus Group

The next phase of interpretive analysis presented another compendium of challenges. My focus with the interpretative component was even more complex because now I was taking the work that I done within the descriptive phase and filtering that as a new experience through my own lens of perception. What I realized was happening was that I was taking the narrative text that I had carefully transcribed, deconstructing it to identify the basic categories, organizing smaller like components within those categories, according to similarities and differences and then reassembling them into new categories through my own interpretative process using my own frame of reference as an insider, all the while being reflexive (Flick, 2009).

Logistically, I found it helpful to use visual aids, so I sorted out data and my perspective on it by using mind maps and linking concepts one to another in a hierarchical fashion. Observing the maps laid out often triggered associations between concepts and sometimes aided me in making connections that otherwise may not have been apparent to me by simply reading text. Lists were also an aid to grouping concepts and organizing categories. Another aid was a word cloud application that allowed me to input text and output a diagram of the most frequently used and repeated words. That whole process of visualization techniques fed into my interpretation.

The analysis was an iterative process of breaking down and constructing through interpretation, as I began to sort through what I will call the units of cultural knowledge (Spradley & McCurdy, 1972). The iteration is all the more complex since it involves processing of each individual members' dialogue,

then processing across the group as one dynamic entity. I found that by using the work of the descriptive analysis and focusing on each individual one at a time, the process felt less overwhelming to me. So over time and through iteration, I began to work through what felt like chaos. Polit and Beck (2012, p. 576) use the term 'incubation' to describe that process of the researcher making sense of meaning. Interpretive analysis yielded the composite themes through the process of induction (Srivastava & Hopwood, 2009, p. 77). Although it was anticipated that rich detailed data and thick description would be the outcome of my fieldwork, the output far exceeded my expectations.

Analysis of In-depth Interviews

For the interviews the source for transcription was exclusively the audio recordings. I had no visual tapes of the interviews. I could not go back to a video and observe each participant as they spoke. Because of that, from the start, I felt it was important to make notes within my transcript as to the quality of the voices (Bryman, 2008). Once again, although I anticipated a large volume of data, my transcription of the six interviews yielded over fifty thousand words. The audio tapes of the interviews were played repeatedly to facilitate transcription and to become immersed into the dialogue (Bryman, 2008).

Descriptive and Interpretative Analysis

Descriptive analysis of each individual interview yielded a total of six analytical documents, one to accompany each transcript. Those six documents were combined and analyzed together to yield the composite descriptive and interpretative analysis of themes woven throughout the structural framework of the interviews (Srivastava and Hopwood, 2009). Like with the focus group, I chose to perform both descriptive and interpretative analysis of each individual interview, comparing similar and contrasting concepts. After that was done, I then did an iterative comparison of each interview with the others. So, I performed individual analysis but I went on to perform analysis across interviews, which added to my value perception of the data analysis overall.

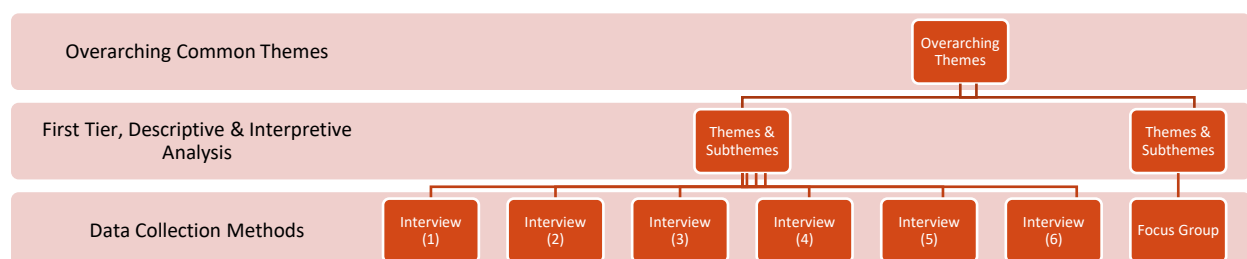
Immersion into the data began by repeated playing of audio-recordings and reading and rereading transcripts facilitated descriptive analysis and coding of emerging themes. Searching to find the meaning and to understand the knowledge of this group, was an evolving and iterative process and I came to realize that as the researcher I contributed as an active participant (Cope, 2002, p. 44). Along with each review of the transcripts and the descriptive analysis, I also reflected on the portion of my

fieldnotes that were captured as my electronic journal, Thoughts on Interviews. What was not expected was the volume of data and the constantly evolving themes and subthemes.

The iterative process led to deeper layers of interpretive analysis that revealed emerging themes and subthemes that overlapped, converged and were separated again over time (Polit and Beck, 2012). As I did deeper dives into the data, I used a software application of mind mapping to assist me in navigating my way through the chaos of the data. This allowed me to reconstruct visually some of the smaller units of data, grouping them by association into larger concepts. At that point in time, the visual aid was helpful to me in mapping out the terrain of the data. The fluidity of the themes was not anticipated and was initially challenging and burdensome to me. Initially, the elusiveness of the meanings made me uncomfortable. I remember that early on, I was naive to think that the initial categories were the end point. I soon came to realize that what I thought was a finished product was merely the early version of my interpretive process. For some time, I continued to attempt to finalize the categories and to tidy them up. Each time that I gained clarity of a concept, at next review, I perceived it slightly differently in a new light. In time, I began to be more comfortable in my realization that these ever-changing versions were part of the temporal phases of making meaning out of my data. Over time, I grew accustomed to the evolutionary nature of the process, my comfort level increased and I came to terms with the process.

Interpretative Analysis of Combined Focus Group and In-Depth Interviews

The themes and subthemes yielded from both sources of data collection were subsequently analyzed together to explore the commonalities and the differences, guided by the purpose of my study and the interpretivist approach to data analysis.



Descriptive and interpretative analysis of data was influenced by the methods of data collection. Although not anticipated, the different environments for data collection provided two very different situations that led to differences in theming based upon the procedures conducted.

The two different methods of data collection enriched the data output and the triangulation of the data provided a more robust and authentic portrayal of the meaning (Fontana and Frey, 1994). Using triangulation was a way to engage with participants singly and within a group sharing event, to be able to describe and interpret emerging concepts across cultural scenes to draw conclusions about overarching themes and to identify patterns (Geertz, 1973).

Iterative Approach

Considering the challenge of participant observation, my intent to use ethnography to expand discourse on a nontraditional role and 'get inside' nursing, led to a broader scope of this study to examine what I initially perceived to be a marginalized ecology (Latimer, 2003, 232). Successive revisiting of the data in the tradition of ethnography broadened to interpretative qualitative research and became a continuous process of constructing and reconstructing versions of reality (Flick, 2009, 19). I realized that as I immersed more deeply into the data, the concepts became fluid overlapping, merging and disengaging over time. In the beginning, I naively composed a list of concepts, themes and subthemes from my initial data collection, thinking that this was a finished product. I soon came to realize that I had not begun to scratch the surface and I was back to reading and rereading the transcripts. What I found out was that with each review, those concepts took on a slightly different connotation and they began to change for me. What had begun as an obvious black and white picture took on a more complex collage that blended sometimes as a chaotic image, before re-emerging as new iterations of the study.

By using a broad interpretative approach, I am able to delve deeper into the understanding of their cultural experience using my interpretative filter of the research experience, deconstructing and then reconstructing through my own interpretation, the meaning of the meaning of my participants. My participants share their experiences, I am then able to offer my interpretation of their shared experiences by processing interpretative meaning to come to an understanding of their cultural knowledge as related to their role and their identity. This iterative process approaches human inquiry to gain understanding of the social world through social interaction, evidenced by my participants' stories, behaviors and actions. An apt analogy of this process is offered by Edel (1984, p. 16) when

discussing the writing of biographies. Each bit of reality that is offered, each story, each observed behavior, is analogous to a single mosaic, which can be deconstructed and reconfigured through observation and analysis, guided by the interpretivist framework, to make meaning of and to understand the social experience of this culture.

Validity/ Reliability

How then do I go about claiming that this work is a quality study, that it has value and that I have accomplished what I set out to do. For this endeavor to be more than a scholarly exercise, it must have interpretive authority, to be true to the voices of those whom I am representing. The issue of credibility is addressed in this section and begins with a discussion of reflexivity and the issues surrounding familiarity.

Reflexivity

Conducting research from the inside, I am a native of this culture (Kanuha, 2000) and I acknowledge my personal affiliation. It has been posited that the qualitative researcher goes beyond observation to be an active participant in the research (Denzin and Lincoln, 1994, p. 7). By immersing into that data, coming to recognize the fluidity of patterns, I began the process of becoming acquainted with the knowledge, a step removed from my own experience, with the awareness that as a researcher I had opened a unique window into this culture. Being reflexive was woven into the process of becoming acquainted with the stories and it impacted my writing, because of the unique position I found myself in as both researcher and insider. This approach has been described as a 'bricolage, with the researcher being termed a bricoleur', someone who can do all of this using reflexivity (Denzin and Lincoln, 1994, p. 2). The acknowledgment of my own position as an instrument of my research allowed me to face the tension of familiarity and address it transparently. I am uniquely qualified to tell the story of these participants. However, there are challenges and benefits associated with familiarity that I will proceed to discuss. I discuss the problem of familiarity here and address what I perceive to be the strengths. I will address the potential risks in the Discussion Chapter, within a section on Limitations.

The Problem of Familiarity

From a position of familiarity, I set out to interpret the stories of my peers, all the while being reflective and acknowledging my position as their colleague and as an insider to the group being investigated

(Atkinson, 1990, p.7). In my dual role as an insider and as the investigator, I acknowledge myself within the process of qualitative interpretative analysis and how I am a part of their social world (Pellatt, 2003). The study of that social world, marginally positioned, becomes a collaboration of their voices and my selected observations, my interpretation and perspective, along a continuum of familiarity (Atkinson, 1990, p. 19). The issue of familiarity is a complex one and I am in a unique position, being native with the participants along that continuum (Kanuha, 2000, p. 440); highly intimate as opposed to being strange, which adds to the complexity of the text (Atkinson, 1990, p. 93). I use the term “native” to mean the experience of being a researcher who is a member of the group that I am interviewing, as designated by Kanuha (2000, p. 440).

To engage authentically for me, means being open to considering how to best represent others ethically while simultaneously leveraging their voice. What I found myself doing at various points in time, during the immersive process, was stopping to ask myself whether what I was hearing was the words of my participants or my own self-imposed voice, or even a mix of both (Srivastava and Hopwood, 2009). Continually questioning myself began to be more progressively natural to me when I was working with the data (Srivastava and Hopwood, 2009, 78). Being reflexive means being able to engage with the data in a way that penetrates the chaos and allows me to get to the true meaning of what the participants are telling me. I had no idea of what that chaos feels like, until I experienced it, and only then could I begin to feel comfortable with that chaos. Being true to the overarching need for openness, to reflect and to recategorize data is inherent in the process. Raising awareness and facilitating recognition of the voice of this culture, is one way of mobilizing the culture to an increasingly more inclusive position within the larger society of nursing.

Strengths Associated with Familiarity

One way to view such a complex issue of familiarity may be to consider my intimacy with my participants as a strength, several benefits exist (Bonner and Tolhurst, 2002). I am both a peer and a colleague with years of professional relationships. I was in a perfect position to select a purposive sample. My professional networking over the years has me engaged with a wide range of individuals from whom I was able to make informed choices of participants.

I am well known and a trusted member of the group with the support of the members and indeed as time passed, a sense of enthusiasm among my colleagues was generated and expressed by participants and by others who heard of the study. Their encouragement was an incentive for me to

keep going. My passion for the study served to instill a sense of urgency and offered me resilience to move on as the study progressed. As time passed I felt critically responsible to represent them as they are. By recognizing the tension, being transparent and constructing a strategy I have placed myself as an investigator in a space that balances familiarity and strangeness, facilitating a genuine interpretation (Atkinson et al., p. 31). The risks associated with the problem of familiarity will be addressed within the limitations section of the Discussion chapter.

Strategy for Coming to Terms with Familiarity

It becomes imperative to build a strategy to fight the problems associated with familiarity. Constant vigilance about the issue of familiarity and intimacy was part of my approach to the data (Roberts, 2007, p. 17). Not taking events, observations, comments and stories at face value, but questioning each one was a routine that I practiced. I found that I began to become attuned each time there was a tendency to think of 'us' rather than 'them', and this required vigilance. I found myself pausing to ask myself if my response was my own or theirs and in some instances, I acknowledged them to be the same.

While reviewing ethnographic literature, I found it helpful to read the early work and the themes and to consider the past. Atkinson and Delmont (1995, p. 5) caution against writing in a vacuum. The works of the Chicago School pioneered urban ethnography and the practice of studying culture within our present-day society as opposed to seeking out native populations. Contemplating tradition becomes part of the strategy to make the familiar strange (Faris, 1967).

'Staying in your own nest' can be challenging but simultaneously rewarding (Roberts, 2007, p. 15). Being intimately aware of a culture can facilitate trust and sharing among participants and investigator if the role of the researcher is clearly identified and established. I found that by keeping my two roles separate, it helped me to retain the distance I felt was necessary to not confuse them. In social situations, I was the colleague, while during the data collection and any follow up that ensued, I was the researcher.

Although sometimes challenging, it is essential that there is transparency of the process. This allows the reader to be informed about the process, how I resolved issues of familiarity and how I impacted the research in my role as an insider (Carolan, 2003). It also enables repeatability of the study. Since this is exploratory research, it is important that other researchers can either replicate the study or build upon my initial findings; therefore, clarity concerning methodology is important for the purpose of

replicating the study. Thorough description of the entire qualitative research process permits the reader to gain a sense of understanding regarding the strengths and weaknesses and indeed the findings of the study (Elo and Kyngas, 2008).

Triangulation – Implications for Analysis, Interpretation and Validity

Triangulation is associated with both validity and credibility and it was used here to strengthen data findings of this investigation (Polit and Beck, 2012). Triangulation is one way to strengthen the evidence by employing two or more methods. The use of focus group and in-depth interviews provided methodological triangulation of data. Execution of each method of data collection was separated by approximately one year. The focus group was executed in May, 2014, while the series of interviews were performed in the spring of 2015. There was no replication of participants between the two methods, for a total sample of thirteen different participants. The decision was made not to offer interpretations back to the participants due to time constraints, but to rely upon triangulation of data. Triangulation of data is one way to facilitate richness of data, validation of data and to cross check the findings. It was implemented as an alternative technique for assessing validity and for comparative analysis of themes and subthemes.

Conceptual Approach

My initial plan was chosen to address qualitative validity using the framework of primary and secondary criteria (Whittemore et al., 2001), with on-going self-reflection. Committed to credibility, authenticity, criticality and integrity, the plan was to return the final interpretations to certain participants for validation as a way to authenticate the analysis. Taking the time necessary to return to all or select participants for feedback would have presented challenges for a timely completion of the study and would have increased the labor of analysis significantly. That plan was slowly rejected in favor of relying upon triangulation of data. For Denzin, validity is legitimacy, and as such is always just beyond reach (Denzin 1997, p. 7). Yet if the work is sufficiently grounded, triangulated and credible, the author can claim validity. I claim methodological coherence, as evidenced by my move to interpretative qualitative approach from ethnography, based on my sensitivity related to emergent data, framework and design.

The framework of evaluation is further described by Thorne (2016) as she elaborates on epistemological integrity, representative credibility, analytic logic and interpretive authority. My full transparency concerning my change in approach from ethnography to interpretative analysis is evidence of demonstrating epistemological integrity. I have laid out the rationale for the change and I have defended it. The findings of my study are based upon my sample of participants who represent the larger group of CWOC Nurses in industry and I claim no generalization beyond my sample. Triangulation of data strengthens my analysis. I have been transparent about the iterative analysis and the rationale of my logic is laid out in my writing trail from transcripts to descriptive to interpretative analysis, including verbatim accounts. I have direct source to verbatim transcripts and in the case of the focus group, a video recording. All work has been framed by the context of the social interaction of the participants.

Although validity and reliability are not as precisely prescribed within the qualitative interpretivist approach as they are considered within the positivist paradigm, the transcripts will stand as documentation that are representative of the dialogue. It was always my intent to be authentic and the chosen method of enquiry features a strong emphasis on the nature of social phenomenon. As an insider, I undertook this research fully aware of the problem of familiarity and defined a strategy to defend that problem. Triangulation of data and methods, in conjunction with authenticity and transparency substantiates the support of validity and reliability of this study.

Ethics of Screening & Review Process

As research is undertaken, ethical issues are addressed to ensure that the interests of all participants are protected. Ethics, concern with rules and principles of human behavior, are an ongoing consideration at every step throughout the entire qualitative research and guide the course of study (Keele, 2011). Non-maleficence, beneficence, autonomy and justice are the guiding principles (Flick, 2009). Welfare of participants comes first and is the motivating factor to drive ethical behavior. The study promises to produce benefits associated with the professional identity and role of the participants and they were supportive of being a part of the study.

This study took place in the United States of America. Access to participants was obtained through my informal professional network. Approval to proceed with the research was obtained after submission

of Research Proposal Form to the Cardiff University School of Healthcare Studies. Ethical approval was received upon review of the proposal by the Ethics Committee of Cardiff University prior to beginning the research.

Confidentiality of Data

Due to the complex and unpredictable nature of this study, sound ethical issues related to informed process consent were used to build on the trusting relationship with the participants (Streubert and Carpenter, 2011). Following a discussion of the structure of the study including the rationale for pursuing this topic, each participant signed an Informed Consent (Appendix) grounded in the principle of autonomy. All participants were provided relevant information about the purpose and the scope of the study; they each had the power of free choice to accept or decline participation. All aspects of data collected from participant involvement are saved and stored electronically on a secure server and are protected with a password, to ensure confidentiality of data.

Anonymity

Data will be published and presented in a manner to preserve anonymity. Due to the nature of the small sample size and the intimate disclosure of data during interviews, the presentation of data may present difficulty in maintaining confidentiality. I carefully filtered all descriptions within the analysis to avoid the risk of participant recognition. One thread of conversation in the focus group was omitted due to the sensitive nature of the discussion. The descriptive content of the data presented creates a situation in which I go to great lengths to prevent disclosure of the identities of the participants (Streubert and Carpenter, 2011). It is something that I was always mindful of throughout the data management. All identifying information is disguised and pseudonyms are used.

Issues of Withdrawal

All participation was voluntary and any participant who wished to withdraw from participation in the study was free to do so at any time for any reason (Keele, 2011). This was fully explained to each participant. The process consent will allow for re-evaluation of consent, appropriate to the emergent nature of interviewing that involves probing questions that may involve unpredictable responses.

Storage of Data

Cardiff University lays out guidelines for management of data during research, which can be found online at the Student Intranet (<https://intranet.cardiff.ac.uk/students/your-study/for-research->

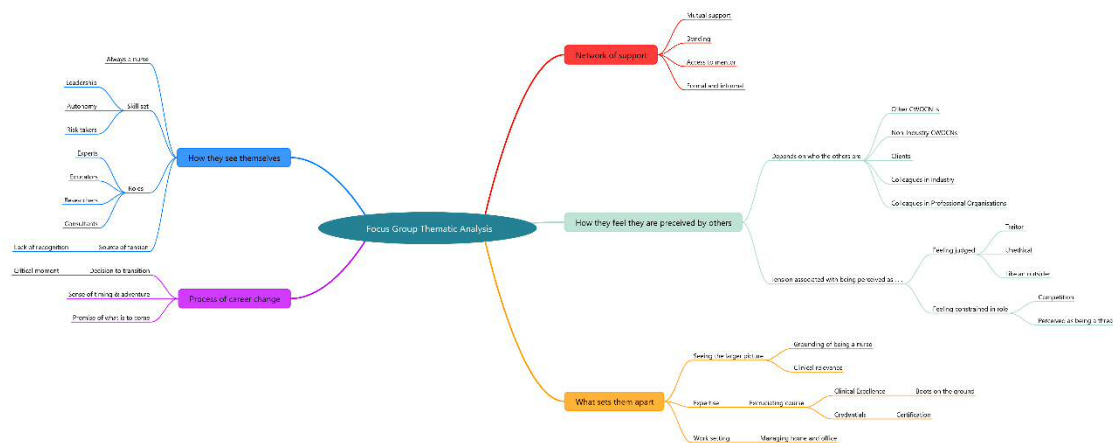
students/managing-and-sharing-your-data/managing-your-data-during-your-project). Variables for consideration include the data management, physical security, potential hazards and back up. All of my electronic data is stored on a secure private server, with all data password protected and backed up to the Cloud. The majority of the data is text as word documents and PDFs, in addition to mind mapping created and stored as a mind map application. I have one video recording of my focus group with two copies backed up to external drives in addition to two audio recordings of the event backed up to external hard drives. Six sound recordings, one of each interview are stored on external hard drives. The data will be kept for a period of at least five years. Electronic data is saved in appropriate folders and files and password protected. Document control is addressed with each version of each chapter being labelled with version number and date written. Only I am in possession of the password. The physical security is addressed. The storage location is secure from unauthorised access. While most of the data is electronic, a minimal amount of hard paper copy is stored in a locked filing cabinet. This is a low risk study that does not require any external approval requirements beyond those being sought through Cardiff University.

Analysis of Focus Group

Chapter Three

This chapter describes the analysis of the focus group. It presents themes that are revealed about the perception of the participants' identity. The themes include process of career change, what sets them apart, how they see themselves, how they feel they are perceived by others and network of support. Each theme is preceded by a description of the context relevant to that theme. Each theme includes subthemes that emerge. Overall key constructs emerged from the process of analysis; marginalization, tension and resilience and are presented at the conclusion of this chapter.

This diagram is a map that provides a visual overview of the primary themes and subthemes associated with the emerging conceptual analysis of the focus group.



The Process of Career Change

This section describes the journey of transition that they have all made, from a position as a direct caregiver, to a position in the world of business. Stories include decisions to transition and their associated feelings about coping with the transition. Each exemplar is followed by the page number for the corresponding transcript. They describe moments that they clearly became committed to making the change. They go on to describe how they feel about change. Those feelings include tension associated with personal relationships and mutual experience of support that they feel for one another. Early in the focus group, the facilitator asked the participants to think about and share how it

was that they made the shift to industry. Each participant seemed to be able to recall the moment when they made the decision to transition to industry and each was eager to share their memories.

(Fay) I know the exact moment, (verbal agreement with laughing all around) I was in, direct patient care I was called repeatedly for 3 months in 1998 and decided, O.K. this is not a joke, I'm going to go for an interview and I took the plunge. (9)

Fay was giggling while telling her story and when she was asked what prompted her to make the switch, Fay responded . . .

(Fay) Uhm . . . a combination of things. One, I was totally floored that someone was seeking me out because I didn't apply for a job. The other thing was I'd been through a major . . . of course emotions are just flying because I'm having to recall this . . . a major life altering event that was devastating for me and my family and to take care of my family it was an accept. So . . . (9)

Here is an emotional moment for Fay that is as evident by her body language as by her words. She expressed surprise and disbelief that she had been sought out by an employer when she had not been job searching. Fay's body posture was with arms folded in front of her on the table, lips pursed, head nodding back and forth. As she was telling her story it became evident from the emotional tone and quiver in her voice, that this had been a major life decision prompted by an event that impacted her and her family. Yet, here she was feeling comfortable enough to be with her peers at the table, in a sort of kinship with them. As she finished her story, she unfolded her hands, waving them up and away from her chest as if physically relieving herself of her emotions as she 'relives' her experience in words. With a shrug of her shoulders, it seems as if she is saying there was no other choice for her. Iona jumps in next with her story of transition below.

(Iona) I always had a reputation of changing jobs every 2 ½ years. I mean that's the way I'd been ever since I was in nursing. I wanted to do everything I hadn't done. I didn't want to miss anything. So I'd done nursing home, I had done hospital, I had done psych and you know, it was about that 2 ½ year mark and I had these 2 guys who owned a nursing home and they came to me, they wanted to start a DME company and at the same time they wanted me to open . . . back then there were no LTACs, no wound care centers but they wanted to start a 6 bed

wound care center in a nursing home and for me to do both of those. The pay was right, and it just was a new opportunity, couldn't pass it up . . . intriguing. (9)

Iona mentions compensation for the first time. With a change in professional role it would seem logical that compensation would enter into the decision, although no other participant speaks of it. It seems as if each participant who is sharing a story incorporates an element of the novelty of change as one of the factors they acknowledge. Iona's memory still reflects on that decision with 'intrigue' after all these years that have passed. Smiling like the Cheshire cat who ate the bird, Iona with her head nodding back and forth, elicits affirmation on the faces around the table as they join in smiling and reflecting a shaking of their heads in affirmation. There is note taking by Cate.

Like Iona, Gwen shares feelings about the transition that are focused on wanting to try something new and different.

(Gwen) Yeh, I was in private practice when I got approached back then by (X Company). They were looking for consultants for their Part B Medicare billing division. And because I was used to being self-employed, it was one more thing, and I thought O.K. this will be fun, this will be different, things I didn't know about. And it basically segwayed into a full time job after a couple of years when my mentor at that company left and they created a position for me. And it just felt like the right move at the right time. (10)

Here Gwen mentions the timing of the opportunity by acknowledging 'it was the right move at the right time'. Cate shares a bit of a different angle, but the bottom line comes down to taking on a challenge. Cate appears to reach out to Fay and Dora when she tells her story.

(Cate) And so when this opening came up and my rep told me about it and he knew that it would give me opportunity to talk . . . which is probably my only gift in life (laughing) but I guess I'm O.K. at it and uhm, so I took the job. Had to move out of town, I had just gone through a divorce a few years before that. So, it was that kind of thing, O.K., this is a life changing decision. I'm driving, granted, only 200 miles away from home, but I'm in a car by myself, driving to Kansas City, going "You're 60 years old – What in the name of God are you doing? You know one person in Kansas City." But it's that challenge and that thing, you know, when you

go through something life altering, you just go well, it's either sink or swim. And I just don't feel like sinking, so it's kind of you know, kind of a cool thing. So I'm glad you brought that up, both of you, about being you know, well, just a little bit, got to make a change in life. (13)

Below, Iona and Gwen talk about the adventure associated with the transition to the role, the diversion, the lack of regime, the spontaneity of performance in industry. The spoken word is accompanied with vigorous body language of the hands and the eyes, connecting with the other participants.

(Iona) Kind of like a sense of adventure. (giggling) When you move in this direction you have to have this sense of adventure. I want to see something new everyday, I want to go somewhere different everyday. (14)

(Gwen) No two days alike. No two days alike, I've been saying that for 20 years. No two days alike. In my situation, I am only the boss of myself. I don't have a team that I'm in the boss of. (14)

Fay uses the analogy of the snowball effect to talk about her experiences.

(Fay) The new challenge is, it's like a snowball, it takes you to another one (level). (15)

When speaking of advice given to her by her boss at the time Fay was making the decision about her career change . . .

(Fay) She said they're going to call you at this time tomorrow and you're going to take the call. She said because this is your next step in evolution. She said, "I don't want to lose you, but this is what you're supposed to do. Honestly, this is where God wants you." I took the call and the rest is history. (16)

Below is a very different take from Dora about her career change decision. She shares her feeling of 'awe' about WOC Nurses in industry. She seemed to feel as if she could not aspire to fulfill such a role. Dora frames her decision around being brave and being driven to do something new by the fear of not taking a challenge. It sounds like her fear moved her to action.

(Dora) For me the transition was, mostly out of fear. My fear was to speak in public. So I was in my nursing WOC role I was given the opportunity to speak in front of physicians and I threw myself into the conference role, went out there to speak so I was building that path and I was always in awe of the clinicians the WOC nurses who were in the industry world. I never thought I could even get there, I didn't think I was worthy of that because I looked up to them. So when an opportunity came it was amazing and I really didn't think I was going to get the job. It was mostly out of what you said Iona, the change, to do something brave and to see if you could do it. If you failed, you failed, and you could always do something else. So, that was why . . . what was the question? (laughing) (13)

Even after two years, Dora still speaks about how amazing she feels that she is actually performing this role in industry. Beth adds to the stories of transition by sharing her lived experience that influenced her decision to move into industry. She viewed the lecture by the pharmaceutical nurses as positive role models to aspire to. Being out of her comfort zone was attractive to her because as she states below, it offers her an opportunity for learning and sharing.

(Beth) I've see a lot of autonomy in the hospital as a WOCN. And I loved what I did when I did it but it was time to do something new. And I watched two pharmaceutical nurses, they were from Schering Plow, and I watched them give us a lecture one day, and I can remember the product too, and I thought, I think I want to do that. So it is a challenge and you learn something everyday and you are out of your comfort zone everyday with something or someone or a certain group of people and that's part of the challenge and that's what makes it fun and interesting. (15)

The comment chain continues with references to autonomy, which become more descriptive of the role, rather than the simple transition or move to industry. Attributes of the role or inducement to career change, perhaps it is the promise of attributes of the role which draw the participants to make a life altering change. It sounds like Gwen is saying that the promise of something new around the corner each day, is part of the allure drawing her to the role.

(Iona) Autonomy. (14)

(Gwen) I love autonomy. And yes, I work from home but yes, I travel a lot too.

Uhm, there's good and bad points about that, but yes, I think really, there's always something new around the corner. (14)

This story of transition is part of the larger conversation on identity and role, while this comment below speaks to the way that Iona feels about the actual transition or mobility of members of this group. The quote below is meaningful on many levels. It sounds like Iona is drawing an allegory below.

(Iona) And I really think the only drawback comes when you realize you really have packed that suitcase and you really did leave home. And now how do you . . . I love what I'm doing on one hand, I'm very happy with that situation, but then I think most of us had to go through a short period of how to deal with home. (37)

When the WOCNII takes on this new identity, he or she does set out on a new journey for which there is no precedence in the literature and everyone who sets out does leave home and starts a transition to a new identity and a new role. What does 'home' symbolize? It is far more than an address – home is the familiar and packing that suitcase might symbolize a packaging of the specialty knowledge and skill set – to transition to a new role or a new context for practice.

Their identity and this role is mobile, it is transitional in the twofold sense that the role is literally mobile, with participants traveling from place to place, speaking in different voices, acting roles on multiple stages, while their identity is in transition; how do these CWOCNIIs tell their story of transition when they interact with social and professional networks who really do not know what they do and how they do it or even why they do what they do? What is happening here in this focus group is that these participants are acting on an opportunity to tell stories of who they are, where they've been and where they might be going in the future. These stories are more about the quality of the journey, rather than the details of exactly what they do.

What sets them apart

The following section describes the theme of what it is that they feel sets them apart from their colleagues. Subthemes touch on expertise and practice setting. This next exchange illustrates how these participants feel about their roles within industry; they seek to support sales, while looking out

for the best clinical interests of the patients. It captures a discussion about how they see their role as nurses within the larger context of industry and making products available to patients. Below is an example of how they approach product selection for patients considering some challenging economic barriers. As Gwen so eloquently states, coming into industry, she feels that they are now positioned at a new vantage point, to see beyond the 'silos' that they formerly practiced within and learn about and use information on payer sources, to manage resources within a complex reimbursement system. So, she believes that she is seeing the larger picture and acting in a role as mediator for patients in a system that turns on a dime. Gwen begins the conversation very engaged, leaning forward with expressive arm motions, reaching out with upper body movement to be with the participants surrounding her. She speaks with passionate conviction, with her hand over her heart and she is met with affirmation from her peers.

(Gwen) I think something that we all see is when we were in our different silos, that's a fair word to use, we didn't have the big picture of regulatory, reimbursement, payer sources that we have to have, and that's a learning curve, it was for me. But to understand who the payer source is, if it's a Part B or reimbursement insurance information, why aren't they willing to supply those products? Well, you know what, they cost too much. (17)

(Gwen) So your challenge sometimes is, well I'm a nurse first, I tell everybody that. But here's the reality, the dollars and cents aren't adding up so we have talk about what can be provided. And that can be a real conflict for us as nurses . . . but it's the reality. (18)

(Gwen) We're nurses first. (40)

(Iona) Safety for your patients and your nurses. (40)

As evidenced by this excerpt, it appears that Gwen is acknowledging the need to align the caring mindset that is the optimal image of the bedside nurse to the reality of the current healthcare climate and find creative ways to satisfy patient needs. In her industry role, Gwen is privy to not only what may be the most appropriate clinical product for a patient, but she now is responsible for product selection based upon the reality of financial considerations. Gwen is acknowledging the compromise that must be made. She knows that is a challenge in healthcare today and she admits to conflict and

feeling a tension between the nurse and the industry reality, that is expressed by her facial grimace. Always at the heart of the matter is the grounding of being a nurse. In her experience, at the end of the day, this ability to see the larger picture and provide for the most appropriate patient need differentiates the CWOCNIIIs from the hard-core business of profit and loss. The conversation below is expanding on how they see their role; their perspective on how they function and what sets them apart from others outside their group.

(Fay) We're more willing to think outside the box, than the typical person . . . You don't hit walls, you move walls, you have to. If you don't, your patient suffers and we're advocates at the end of the day . . .(18)

(Dora) I agree with that. (18)

(Dora) I think that in this role, you can't be that nurse that's bounded by boundaries, you have to be open to what people have to say (18)

These participants are excited by the opportunity to draw on their resources, to be creative in the way that they think about care delivery. Free from the task of daily caregiving, they can focus on innovative ways to navigate the system to provide for patient needs across a more broad landscape. There is a definite sense of excitement that is portrayed by their body language; they way that they lean in toward others in the group, visibly reaching out with positive facial expressions and arm gestures. Part of what they feel sets them apart is their unique work setting. They practice within their own microenvironment, positioned within their own company. Within the context of industry, these participants share a common bond that includes a work setting that merges home with professional role and blurs the distinction between the two environments. Dora feels that was a hard transition. Dora expresses a tension associated with transitioning to establishing her work setting within her own home environment. She also speaks to the organizational skills required to do so.

(Dora) I think the tough thing for me was organization. I'm not sure that I could just . . . because nursing is so regimented, you get up, you go to work, and then you leave. But with this role, you're your own self-motivator. You have to be highly organized. Your house is now your home office. That was the hard transition. (41)

Fay reiterates the feeling of merging the two settings of home with work when she observes that for her, she never turns off work. With the fluidity of the settings, Fay feels that it is difficult for her to leave work behind at the end of the day.

(Fay) You never turn it off. There's never an eight hour day. (41)

Cate cites an example of how her work and home life are blurred and how her work schedule or lack of schedule impacts her life. This example rings true for the other participants who affirm that they share the unpredictability of work time.

(Cate) . . . the fact is, when I first started this job, I had to move to a different city so I looked for places that I could go and even do volunteer like at the street clinics and things like that, well, they kind of want you on a schedule and unfortunately with our life . . . you know, I'm trying to have new windows put in my house. When will you be there, well let me get back to you. (54)

The sense of self-satisfaction from work done is spoken of by Fay when she states that despite the lack of hands on experience, she can see how her work and the work of her colleagues in industry has made a difference. She speaks not only for herself, but for all the participants in the group. Indeed, she says that they all acknowledge and are united in the intent 'to pay it forward' with a sense of determination.

(Fay) So you actually, you're not hands on, but at the end of the day you can see where you made a difference. (52)

(Fay) We all understand the importance of paying it forward. That's us, at the end of the day. (57)

(Fay) One word, determination. (16)

Cate speaks of the feeling of camaraderie and love that each of the participants share as one group set apart from other nurses. She feels that over time the participants have come to share an emotional kinship that extends beyond the professional interface. Like the merging of work and home, for these nurses, their network merges professional and personal.

Cate) We have all known and grown to really love many of the people in this room. And it is because, please if you come away with nothing else, what you need to understand, at least in this group and many other people in industry, don't ever be afraid to voice anything, because we all have at one time or another, I mean because like basically, it's like seriously, I'm doing this for what? (39)

Cate feels there is something else that is special and sets her group apart. Beyond the challenge, the adventure, the autonomy, each participant shares the desire to learn, to be open to learning. For her, being the educator is inextricably linked to learning. She also sees this as a driving force that goes beyond learning simply about the product that a company sells, but rather learning about how to impact the general quality of patient care. Cate feels that this openness to learning sets her and her cohort of CWOCNIIIs apart.

(Cate) The other thing is, everybody talks, I mean everybody, person around here, talks about the adventure, the autonomy, the challenge and all that but here's the thing, each and every single one of us here at this table and many, most of the people that I know in industry always are open to learning. You talk about education, you cannot deny that every time you teach, you learn something new. We are driven to learn more about whatever. O.K. so you work for Company X, you know wounds, O.K. but every single one of us don't stop at just doing wounds. We want to know more about all that impacts our patients. We're just never satisfied. (17)

In the exchange below, Iona speaks to research; both the performing of it and the dissemination of it. Performing of and sharing the research is integral to their role in industry and their ability to perform sets them apart and adds perceived value to what they do in the eyes of their customers and their employers. The comments then expand on how their clinical background enhances their ability to disseminate research and how to stay clinically relevant.

(Iona) And that's the other part of our job, is research. Whether we're doing the research or reading the research, we're sharing that research and that is very valuable to our colleagues, back still doing patient care. Not back, but on the other hand, doing patient care. (34)

(Cate) I honestly believe that one of the primary roles of any nurse is education. It's what our life is about. (35)

(Cate) So yes, a nurse who comes into industry, who maybe doesn't have this background (as a CWOCN), will want to learn it. But if you haven't gone through the excruciating course to get that . . . (laughing) you don't understand. (35)

(Iona) And the other part of that is, you can go through the excruciating course to get it, but if . . . you don't follow up with going to conference, continuing to learn, ordering the journals, reading the journal, listening to the educational programs that are offered, then you become not very valuable and I sometimes think that those people may bring our industry nurse image down. (35)

(Gwen) . . . boots on the ground (35)

Cate speaks to the 'excruciating course' as a term to describe the empirical experience that is their roots and she shares her observation with a knowing chuckle. Despite the fact that they have transitioned from patient care, they have roots to patient care and they see this as enabling them to connect with their customers. The historical source of their knowledge is the link that associates them with their customers and derives the value perception. This places them in a unique position within the larger nursing society and sets them apart. To maintain their roots these participants feel that it is important to keep themselves and their knowledge relevant in various ways, through reading and being involved in research, by attending conferences and professional meetings. They feel that if they do not maintain their roots with follow up such as attendance at conferences, reading journals and continuing education, they feel that they are not perceived as 'having boots on the ground.' It sounds like the reference to boots on the ground is an historical link to their heritage. It is quite interesting that they call their own career path an 'excruciating course'. That is an area for further probing.

Within the scope of their role, they perceive themselves as educators and as advocates, for their customers, both patients and caregivers. In addition, their non-nurse colleagues within industry are also their clients, in effect, their client base has multiplied. The concept of education comes up many times throughout the course of the focus group. Education is at the essence of their role. As such, for them, to be relevant in educating means that they target their communication with their audiences appropriately and they are acknowledging this below when they describe.....

(Iona) I'm just like Cate, I have the gift of gab and I don't mind talking. I know people everywhere, so now it's learning how to talk to different people. And I think that was my number one drawback, I had to learn how to talk with nurses, administrators, it's all a different conversation. (36)

(Fay) If you want me as a patient advocate, you've got the right person. If you're asking me for a mouthpiece, you don't need me. (40)

(Iona) Safety for your patients and your nurses. (40)

Iona explains her experience in learning how to develop this skill of speaking with and relating to different people. She explains how even with her natural tendency toward being loquacious, she has had to learn how to speak to different audiences and that was not easy for her. Her ability to communicate on multiple levels and the judgement that enables this is part of what sets these participants apart. They have moved from being just caregivers of patients to caretakers for both caregivers and patients, retaining the advocacy role but expanding upon it. Fay states that for her, engaging with industry meant being true to her role of being an advocate. What sets them apart contributes to the way that they are perceived by others.

How They See Themselves: leadership and expertise

This section describes the way that they see themselves. One of the ways that they see themselves, is as leaders who are autonomous, in roles such as clinical experts, and teachers and researchers, while always being a nurse.

Leadership

Dora makes an observation on leadership.

(Dora) The nurses who are in this role are nurses that are leaders, I feel, are not scared to go for what they want. So within that group of leaders there's competition. We are open minded, we are not super biased, we are leaders, we are not fearful. We want to stand up more and do more for the nursing profession. I don't want to sound elitist, but I think it's really hard to get into this role. So within this group there's competition because there's strong leaders. (44)

This is the first reference to being leaders. Dora is peeling back the layers of their role to share her feelings about leadership. Leadership in and of itself is a concept to explore and it is part of the multi-faceted role that these nurses perform. Dora begins by saying that she doesn't want to sound elitist, but her words may not convey her feelings. It sounds like she has a realization that seeking out such a position translates into being able to compete for a position from among a large cohort of experienced individuals and she had what it took to make the grade.

Iona then offers a personal insight about how she sees herself and her colleagues. She speaks with passion about the importance of her professional interactions with other nursing groups and organizations. She speaks of the important contributions that they have the power to make politically at various levels of government. Positioned in industry with the clinical heritage of direct patient care and the expertise of her specialty, Iona feels and is confident that her group of CWOCNII has the potential to make an impact on healthcare, if given the opportunity.

(Iona) I think what I'd like to say . . . is, we know this in this room, we know we are important to all of the membership organizations that we go to. We're important and could make a huge impact with our government, both state, local . . . local, state, regional and even what's going on in Washington right now, if we had those opportunities. And the vehicle for us to get there is most important I think, for this group to look at going forward. (57)

With this acknowledgement of self comes the call to act. If these participants see themselves as agents of change, what is the next step in the evolution of self-awareness? How does that awareness operationalize?

Expertise

One of the ways that they see themselves, is being an expert. They feel it is part of who they are and they describe being recognized for their expertise. Below is an extension of the dialogue on how they see themselves. An integral part of who they are and how they see themselves is their clinical nursing specialty and the recognition that they receive from going through that 'excruciating course'.

Continuing the discussion on how they see themselves, the facilitator asked the question - what is it, what are the special attributes that you all, as nurses, bring to industry, what is it that *they* (industry employers) are looking for? The following is a chain of comments in response to that question. The responses are all about what they perceive to be the special knowledge and skill set, the expertise, that

each of them brings to their role. The following is more about how they see themselves and the value they perceive to be associated with their roles.

(Iona) (Speaking about industry) They're (employers from industry) looking for our knowledge . They're looking for our relationships. (25)

(Beth) Because if you can't relate to that staff nurse you are meeting with, or that director in the hospital, they're not going to hear you. (25)

(Cate) Every single one of us drives change in industry. Every single one of us does that, I believe. Because we go and we look and well, this is what we're doing, here is what our nurses want. (25)

Iona and Beth speak to the social interaction and the value that is perceived by their employers. Beth feels that she can speak to and with clinical personnel because of her shared legacy and her clinical relevance. In a similar vein, Cate sees herself and her colleagues as driving change in industry by using their clinical relevance, relationships, expertise and advocating for what nurses want and need. All of that is part and parcel of their expertise.

The knowledge is their expertise, the clinical experience of being at the bedside, combined with their educational didactic learning acquired over the years. The relationships are the network of individuals who are built up over time, working within patient care and within patient care delivery systems. These relationships and their shared historical legacy, is part of what makes these CWOCNII so valuable to their employees in industry. They facilitate the social interactions of industry who manufacturers or distributes to their target populations of buyers. They act as a bridge between industry and the end users of products because they relate to both parties. No one else in industry is positioned to do that.

Teachers and educators

Teaching is an output of the expertise and Beth notes that in industry, she is able to expand the dissemination through teaching a wider audience of nurses. Beth describes herself and her colleagues as experts.

(Beth) I was going to say, the teaching part of it is really huge with all of us. We all taught, we were all the experts in the hospital at whatever. And we taught. So when we teach in the hospital, sometimes we get a class with 30 people in it, but a lot of times we teach one on one, two on one, you have two nurses with you and you say come with me, I want to show you something. But when you teach now in industry, you have 15 people here and then you have 15 after them, so you're reaching a lot of people. And then they become resources for a lot of other people. So you're spreading the knowledge which is helpful. (16)

Lack of recognition of their skills

As the dialogue continues, Iona brings up something that sounds like a source of tension for her. With a passionate voice, she states up front that it really bothers her. The others chime in with verbal affirmation and body language that shows a synergy of coming together with Iona. She talks about how she shares equal education and knowledge with colleagues, yet when she contributes to collaborative work with professional organizations they deny her the acknowledgement of her contribution to the joint effort, be that a paper or a project. She feels as if she is not being recognized for her contribution and her expertise.

(Iona) And one thing that really bothers me . . . when someone tells you, that you can write our paper, but we don't want to put your name on it because you work for industry, it will not be as valuable as if you write it and let us put our names on it. And we have the same education, the same dedication, the same knowledge level as somebody who teaches at a university . . . I think that's very unfair. (25)

Iona speaks to the ethics of not being given the recognition and acknowledgement of her expertise. She states that although she has the same education and commitment as her non-industry colleagues she is not bestowed with the same acknowledged recognition when she participates in certain projects within professional organizations. The very act of contributing but being told that she cannot be given the credit is deemed unfair in her eyes. This would appear to be an example of being marginalized and brings up an issue of ethics.

Closely integrated into and a part of the discussion on expertise is how that knowledge and skill set of these WOCNIs are devalued and their role deconstructed to benefit 'others' for whom and with whom they collaborate. They acknowledge that this is going on, but there is no talk as to how they can

foster change. The next comment relates a specific example of how Gwen feels about her role and her expertise within her company. Gwen tells us about her colleagues at her company who are not CWOCNs. She fears that they may misrepresent her and the special knowledge and skills that she brings to the table. Here is an example of guarding the territorial boundary of her knowledge and skills, her expertise. It sounds as if her expertise is not being recognized and that all nurses are being lumped together.

(Gwen) We've recently expanded our clinical team. And we added another CWOCN so I finally have help. Now the push is to add more nurses to do regional support. Well, none of them are CWOCNs and they're getting pushed into being able to handle some of the front line things that normally I would be doing . . . I'm a little nervous because the last thing I want to see is somebody misrepresenting what myself for my WOCN colleague can bring to the table. (30)

Here is another example below offered by Beth of her experience in her company. She expresses a similar perspective as above, that in the eyes of select 'others', a nurse is a nurse without the recognition of differences in expertise. She states that in her experience some people lump all nurses together.

(Beth) I know that my employer, and I'm sure that others, they want us to learn more. The more that we learn, the more we know. Since we're all the thirsty ones, it works perfectly. Uhm . . . I was going to say something else about that . . . unfortunately at some point and in some places, whether it be industry or other healthcare places, is that some persons in certain places will think that nurses are like plug and play too, that "Oh we don't have a wound care nurse, so an RN will do it." And I think that happens too. (31)

Beth works for a company within a team of RNs who all share the same job description, but she is the only one who is a WOCNII. She is often called in to intervene for her peers in situations where her credentials and her expertise make the difference in the relationship. This company has proceeded to hire RNs who are not CWOCNs. This participant has commented on what can happen when 'others' who are unaware of the nature of the special knowledge and unique skill set of WOCNII, do not differentiate between the expertise of WOCNII and other nurses without their expertise and certification. Cate calls attention to the expertise that she references routinely in her role.

(Cate) And so, yes, I sometimes say, I miss hands on, and I do, but at the same time, you get that kind of almost hands on because you're still referencing all of that material that you had. (53)

All of that material that Cate speaks of is the combined knowledge, education and clinical experience that is her expertise. Iona's comment below is a summative statement on she feels about her identity, her role and her expertise.

(Iona) Corporate America looks for one thing . . . and we all know this, profit at the end of the day. O.K., what we bring is ancillary services out there that support that profit at the end of the day. And it's our training, our skills, our ability, our knowledge, our willingness to be adventurous, travel and keep learning and go to school and come to WOCN and go to these classes, go to all of the conferences and sit in classes so we can keep learning so we can share that with our customers. There's nobody else that can do that or will do that. (31)

Iona's comment brings up a discussion of profit. She is the first one to speak the word profit. This participant has grouped together all of the knowledge, activities and responsibilities that WOCNII pursue, and has packaged them together as the unique skill set that WOCNII offer to industry. This package of knowledge, activities and skills is the expertise and the legacy of this group. She has acknowledged a new context for the WOCNII, one of performing a new role on a stage that is still being constructed.

How they feel they are perceived by others

In the excerpts below, the participants tell stories about the way that they feel they are perceived by others. The identity of others influences what their perceptions might be. The group are asked to explore how they believe they are received by the colleagues they left behind at the bedside; how they feel that others perceive them and their roles. Of course, the basis of their feelings is a product of their interaction with others. Iona replies by saying that perception of how they are perceived has everything to do with who the others are. The participants around the table chime in to reaffirm the comments below.

(Iona) Depends on who your're talking to . . . (33)

(Fay) The customers are looking to us for answers. (33)

(Gwen) Credibility, you've got credibility. (34)

(Fay) You know what you're talking about. You've been there, you've done it. You eat it, you sleep it, you think it. (34)

(Cate) That is one of the high points that industry in and of itself appreciates too. Because not only have we been there, but we can talk with clinicians, understand exactly what they are asking and saying and we can give them an adequate and clinically correct evidence based response. (34)

Cate brings up the term 'evidence based'. This is the first time evidence based has come up in this dialogue; evidence is at the heart of this whole role based discussion . The excerpt above describes the value perception of credibility as perceived by the participants; coming from their interactions with customers and from colleagues within industry. In their role within industry, when they interact with customers, they feel that they are perceived as being believable, they feel that they are credible in the eyes of their customers. Their credibility is associated with their historical link to direct patient care, their clinical experience and their expertise. It is apparent by each of the participants' body language and verbal affirmations that they agree about how they feel they are perceived by customers.

Being a 'traitor' and feeling judged

The exemplars below describe the way that the participants sometimes feel, that is not always experienced in a positive way. Noting that so much of what they bring to industry is good, the facilitator queried the participants to ask if there is anything from their past work life that perhaps does not translate as well in their new role. The way that they feel they are perceived by others in some cases is not always positive as illustrated by comments below.

Here is the first time that being a traitor is mentioned. This is part of the individual and the group experience of being, but is spoken of in the third person. It is a meaning that is interpreted by Iona gleaned from 'others' who she interacts with professionally, but it is not owned solely by her. Speaking deliberately, slowly, with upper body extended, she leans out to connect with her peers, but the others around the table are not so quick to engage. Others do not meet her eyes. She speaks of being a traitor as a label conferred by 'others' but given unjustly. This is a feeling expressed by Iona about how 'others' perceive her and others in her group. The other participants at first seem hesitant to

acknowledge what Iona is saying, after a brief pause, two others add their own observations. Iona, Cate and Dora are speaking from their experience, so for them, their perception is the truth.

(Iona) Coming into this role I did find a huge negative. The negative was, I think although it went away for a little while, not as bad as it used to be, but a nurse that moves from patient care into an industry role is seen as a traitor by other nurses who are certified in that area. Many times you can overcome it with your direct customers, but when you come to a conference or you are trying to work with a membership committee, then you aren't treated equally. (20)

(Cate) The thing is that somehow we are judged as leaving our ethical side, our intellectual side over here, because now we work for company A. And everything I say will be based on, "O.K. I work for a bed company so everything I say is only about my beds." And if we were to talk to each other, we couldn't because she would only think that her product was the best thing out there. (20)

(Iona) That's so not true, within this group. You see how friendly we are. (21)

(Cate) It comes from . . . uhm, maybe it's, I'd like to say it's our own, you know, we just kind of made this up and it's conspiracy, but . . . when you are basically flat out told that you may not serve in higher echelon capacity at most national organizations that deal with wound care, that deal with safe patient handling. You may not speak at most of those conferences unless it's labelled a 'vendor session,' . . . uhm, it maybe is a little bit of a conspiracy theory on our part, but it's hard not to think that way (21).

(Dora) I think it's from everyone, except from patients. (21)

(Cate) Nurses who know us, know that's different. And nurses that we have worked with consistently accept that. (21)

For Cate, being a traitor is equated with being unjustly judged as unethical. Iona quickly jumps in and denies the truth of that accusation. Being a traitor is expanded upon by Cate, commenting that in addition to being a traitor, she and her colleagues in industry are labelled unethical. 'Over here' sounds like she is referring to an invisible line in the sand, that designates a threshold beyond which

ethics is compromised. Cate goes so far as to label the issue of being a traitor as a conspiracy. Conspiracy is a strong term that engenders a certain meaning, a certain negativity, as does 'traitor'. This is descriptive of her experience.

The exchange goes on to attempt to categorize 'others' as being participants in this conspiracy theory. Who is influencing this conspiracy theory? Is it their peers? Is it patients? Is it their clients? What is the rationale here, in trying to single out where the meaning of conspiracy is coming from? If they have identified a conspiracy, does that imply that they are victims of this conspiracy? In any case, it appears to be insidious and discrete to others outside this sphere, although manifested by certain regulations within policies of professional organizations.

(Cate) But let me explain something. I have a friend who was asked to speak at a national conference for a reputable group. Everybody in that entire group and 99% of the entire world know that this woman works for industry. There was one large amount of backlash and yet this is a woman who is principled, who is ethical and not one time in that entire presentation did she mention either the products that her company makes or even talk about her company. And if you would like to know who that woman is . . . and seriously I think that she was very hurt and upset that not only did that happen, it happened by her peers in the organization that she belongs to. Would you agree Iona? (23)

(Iona) Actually thought that there was going to be a law suit brought against me, personally. (24)

(Gwen) 'Oh for Pete's sake.' (24)

This comment is related to both the subtheme of traitor/conspiracy, but also is associated with competition and the fear of conflict of interest, since it stems from the tension generated between companies and the tension generated between affiliated companies and professional organizations. This passage tells the story of the events that were set in motion when a WOCNII spoke at a national conference within concurrent sessions rather than as a vendor presentation. The principle actor in this story told by Cate, was Iona, another participant in the focus group. Iona was very quiet throughout Cate's rendition of the story and her face was stoic throughout the narration as it was related. After a few moments, Iona responded with the admission that she had thought the incident might lead to a

lawsuit. As an insider, I know she felt very hurt when this experience transpired two years ago. I was aware of the story as it was happening two years ago, and I recognized the story as soon as Cate began to tell it. I was interested to see the reaction it would foster, and I was frustrated when Gwen broke into the conversation, thereby effectively disconnecting the flow of the dialogue and preventing the principle actor from spontaneously elaborating. Gwen was unaware that the story was about Iona's experience and her comment 'oh for Pete's sake' expressed her feelings of the absurdity of a lawsuit. As a new employee at a for profit educational company, Edith shares her feelings below.

(Edith) This is my first conference since I started with the organization that I am now with, and so I am so glad that I have heard what you're all said because all of that I was feeling inside and I felt like I was probably the only one. I wondered if the WOCNs were going to see me as a traitor since I'm now with this organization, which to me is nothing but help, because it's putting more clinicians at the bedside where they need to be. (37)

It sounds like Edith is expressing relief to be able to name the fear that she was harboring inside. She found words to describe her fear. The emotion in her voice was palpable during her confession as she revealed her suspicion of feeling as if she was the only one who experienced those feelings; she had felt alone and isolated. She is now brave enough to speak of it and she can find confidence in knowing that others have similar feelings.

Feeling like an outsider

The excerpts below describe the way that the participants can sometimes feel about how their role is perceived by others. The scope of the exchange on being considered as a traitor, expanded to talk of ethics and being considered a vendor, which then led to the experience of being at a conference in the Exhibit Hall. A comparison is drawn on what it was like to be in the exhibit hall as a nurse who worked at the bedside, compared to what it is like to walk an exhibit hall as a CWOCN who works for industry.

This first comment below is very revealing, it sounds like she feels that her recognition is a constraint to her being able to access a learning and a social opportunity within the Exhibit Hall at a conference, with colleagues identifying her as a competitor. Dora feels passionately as expressed by her body language, that her facial recognition by others is labeling her in such a way that restricts her free access to a highly regarded learning opportunities at conferences. She feels that learning and education are important to her role and her identity and being denied access to opportunities is impacting her

negatively. She is saying that in her industry role, she is being limited in a way that she did not experience as a professional caregiver. A venue that formally provided an opportunity to learn about the most current technology related to wound care is now closed off from her because others recognize her as a symbol of someone who works in industry and they shut down their interaction with her.

(Dora) My face is known because people know me as a competitor, they know me, I can't go and learn things as a nurse (at a conference). I can't walk around to vendors (in exhibit halls), I can't, you just don't get the same response like when you were a nurse, because they don't want to teach you things. (21)

(Fay) The companies won't talk to you. (22)

(Dora) That was huge thing for me. My first year I was hired to work the booth, I was so excited, I was walking around and immediately they looked at your name and saw industry and you were done. (22)

(Gwen) If you wanted to learn something you had to go send a spy. (22)

(Fay) You're the competition. (22)

Interesting that the discussion on being a traitor within the context of the conference exhibit hall led to their experience of identity linked to competition among vendors. In the context of attending conferences, these participants each express their dissatisfaction with losing the freedom to interact with various companies and learn about the state of the industry within an Exhibit Hall, because they feel that they are perceived as the competition, or as a threat. The reference to spying sounds a bit dramatic, but when Gwen expressed it, the other participants showed agreement with their body language, shaking their heads in affirmation. What makes this so impactful is that as one participant stated, it is the lack of an opportunity to learn about the latest trends in medical devices. By being limited in their access to circulate through the exhibit hall and learn about new technology, they are expressing a dissatisfaction that they are no longer entitled to that learning opportunity that they once had as direct care nurse specialists. They see others as putting a constraint on them. That learning opportunity is a significant facet of what they perceive their role to be, so to be denied that opportunity impacts negatively on them. The interaction that they are denied is also partly social, not

only is interaction of an educational nature, it is also a way of networking and maintaining professional relationships.

Feelings about competition or being a threat are being expressed on multiple levels, by participants. Below the dialogue branches out to talk about what Dora is calling competition, something that is perceived between the participants and their colleagues who are not in industry; between them and the nurses they left behind at the bedside. As Dora expresses her feelings, another participant, Gwen with many years in industry, jumps into the discussion speaking directly to the participant rather than through the facilitator.

(Dora) From our colleagues, a little bit could be jealousy. Oh you know, I wanted that role too and I didn't get hired. So a little bit of jealousy. Instead of supporting you, being so happy that you took something new in your different role and you're doing well, there's jealousy. I think, that's my opinion. In the industry world, there's competition. (23)

(Gwen) Just a question Dora, because you've only been in industry for two years and I guess I'm feeling like I thought that things have gotten better and you're telling me that it probably hasn't. (23)

(Dora) Well I've heard from experienced industry nurses that it is much better for me, than it was for you then. (23)

(Gwen) It feels like it's better. (23)

Initially there is no engagement from the group when Dora begins to speak, and it seems like she is hesitant to proceed. It seems as if she perceives their lack of engagement as a sign that they might not share this feeling that she is expressing about competition among CWOCNs in industry (CWOCNII). She even feels the need to state that it is her opinion. It is almost like she feels an outsider because she has shared this feeling, here could be a hint of isolation. Dora's confession is her expression of competitiveness that she has experienced on a more personal level one on one between peers within each company organization.

In turn, Gwen responds directly to Dora (rather than through the facilitator) in a moment of more spontaneous inquiry and sense of urgency. As an observer, I could feel the tension in the air. The fact

that Gwen with 20 years of industry experience, comes right out and states that her colleague Dora has only been in industry for 2 years, it sounds like she is almost incredulous that her own perception of her reality may not be that of others. The fact that the experience of her colleague appears to invalidate her own feeling is troublesome to her. Gwen has the final word in this exchange by validating her own feeling that things are better, for her.

This dialogue is an example of an exchange driven from a temporal perspective; one participant relatively new to industry (2 years) expressing her opinion and another participant with a longer history in industry (20 years) taking a reality check on her own experience. What feels better, what feels worse, appears to be a matter of relativity and where one is positioned in time and place. There is a continuum along which this competition, this conspiracy theory moves in both time and space and it's all relative to the person experiencing it, in the moment.

Network of Support

This final section is a theme about the feelings that the participants express among one another regarding support during and after their transition. They describe how a sense of mutual support and a feeling of being bonded with one another impacted their transition to industry. The facilitator asks if anyone can share their thoughts on what might have made their transition from patient care to industry smoother.

(Iona) A little bit of a mentor in our new job would have helped, which I have basically turned into. (38)

(Beth) I had a wonderful mentor (laughing because Iona was her mentor). (38)

Here is an exchange, about being able to have support perhaps in the form of access to a mentor. A bit of banter between participants, Iona and Beth, who are friends and colleagues. Iona in fact did mentor Beth when Beth went to work at Iona's company. Beth who replies that she had a wonderful mentor, was speaking in a complementary way about Iona, who mentored her and who was part of the focus group that today. They both worked for the same company and Iona the 'veteran' supported the new hire, Beth, so in fact mentorship does occur in an informal fashion.

(Iona) There's absolutely no literature out there about nurses in industry. Actually, me and several other people, we started the Nurses in Industry Committee which

got dropped two years ago and it took us till now to get it back on at this meeting. Maybe there needs to be a formalized group for industry nurses, not including just WOCNs, nurses that work with surgical devices, nurses who work in pharma, nurses that work for whatever. (43)

(Cate) It's absolute great support. Seriously, that's where you learn that this is a group of people that are just like you. They have the same problems, whether they've been in a year or ten years or more, they are or we are open and willing and we accept anybody who comes into this group because we understand. It's like any other real support network group. (44)

(Dora) It's also common ground. (44)

The participants all voiced affirmation about this idea for a formal support network. The committee that is being referenced by Iona is an annual networking opportunity on the afternoon prior to the beginning of national conference. All of the participants of this focus group were heading over to the networking meeting following this focus group. Several years ago, some of the participants present lobbied the national conference planning committee to add 'Nurses in Industry' as a subgroup to an existing structure of subgroups already meeting for the purpose of networking. The dissatisfaction expressed above by Iona was with the disintegration of the Nurses in Industry group two years ago. It is now up and running again, due to the lobbying efforts of certain individuals.

It appears that an idea may have emerged during this focus group for an independent support network, beyond the confines of this conference and this nursing society. An expressed need is made for this as a way to provide and seek mentors. The participants continue to offer affirmations for a professional support network below.

(Dora) . . . So to have a forum I think, would kind of make it like us, you know, even though we're co-conspirators, we're colleagues . . . and I kind of miss that a little bit, because I don't feel like I'm that way but I definitely felt with colleagues that are in my industry, are really strong and competitive. (44)

(Fay) What we're able to do is leave our hat at the door. (44)

(Fay) We're able to sit down and communicate. (44)

(Iona) And we learned, that wasn't handed to us fifteen years ago. (44)

(Fay) No, we developed that. (44)

(Iona) We developed that within our group. ((44)

Here we have a conversation loop that speaks to the potential and the ability to offer support among the members of this group. What they appear to be discussing is a more formalized network to come together, beyond simply the annual event associated with the national conference. Some participants do come together informally during the year when attending specific meetings or conferences; expanding on this informal meeting is an expressed need to connect formally. The idea of a new support network among a variety of nurse specialists who all work in industry may be a positive outcome of this focus group.

Married to Industry

Participants describe how the work has impacted personal relationships, during the transition and beyond. The stories of transition begin to focus on the commitment and the time dedicated to being away from home as part of the role of the CWOCNII. Below, Dora shares the tension she has felt and continues to feel surrounding how her time away from home has impacted the relationship with her husband.

(Dora) The hours are a lot, I'm sometimes so exhausted, I'll tell you the transition impacted my marriage. I mean we had to sit back and have this dialogue and go through a transitional phase. I don't know if you all did or not, maybe you all have great husbands, but my husband, you know, was used to the nurse who was there 9 to . . . 7:30 to 6 and she's not there anymore. (55)

(Gwen) That's right . . . (55)

Chatter all around . . . (55)

(Dora) I'm gone all this week until next week and he's like, 'Where is our marriage?' So there's the conflict of that too. So I think that the hours are a lot and that's a struggle. (55)

(Cate) Well, my plants don't care. So I simply get someone else to come in and take care of them when I'm gone. (55)

(Iona) Cate, wait till you've been married thirty years and they'll start saying, 'And when are you leaving?' (55)

Interesting here that throughout the participant's narrative on how the transition impacted her marriage, only one participant is visually identifying with her comments. The others are sitting passively with their eyes not meeting other eyes, a vague expression on their faces. This is definitely a delicate area to explore, but definitely an area that is full of tension as expressed by this participant. Despite the tension, she has chosen this path and appears to be steadfast in her choice.

Although no one spoke up to acknowledge similar experiences, two participants did speak up to speak to the contrary. It may be that the other participants weren't identifying because they made that initial transition years ago and they have accommodated to the situation or it may be a more distant memory. It may be that they simply chose not to comment, or it might have been threatening. It is probably all individual and experienced in different ways by different couples depending on relationships. Seemed to be greater identification with the last comment. The comment about the plants was a bit unfeeling, I wonder if she realized how she came across, no one laughed here, if that was the intent, while laughter was the response to the last comment.

Discussion of Key Constructs

From this analysis, key constructs emerged as central to their experiences: marginalization, the tensions inherent in their role and their resilience. Each of these constructs are perceptions of feelings that the participants experience as emotional labour associated with the boundary work.

Marginalization

This group of participants have expressed feelings of being set apart by others. They are a subgroup of nurses within the larger geography, a focused specialization in wound, ostomy and continence, and further carved out in a separate group associated with their work setting, in industry. By their own admission, they consider themselves nurses first and foremost, nurses who happen to work in industry. By that same token, they feel that they are perceived by other nurses (who are not in industry) as being on the periphery of nursing practice. This feeling of being on the periphery is expressed in their perception of feeling

judged and feeling constrained by others. They feel as if their ethics are questioned because they have made the decision to work within industry. They feel that others see their career choice as a denial of a commitment to patient care. They feel as if they are covertly and in some cases overtly excluded from full recognition as part of the larger society of nurse specialists. There are barriers put upon them concerning candidacy for national positions of leadership and authority. Much of this feeling appears to be fostered by a perception based disconnect between themselves and others. This disconnect perpetuates the unknown and challenges the communication that may facilitate sharing. Sharing and open lines of communication breaks down barriers and may indicate a way to resolution of conflict beginning with open dialogue. Deconstruction of the role with clarification on function and collaboration with others may erode that feeling of devaluation and build positive bridges with others. They acknowledge that marginalization is going on, but the data does not indicate how they might foster change in perception. This is one area for further exploration in the participant interviews.

Tension

Tension is a common theme throughout the data of this focus group. It is pervasive and appears in each of the categories of Identity, while it is apparent in the stories of each of the participants. Mindful conflict expressed as tension is integrated into their sense of self, their own self-perception and impacts the way that they act and interact with others. Tension appears to be a product perceived by them as an output of a disconnect between how they see themselves and how they feel they are perceived by others. Despite the tension experienced by them, their intent to continue down their career path is strong and not deterred by feelings of conflict. They continue to be vitally engaged with their roles and express self-satisfaction through their professional identity and their contribution to the nursing profession as leaders from their position in industry. An area of investigation related to this tension is the resilience that they display and their methods of coping and support.

Closely integrated into and a part of the discussion on expertise is the tension the participants expressed about how that knowledge and skill set of these WOCNIIIs are devalued and their role deconstructed to benefit 'others' for whom and with whom they

collaborate. The tension is an output of the disconnect between their own self-perception and their interpretation of the way 'others' perceive them. They acknowledge that this is going on, but there was lack of discussion as to how they can foster change in the perception of others. This is another avenue for exploration in the participant interviews.

Tension appears to be generated within their social network; in the context of their perception of associations with others: other CWOCNs in industry, colleagues who are non-industry CWOCNs, colleagues in academia, other non-nursing colleagues in industry and colleagues in other professional organizations.

Resilience

Despite the experience of tension within their own selves and between them and others, these participants appear to be resilient, vibrant and convinced of the professional worth of their role as CWOCNIs. Responding to the facilitator of the group, when asked if they would consider leaving their present positions to re-enter direct patient care, each participant replied that they were happy to be in their current role and would not depart for another work setting. In fact, one participant said that the only way she would consider going back to patient care was if she lost her current industry position, because she did not wish to relocate. After dwelling in the data for some time, noting the frequency of their expression of conflict, it became apparent that despite being impacted by multiple sources of tension, they maintain and sustain a passion for who they are and what they do in the face of conflict, this is a tribute to their coping mechanisms. Surprisingly, there are few mechanisms that have developed during the process of career transition as a way of coping with the tension and conflict of their roles, beyond their strong sense of camaraderie. Primarily, they depend upon one on one encounters with their peers in industry as a way to cope, while a need was expressed during the focus group for a more formal support network to sustain resilience. The informal network of support that these participants share appears to offer resilience, both therapeutic and collegial, in the face of the emotional labour that they perform.

Discussion about ways of coping with the tensions and the sense of marginalization focused on a new idea that arose from the dialogue, to form a Network of Nurses in Industry and to include nurses of various specialties who work within the medical device industry, rather than being exclusive to CWOCNs. Supporting one another by connecting around their shared experience, both one on one and within larger social networks, is a way of maintaining and sustaining resilience among the participants. Resilience is noted as being a potentially separate theme that underpins the professional identity of these nurses.

This chapter has presented the data analysis, descriptive and interpretive, of the focus group and the themes and subthemes that emerged. The next chapter will present the data analysis of the interviews.

Analysis of Interviews

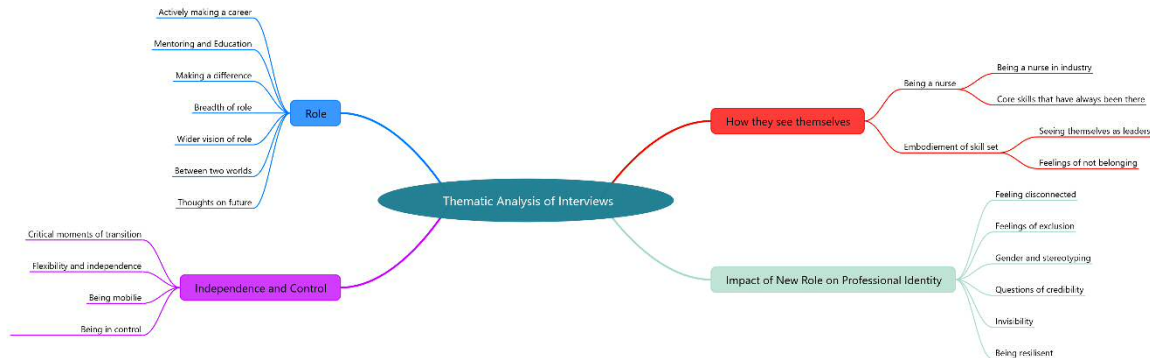
Chapter Four

This chapter is about the descriptive and interpretative analysis of data collected by interview method. The primary themes that emerged are how they see themselves, role, impact of role on professional identity and independence and control.

Early on in the analysis, the diagram below identifies the recurring themes that emerged from within each interview. Overall, ten themes emerged and recurred within the six interviews. The five themes, of being a nurse, role, identity, barriers and enablers and space and place occurred in all interviews. Career and Job vs Career occurred in five interviews. The theme of gender in nursing occurred in four interviews and Boundary Work and Ecology occurred in two interviews. Identifying, sorting out and diagramming the recurring concepts was helpful to begin to make sense out of the chaos.



These ideas and concepts were later developed and re-organized under the major categories of the primary themes; How they see themselves, Role, Impact of Role on Identity and Independence and Control, with subthemes, visually mapped below.



How they see themselves

This first section is about the overall theme of how they see themselves. Participants reveal themselves within the narrative of their stories through these interviews. Through their stories, they permit us to share glimpses of the way they see their own sense of self, descriptive of their experience of being a nurse. Their Identity is reflected in examples of self-expression, emerging as an interpretative blend of meaning, a product of their social interaction with their environment. The participants express that their sense of self, the way that they feel about themselves is closely linked to their professional role. The themes that emerge within how they see themselves include being a nurse with the subthemes of core skills that have always been there and being a nurse now. Other themes include embodiment of skill set, seeing themselves as leaders and feelings of not belonging.

Being a Nurse

The theme of being a nurse as central to their identity was embedded within all of the six interviews, emerging throughout participant stories as a way that they see themselves. It embodies the special skill set that is inherent to their clinical experience; their knowledge, their way of being, the network of relationships.

The way that the participants present themselves to others is framed as the social identity of being a nurse. For some of them, being a nurse is shared as a reflection of their childhood memories and part of their play activities. This identity of being a nurse is

something that they trace back to an early age. For some, those memories of making a career choice are described as being influenced by family, a parent or a sibling. While for others, their memories are tempered within the context of gender and the expectations of what was considered appropriate at the time they were making career choices.

Jane has an image of herself as a nurse from an early age and she describes childhood memories depicted with all the accessories for play including stethoscopes and syringes. Although practice environments changed, nursing was a constant for her, in her own words, 'it was in her blood'. Reminiscing, she associates being a caregiver with the inevitability of being a nurse and shares how she was always the 'nurser'. She coined a variation of the noun nurse as an active noun, 'nurser'.

. . . how I got into nursing was that I always, I pretended to be a nurse from the age of five. Sometimes when I start my programs, I'll say I've been nursing for many, many years since I was five years old. And the stethoscopes, the play syringes, all of it. But always, I was always a caregiver. I was the one who, for whatever reason, it was just in my blood to sort of be the caregiver, sort of the nurser of all things. (Jane)

Lolly reminisced about the familial influence on her chosen career. She describes playing with nurse dolls at a young age and as she grew, her role model was an aunt who she greatly admired. Lolly recounts how that aunt really wanted her to be a nurse. Later on, as Lolly made plans to begin her nurse training, she wished to leave home for the big city, but she described the only alternative available to her that was acceptable to her family was a hospital in a town close to her aunt.

What drew me there (to nursing)? Is my family, a family of six kids, and I was programmed. I was given nurse dolls, and my sister was the teacher and I was going to be the nurse. I had an Aunt who graduated from a metropolitan hospital during war time and she was a great mentor, and really wanted me to go into nursing. I grew up and I wanted to get out and get away. I wanted desperately to go to the city . . . he (her father) thought being near my Aunt and she was a nurse, that would be a good

solution. So that's how that shook down. . . Family influence and I've had no regrets, I've loved it and it's been a great career. Love nursing. (Lolly)

Like other participants Gwen shares a story of familial influence on her career choice. She also identified the influence of an aunt who had been a nurse, but for her she describes always wanting to be a nurse, 'period'. She describes feeling 'lucky' that she was aware throughout her growth and development that she was to be a nurse, there was no question for her, she knew nursing was going to be her life's work.

Well I had an aunt who was a nurse and as I grew up I never thought to do anything else. I guess I was lucky in that respect. Some people have to find themselves. It was never a question for me. I was going to somehow figure out how to do what my aunt did. So I went to nursing school without ever another thought to it . . . that was always what I wanted to do. It was kind of weird, because I know many young people who struggle with all the choices in front of them. It never happened that way for me. It was just, I was going to be a nurse period, no other thought or discussion . . . Yeah, always wanted to be a nurse. (Gwen)

Edith also shares memories of being influenced by her older sister and her studies, shaking her head and softly laughing as she spoke. Her exposure to biology textbooks was through her older sister's nursing studies. She describes how that experience sparked her interest in biology, science and how the body works. She describes the lure of biology and science and how the body works and how she loved nursing and was good at it from the start.

. . . because my sister's a nurse and she's older than I am. She had all of her anatomy and physiology books spread out all over the floor when she was studying and I thought it was cool. Oh, I want to learn about that, so that was that . . . (continuing to chuckle). So she was a huge influence on me and it wasn't so much what nursing was going to be about at the time, it was more that I wanted to know more about the biology and the science, you know, how the body works and how we could help people with their diseases at the time, I guess. . . I didn't know that I knew what nursing was

all about when I went into nursing cause I was young, but I excelled in it and loved it from the minute I got in. (Edith)

Being a nurse in industry

While each participant shared childhood memories of their chosen path to nursing, being a nurse is now associated with the multi-faceted role that they play within industry. Nursing frames their current role and it is the essence of their clinical experience that differentiates them from their co-workers in industry. It authenticates their clinical perspective as a professional caregiver and while the practice setting may change, for them, the essence of 'being a nurse' remains constant. Participants comment on how they primarily think of themselves as nurses.

Edith responded to a probing question concerning the nature of how she thinks of herself today. Regardless of the place of employment, she shares that she thinks about herself as a nurse and as she puts it, it is a part of who she is, her identity. She describes how that will not change, regardless of where she is employed. Here Edith comments on not knowing how to 'take that (nursing) out of someone'. By her language, she feels that nursing is a fixed part of her identity.

I say I'm a nurse. I don't know that that's ever going to come out of me (a bit of a chuckle). I still use my skills whether it be gosh on an airline with a patient having a heart attack which has happened to me or running upon car accidents. I am this pseudo-nurse for the whole company which is really funny because we don't have an occupational health nurse at our company. And so I go to corporate and probably within that first hour I have three people come up to me and ask. . . I truly don't mind, I think it's wonderful that they have the confidence that they can confide in me and tell me their issue. . . I don't know how you take that out of the person. (Edith)

The participants associated 'being a nurse' with the credibility of their current role as a CWOCNII. They describe how their training and expertise as a nurse now means that they are able to relate to direct care nurses from their position within industry. Candice states that her previous experience with direct caregiving and as a Nurse Director in a hospital, has

an impact on her current role and she offers an example of having led an installation of software in her hospital. Candice feels that her ability to 'relate to' nurses' work at the bedside, using her experience of the software installation as an example, adds credibility to her professional interactions, while her comment that she feels that she can 'cross boundaries' exemplifies how her clinical experience translates from the bedside to industry and back again.

You know, but I can still say I came from a Level One trauma center, as director of wound care and wound care program had nine nurses that we developed from 1.5 FTEs. So I can relate to what you're doing. I can relate to they're saying they turn the patient and they're not. I relate to electronic, making electronic records, it rolled out after I left, but I designed it with Epic. So I've been there, done that. That part has really come in handy, that I can cross boundaries because it's not been so long that I've been in a hospital. (Candice)

Gwen spoke about her perception of the way that sales representatives in healthcare sell to nurses and how for her, that experience of selling is framed by her legacy of being a nurse. She described how being a nurse is vital to appreciate and understand the stress that nurses are under when they care for patients. That empathic understanding comes to her through her history of being a nurse at the bedside.

Well you have to have a true appreciation for the stress that nurses are under. Having done it myself, you know, I always say the crux of someone who's never been a nurse, trying to sell, they really think they're important to these nurses that are giving up their time. They don't understand that the nurse if she gives you any time at all, you're lucky! You know I have that compassion. As for people in their role, I knew what it was about for them. (Gwen)

The legacy of being a nurse characterizes the way in which participants approach and carry out their role in industry now, impacted by the nursing process. For Candice, she shared the way she feels about professionally interacting with colleagues in industry at conferences and in exhibit halls. She frames her interaction as a nurse inquiring about products, while

also being transparent about her role. Here again, the experience of being a nurse is at the core of her identity.

I'm going to say as a friendly, inquisitive person, I have no problems in going up to a booth, when I see someone with a new bed, I have no problems, I'll tell them I'm a wound care nurse you know, yes I work for a company, I won't lie, and I'm curious about your bed because I still am a wound care nurse. I want to see what's on the market. . . . I used to be a customer and now I'm a competitor, but that's O.K. (Candice)

Core skills that have always been there

Many of the participants trace back their traits and skills to an earlier time in their personal as well as their professional lives. Participants share stories of how core skills that serve them now have been part of who they are, from a young age.

As an example, sharing what she describes as her greatest strength, networking and relationship building, Jane draws a temporal analogy and associates her youthful social interactions with her ability to be socially interactive as a professional. Jane reveals how she feels about her own sense of honesty and the way that she sees herself as being transparent to others. She expresses a belief that the personality traits and social skills that she demonstrated as a young woman facilitate her being a nurse; she feels that those skills have always been with her.

I'd say what makes me most unique . . . my most probably, my strongest skill set is in networking and relationship building. Right back to the party girl in high school. You know, I was at every party. Had all friends from all the schools, everybody is a friend to me, and I think that my skills around network development and I also think I have, I'm honest and I think that's easily recognized. I had a hard time, I'm very transparent. I have a hard time talking about something I don't believe in. Can't! (Jane)

The demographics of the participants illustrates that they share a temporal experience of having grown up as young professional women of the 1970's. Gwen offered insight into how she sees herself when she responded to a probing question about her expectations of

nursing. She spoke emphatically with direct eye contact and made a connection with the investigator, while she associated how her experience during the 1970's was a part of the way she saw herself. She described how it was difficult to enter nursing school and those who did so were required to have academic skills in addition to the qualities of compassion and dedication. She states that she saw herself as being 'top draw.'

I knew it would be demanding (spoken with great emphasis) and the school I went to . . . we're in the same age group, way back when in the 70's when I went to school, you had to earn the right to stay in that program. I mean they would get rid of people in the nursing school if you didn't have the academic skills as well as the compassion and dedication, you had to be top draw to do this job and that's exactly who I saw myself as. (Gwen)

Embodiment of Skill Set

Having a nursing skill set is alluded to throughout the interviews and includes characteristics that the participants describe and attribute to themselves, including being autonomous, expressing creativity, liking a challenge and being a risk taker. Importantly, they described this skill set as having a key social component, including relationship building and the ability to network. The participants described that these skills were acquired as part of their legacy of nursing and are an amalgamation of accumulated nursing experience and education and include expert knowledge about disease, health, conditions, treatment and prevention.

Gwen shared an image of herself about the way she perceives her life work in industry. She admits to liking a challenge and she feels that the skill set she developed during her nursing career has enabled her to meet challenges and to be successful in her role in industry. She feels that she is using skills she already had developed as a direct care nurse. That skill set was acquired over years of working many different nursing roles around the world.

I found I enjoyed challenging myself, directing myself. I'm good at all that. It just worked for me. The skills, that it took to do the job (in industry), were skills that I had already developed. So I could start out being quite successful. (Gwen)

Responding to a probe about what Lara considers to be the primary skill set that she brings to industry, she associates her legacy of being a nurse with the experience and knowledge she brings to industry. She draws on her previous clinical caregiving experience, her wealth of knowledge and her expertise about wound care to inform her role within product design. Lara describes how she feels that she relates to what nurses do every day by drawing upon her own expertise. She talked about knowing what patients and their significant others go through and about knowing the course of the disease and the treatment. She goes on to describe how the technology surrounding the treatment of wounds is changing, based on the evolving science. She describes how she feels that the new research and innovative technology is very interesting as it relates to wound healing.

It's probably understanding, having the basic disease entity understanding. For a long time a lot of the products that I supported were in support of pressure ulcers. Well I know about pressure ulcers, I took care of them. I knew what patients went through, I knew what families went through . . . So it's having that really good skill set of the disease, of the treatment, being able to research it. I took care of a lot of venous leg ulcers in home care, wrapped them. But the science in that is changing and it's just fascinating. The whole thought process, there's lots of research going on over in Europe. Very interesting what's going on and how it's effecting healing. (Lara)

Seeing themselves as leaders

The theme of being a leader is a frequent descriptor employed by participants as they refer to the way that they see themselves and an important embodiment of the skill set that has evolved over time. However, each of the participants defines leadership in their own way. Many of the participants describe how the legacy of their special nursing skill set and their leadership abilities pave the way for them to make a difference in the way that they perform their role as part of their professional identity in industry.

Jane describes herself as the voice of the bedside nurse, she uses the analogy of a bridge. Although it is not formally a part of her role, she describes how she feels good about raising awareness of the voice of nursing within industry, being a leader by 'taking that voice up the

flagpole' within industry and throughout the larger nursing community. She feels that she is one of them and uses the pronoun 'us' even though she is no longer working at the bedside. Jane speaks in the third person plural, counting herself among those clinical nurses for whom she speaks, identifying herself with being a nurse. Referring to other nurses in industry, she admits that she cannot speak for them, but she feels that being a voice for nursing is part of her role and that being a nurse is how she sees herself.

I like the building bridges. But I don't know that there was ever not a bridge, I just don't think there was a voice. So I feel as if I'm the voice for the bedside nurse that never really got recognized. And so it's my job, not my job, but it's what I find an extreme pleasure, in taking that bedside voice straight up the flagpole. Look what we're doing out there. We're improving patient outcomes. We, I count myself among them, I just don't happen to be at the bedside, but I still feel as if I'm one of them . . . us! I don't know that all industry nurses feel this way . . . you see I think this is a role of mine, is to give people, talk about their work. There's fabulous work going on out there. And it's not being recognized. (Jane)

In response to a probing question about how she sees her attributes, Lolly shares what she feels is one of her vital contributions that she brings to her role in industry. She feels that she is confident as a leader 'to speak up' publicly 'to deliver her message' whatever that might be, from the nursing perspective. She admits that as a young nurse, she soon learned to modify her approach and to be discriminating about how she voiced her opinion, that nothing was accomplished by 'burning bridges'. She describes how she has learned over the years to temper her speech by a self-awareness of how best to deliver her message. She laughs as she describes herself as fearless, confident and loving a challenge.

As far as . . . public speaking comes easy to me. So that was something that I took . . . when I got my Bachelors in Nursing I did take a speech, it was elective, it wasn't required, but I did take public speaking. And that was the first time I did that . . . that was my first real exposure and in that classroom, I was the only nurse there. Nursing didn't even come into the realm. So, how you could deliver your message. So I learned that and

when, I was often, even in the very beginning of my career as an informal leader, because I spoke up. I was verbal and sometimes I had to learn to be careful about, I put an additional filter because I was always go for the right thing. Sometimes that was not always the politically correct thing to do. I learned that as a young nurse, you get your hands slapped a little bit. Or what I found out was that I didn't accomplish anything by burning a bridge. And that's, I couldn't live with that. So, I modified and so I think that's an attribute. I'm confident, I love a challenge. Can't really scare me (laughing). (Lolly)

Speaking about who she believes that she is, Jane touches on the very essence of her identity and how that identity, fits her role. All the attributes that she sees in herself, including teaching, autonomy and creativity, she sees as suiting her well for her current role. Tentatively she explains that she sees herself a 'bit of a leader'. She is very animated during this revelation with her voice rising and a bit of a lilt and excitement coming through.

And so I thought, what I'm seeing about this are a couple of things . . . teaching, autonomy, creativity, which I . . . I guess that's been part of my problem all along, wanting to dig into new things, creativity! . . . and the ability to sort of call the shots, which you know I think I'm a natural sort of . . . I don't need people telling me what to do, necessarily in my role. I'm good to be a bit of a leader . . . (Jane)

Gwen sees herself as a leader and for her, being a leader is about being a doer, someone who organizes and can make things happen while being strong on 'implementation'. Her engaging body language expresses her passion as she admits that, regardless of whether it is a good thing or a bad, 'can't beat it out of her'. She feels her strength is in her ability to organize rather than to create, she feels that is where her leadership skills reside and that is who she is.

I have always been a leader, always. Can't beat it out of me. I've learned over time that you have a choice, sit back and let everyone else . . . you don't have to. In fact, you know it's bossy and it's just let it ride. I can let things ride now, whereas in the past . . . but I'm definitely a leader. That's

my tendency, is to just organize everything. I'm not as much an idea person, I'm not saying I don't have great ideas sometimes, I do, but my strength is not the creative side. My strength has always been implementation. So let's see now, we want to accomplish A, B and C now, O.K. we can get that done, I can figure it out. That's always been my strength. Yes! I'm going to make it happen. I couldn't have thought that through, but you're right that's a great idea. Now let me implement it, I'll make that happen. (Gwen)

Lolly feels that the way she is perceived by other WOCNs who knew her as a leader in her professional organization prior to her transfer to industry, can impact her professional interactions with those other nurses now that she works in industry. She attributes this impact to 'pre-conceived notions' and she describes how pre-existing relationships can be both an advantage and a disadvantage to her now in industry. She sees herself as a leader, someone who is a strong outspoken risk taker, and her body language and direct eye contact with the investigator support her feeling of confidence. Her role in industry now places her in a variety of hospital settings, where she observes the professional behavior of nurses practicing in acute care. She sees herself as being empowered, but when she visits hospitals she feels that often clinicians are not empowered.

I have a hard time in my work territory because of my . . . although it's an advantage to have pre-existing relationships, it's also a disadvantage. a disadvantage . . . because preconceived notions about what you can do and what you can't do or what you may do, uhm. . . I'm strong, I'm outspoken, I have opinions, I'm a risk taker, I can present, an informal leader, a formal leader . . . all of those things and I think that, I've gone into hospitals where there have been clinicians that I think, 'Wow! I just stepped back in time.' This is an unempowered clinician, not a confident clinician. I can tell right away when I go into a facility or an institution, if it's a medical model or a nursing model. (Lolly)

The participants' expressions on being a leader and what this means offer an insight to the way that they see themselves. This aspect of their professional identity is expressed as a strength that enables their role performance.

Feelings of not belonging

Some of the stories told are directly associated with how participants interpret the way that other CWOCNs, outside of industry, see them. The participants' interpretations of the way that others see them influence the way they see themselves, consciously or unconsciously. Identity is always evolving and is integral to the continuous ebb and flow of feedback that is their social environment. Perceptions that other nurses have of CWOCNIs run the gamut from being curious to being envious. This story tells about feelings of not belonging, of being marginalized from the large group of CWOCNs.

Gwen describes her feeling that other nurses in general are curious or envious about her, while describing her own feelings of not belonging. She feels her position in nursing has changed since she transitioned to industry. She elaborated about what she calls 'the club'; and how she feels that she is no longer perceived by other CWOCNs who are not in industry, as being a member of 'the club'. She describes how membership in 'the club' hinges on taking direct care of patients. In the event that she interacts with members of 'the club', Gwen shares how she deals with them by acknowledging that everyone is entitled to their own opinions, recognizing them while remaining self-confident. This is a complex scenario and frames all her professional interaction. Gwen feels that for the most part other nurses who are not in industry express a sense of curiosity in her role. She refers to a wide scope of her experienced perceptions from being a 'sellout', to being an object of envy.

Nurses in general want to know how I got my job. That's been my experience. Very few nurses in general have said, . . . well you're a sellout, you're not doing patient care anymore. Most of them are envious. That has been my experience (said emphatically). They want to know. As far as CWOCNs and CWSs, I am confident that they look down upon anyone with my credential. . . . and they don't know me but they will judge me immediately because I didn't do it their way, I'm no longer doing patient care and I'm not part of their club but that never upset me at all. Everyone

is entitled to their opinion. That's my way of approaching it. They're going to think what they want and that's O.K. Oh yeah, it doesn't bother me if they don't think that I'm the cat's meow, you know (Gwen).

Overview of How They See Themselves

The theme of how they see themselves begins with their stories of being a nurse depicted with reflections on family and cultural influences, mentorship and acknowledgment that they began their career in a very different time and space. This group of participants are of a certain age and have lived through significant social and political cultural change with a resilience that is apparent in their narratives. The theme of being a nurse is expressed by some participants as inherently possessing core nursing skills as part of who they are while some describe their experience of being a nurse now in industry.

Seeing themselves as nurses with a special skill set frames their personal and professional experience. They embody that skill set acquired during their clinical experience in direct care delivery and it impacts the way that they approach and function in their role. The skill set is their clinical experience in direct patient care; their acquired knowledge and relationships.

They describe how these skills inform their performance as leaders. The concept of being a leader arises frequently as a way to self-describe, both informally and formally, while confidence is exuded in body language, leaning in to the investigator, direct eye contact. Being empowered, strong, self-directed, autonomous, self-motivated, creative, are all descriptors they employ to speak of themselves. These expressions of the way they see themselves, as nurses and as leaders, enable the way that they perform and the way that they frame their roles.

Reflected throughout the interviews, the way that they see themselves is a product of their social interaction and a blending of the way that they interpret their interaction with the objects of their environment. These participants describe constantly filtering perceptions others have of them within their professional environment. There is a continuous process of exchange through interaction along a continuum that enables an evolving identity. In the flow of professional interactions, those meanings influence the way that they see themselves, their identity and the way that they function in their roles.

Role

Role is about how the participants see themselves as being able to perform a unique role in industry and they describe how this is grounded in their legacy of being a nurse. This legacy facilitates networking and relationship building as a foundation to relate to other nurses and the wider professional network of individuals in the wound care community. They describe how their clinical experience enables them to generate clinical evidence that supports the sale of products and devices of their companies. Facilitating education, transferring knowledge, gathering and disseminating evidence and performing and translating research while supporting product development and product sales are all facets of their performance and the way that they function within their role. This section focuses on the stories they tell about their roles, what they do and the way that they feel about their work. The themes that surface include actively making the job a career, mentoring and education, making a difference, breadth of role, wider vision of the role, between two worlds and thoughts on the future.

Actively making a 'career'

The theme of actively making a career shows how the participants feel about role as a career. They all spoke of their role as a career, rather than as a job. They state the importance of their own educational progression as facilitating their careers and opening professional opportunities for them. By embracing a career, the participants describe a level of commitment to their chosen profession.

Seeking to invest in a career versus simply a job, Lolly linked her educational progression with career. Speaking methodically in a well-modulated voice, she acknowledged her conscious decision to have a career. That decision to return to work and actively pursue a career rather than a job led her to complete her undergraduate degree in nursing. Her conscious choice to pursue a career was a trigger for her own educational progression.

Actually, the philosophy at the Hospital at that time was that if you were a part-time nurse, you weren't a professional nurse. . . From that point in time when I wanted to return to work full-time, I decided I needed a career. I wasn't going back to a job, I was going to have a career. So I had been taking some courses and I finished my Bachelor's in Nursing. (Lolly)

Being able to write her own job description is part of how Edith has built her career and she describes how this process enables her to grow along with the company and enables her to take ownership of her career. She shares that her role is primarily research and education. Through her body language as well as the tone of her voice, she communicates passion for research and education for what she does and for her career.

So the role is such at our company because it's such a small department, we literally got to write our own job description. So they've had tremendous growth. And so in that period we've been able to write our own job description. Things that I am currently responsible for are all the research within the company, whether that's trials or white papers or posters, that's a big chunk of it. The other part is education. So they have combined research and education. So one of the things I enjoy is taking complicated research and translating it for the sales force. Then with our customers I do of course classes for them. (Edith)

Like other participants who share stories about their roles and frame their professional lives as careers, Gwen refers to her professional life as a career and shares how her career progressed as she left working at the bedside to transition to roles in education. Moving away from the bedside opened up opportunities for her in the field of education. Enthusiastically she admits to how interesting it has been for her, while she links her own educational progression to the evolution of her career.

I got away from the bedside early in my career actually, did lots of education. Ended up getting a Master's Degree fully paid for by the National Institutes of Mental Health, and I am a Clinical Specialist in Psychiatric Mental Health Nursing. Oh yes! I've had an interesting career that took me away from the bedside. (Gwen)

Some of the participants spoke about how their professional career impacts their personal lives. Advancing from the concept of a job to a career impacts life and may indicate that an individual is committed to another stage of their life and the next level of professionalism. Part of that impact is related to the mobility of their role. For some of them, there is accommodation by significant others and their family members. As an example, Gwen

shared how she and her husband and have accommodated one another's careers; she explains how it worked out for them . . .

The military, like I said, if they had wanted you to have a wife, they'd have given one to you. So I was the one at home raising the child, I did a little work here and there but it was all about supporting that role. Well my husband retired in '91 or '92 and at that time, we were used to separation, is what I'm trying to say. He would leave me and my three year old for three weeks at a time to go play Army in Europe or whatever. You know what I'm saying . . . and so when he retired, he didn't know what he was going to do with himself, well that's when my career started. And so, then he would be at home supporting the home and then I could travel. (Gwen)

Mentoring and Education

The theme of mentoring and education is another theme that is descriptive of their role. The participants speak about making an impact and feeling good about the contribution that they make to their profession. Participants express a desire to continue to be educated and to educate others. They feel that mentoring is integral to their role, while simultaneously offering them a sense of professional satisfaction. They describe feeling responsible to share their knowledge by educating, researching, gathering evidence, supporting quality product development and by mentoring others. The following excerpts are about their thoughts on what they do, their interactions and their functions as they go about their daily labor of work, positioned as they are between industry and clinical environment.

Edith spoke about her experience with mentorship while she associated her own educational progression as an enabler to the mentoring process. She feels that education opens doors, strengthening and broadening the professional scope of her career.

I've mentored a lot of people and I've been a preceptor for a lot of people and I always tell them, every time I got another certification or a degree, it opened more doors and gave me opportunities. That was how you advanced. Yeah and so I thought I want to do more because I don't want to ever have any doors closed. You know, I want to be able to say I can apply for that and if you didn't have a degree, you couldn't . . . (Edith)

For these participants, mentoring other nurses is instrumental in transitioning from a job to building a career. They are actively pursuing this career. Lolly shares how for her, mentoring means being able to disseminate educational resources to nurses working at the bedside. Lolly frames mentoring as a way to empower nurses. She describes herself as a conduit to share educational resources with other nurses who in turn use these resources to care for patients at the bedside. Like other participants, she feels that she impacts care not only for a single patient, but for a ‘multitude of patients’.

They (her company) empower me to do more! (volume of voice rising) I’m enjoying it, I’m enjoying it! I love impacting . . . I’m mentoring clinicians in a different way . . . in a different way, in helping them get the tools they need to have to be confident, to be empowered, to fight the good fight for doing right by patients. Not just the one patient, but a multitude of patients. (Lolly)

When asked about what they feel is the most important contribution of their role each of the participants shared a story that included education and sharing of resources. Giving an example about therapy and microclimate management, Candice sees education as being a way to change practice.

In my role . . . education, education I provide. I’d say the education . . . I definitely impart a lot of knowledge to those folks. Hopefully it does change practice. You know when we talk about different types of therapies and microclimate management or whatever is going on. (Candice)

The participants describe their feeling of having a responsibility to lead by translating and interpreting research and education. Lolly describes how she sees her role as a leader in translating and interpreting evidence. She shared a story about mentoring a discussion group of her local CWOCNs on the current relevant literature. She details how she perceived a lack of information among her colleagues and what she did to facilitate the sharing of evidence on clinical practice guidelines. She describes how that exchange is part of her role and her responsibility. She goes on to say that she feels she is privileged to be exposed to education and research. She has multiple opportunities to attend conferences

and hear key opinion leaders speak. That is part of her role; being on the cutting edge of care. She shares how her perspective is different from that of the bedside nurse, she is positioned at what she calls the 'birds eye view', which enables her to improve patient care. The following story illustrates her satisfaction in her role and to a greater extent the way that she envisions her career. She shares how she assessed knowledge deficits and then proceeded to fill this educational gap.

I'm going to bring an article, we're going to look at the NPUAP/EPUAP/PPPiA 2014 Guidelines and we're going to look at skin assessment and risk assessment, those sections. And try to digest that. So, and that, that's where I think I make a huge impact because that group of nurses, many of them didn't even know that publication is out. I've been into big academic centers where they did not know. And so I brought that up to the local organization group. And some realized that there was a condensed version, but they didn't ever know that there is a full version with all the references and all the explanations for the recommendations of which 91-92% of them are expert opinion. So, and that was alarming to me, that was alarming to me . . . And we had a frank discussion about that and said, well how does a clinician find out about that? Find out and does she get an alert from NPUAP? Does she get an alert from WOCN? An email to say that there's a new publication? Hey, you? That doesn't happen. So, I think industry nurses play a huge role in the communication of those resources, because we aren't doing direct patient care. We are up here at the bird's eye view of things and we're not at that level, so we have the luxury of being exposed to all this, and what I believe, I'm obligated to do as an industry nurse is to share that and make sure that my customers, even not my customers, that I interface with, get that information, because I'm privileged, being exposed to that and I want you to have it too. Because if you have it and you are going to impact direct patient care at the grassroots level. So I think I play that role. And that's a huge job satisfier for me at this point in my career. So I'm happy doing what I'm doing. I mean it gets frustrating like any . . . (Lolly)

Like Lolly, Edith shared that being both a resource and an educator is integral to her role performance. She added that one part of education is translating research findings into understandable components that can be shared with nurses in such a way that the research becomes evidence that is understood and applied at the bedside. She expresses her opinion that she is skilled at doing that. She shares that when she uses her skill she can see ‘the lights go on’ for others.

I think it's my role as a resource and educator. Secondly, I would say . . . included in that would be the ability to read research, translate it and have everyone else understand it. Because in nursing, I don't think we do a really good job of that. So being able to take information from research and teach it and see the light bulbs go on for your other WOCNs or the staff nurses. I think that is definitely something that I am good at and is an asset for our department or our company. I find it very rewarding. (Edith)

Like other participants, Gwen talks about how education is a big part of her role. Gwen sees herself in her role as facilitating a transfer of knowledge, an educational flow, a double-edged blade of education, not only educating clinicians, but also educating non-nurse colleagues in industry and sales. She describes that for her, the role of being an educator is her primary role and that she considered the education of her co-workers in industry as important as the education of direct care clinicians who purchase her company's products. She shares how sometimes there may be a lack of understanding between the worlds of business and clinical experience; she describes how she offers a ‘reality check’, while educating both of them.

Any time that you're a nurse in industry, you are an educator, primarily (said slowly and distinctly with emphasis) and you're not only educating your customers who desperately need education on these issues but also the company in which you work. That to me was always a very important part of what I did. Like I say some nurses can't understand where they're (sales) coming from and you've got to respect where they're coming from. You know, it's this whole thing called paychecks. So here's all the sales representatives and we're going to do this and that and . . . excuse me,

excuse me, that will not go over well with your clients. This is why . . . because nurses see it this way, not that way. Give them the reality check, we're not selling widgets, these are people and you have to understand what will make sense to a nurse and not to over claim. That's the other thing that business people in sales want to do. And that . . . so in that sense, I always felt both of the educational roles were extremely important. How can I explain it to the customer in a way that they like it, they get it, this can help me. (Gwen)

Making a Difference

A feeling of making a difference is a phrase used by participants to describe the clinical significance of their roles and describes another theme associated with role. For some it is the ability to share knowledge through education, for some it is being able to connect with nurses who are customers of the companies that they work for to offer recommendations for practice that can improve patient outcomes, while for others it is the opportunity to embark on the development of new products and new technology that can change the delivery of healthcare. All of those opportunities may result in their feeling that they are making a difference in the quality of care that is delivered to patients and their caregivers.

The participants express a sense of passionate satisfaction about the way they perform related to their ability to make a contribution to their profession by making a difference for both patients and caregivers. Making a difference is a feeling expressed by participants throughout the interviews, they describe it as a source of role validation. They describe how it makes them feel good, feel satisfied and they draw on this to demonstrate how they feel that they are making a difference. Gwen says that she feels it is important to make a difference and she believes that her role in industry has allowed her to do that, especially through teaching. Gwen describes how she uses her skill set within industry, to reach out and teach other nurses, ultimately contributing to nursing outcomes. She describes feeling good about the seminars that she teaches, and she described the recognition that she receives from her students. She captures the essence of what she is feeling when she says that the students 'sing her praises'. Gwen shares how she feels about the importance of

making a difference, not by administering direct nursing care at the bedside but through education.

I do one day seminars. I really feel like they make a big difference. I like that (said emphatically). You know, I know that these people are going to be able to go out and do better than before they went through this class. You know, before they heard that seminar. So I still feel very good about what I do. It's more my own desire to keep making a difference, that keeps me working. It's more to me of a closed acknowledgment (speaking about direct patient care) . . . that you made a difference with that patient. I mean there is nothing better than finish training twenty students, we spent four days together and half of the evaluations are singing your praise. I mean I have it in writing that I was pretty darn good at this. And that's a big difference to me . . . and training other staff, who will train other staff. You got it! It's kind of cool! (Gwen)

Lara shares stories of the satisfaction she feels related to her work, admitting that life as a nurse can be a struggle, regardless of where a nurse practices. She openly describes the satisfaction she feels when she is doing a good job, while acknowledging that on certain days, she can also feel challenged. Reflecting on her time in home care she describes how she experienced days when she wondered how she might have done things differently and she admits that she also has those kinds of days now that she is in industry.

I like what I'm doing. Yeah, I get satisfaction from it! I feel like I'm doing a good job. Sometimes it's a real struggle. Go back to the drawing board and do it again. But there were days in practice when you came home going, Wow how could I have done that differently? That didn't work out too good, how could I have done that differently. It's no different than what we do now. How could we have done that differently? (Lara)

For Lara, an exciting aspect of her role is her chance to be involved with new ideas and helping to bring those ideas into new product development. She is able to personalize that experience and it is visually apparent by the expression on her smiling face and by her open arms. By her own admission, she is having fun. She feels that in her role she can be

involved with technological innovation and she describes how rewarding it feels for her to walk around an Exhibit Hall at a conference and see the examples of new and innovative technology and how it can make a difference in the progress of wound healing.

The other side to that is being able to work on new ideas. In this day and age, innovative technology that potentially changes the way that care is done, healing rates, you know whatever the case may be and I think that they are just coming faster and faster and faster. You look on the Exhibit Hall floors and it's like . . . advanced technology and it's very rewarding to be a part of that. It takes a long time sometimes, to prove it and bring it to market, but when it works and you see somebody who's happy about it and it changes their life and all of a sudden they see progress in their wound . . . and it's fun, I'm having fun! (Lara)

Participants' feelings of satisfaction about what they are doing support their continued practice. Making a difference appears to be rewarding in and of itself, while for Edith it allows her to connect with other nurses by making recommendations for solutions to their problems in practice. She describes an example of being able to offer suggestions about safe patient handling and how it is rewarding to her to be able to reach out and assist bedside nurses. As Edith describes it, her ability to reach out and share her expertise means that she can influence on an individual level by supporting both patients and staff. With a confident voice she leans in to say that as a CWOCNII, she has a valuable skill set to offer and that she can *make a difference*.

So what is helpful is when for example a customer or a nurse will call and we'll talk through a patient. And a lot of times they have an idea or they think they know what they're supposed to be doing and so just helping them walk through the process and say what's going on with the patient, what have you tried, what else would you like to try and it's almost like consulting over the phone. I don't get to see the patient but they'll describe to me everything that's going on with the patient. And so we had cases recently where because of the equipment we make, the nurse will say, we have a guy, he's X pounds, what can you help me with? They're

literally dying out there. They're struggling with safe patient handling, they're struggling with equipment needs, they're struggling with skin care. So it's not uncommon to get those calls and it's very satisfying and very gratifying to say, O.K. I suggest you try A, B, C, D and they call you back and they're like, oh thank you so much, that worked. So I think that's rewarding in and of itself, knowing that yes I'm not doing hands on, but I'm able to influence a bigger group of nurses and in turn they influence their patients. I think that's just the reality of nursing and so the fact that we can influence safe patient handling, safe use of equipment, if we can help any nurses not leave their career or leave the profession because of back injuries, I'm super satisfied about that. And so the more nurses I meet in industry, the more I'm convinced we have a valuable skill set to offer and that we can make a difference. Whether it's education or research or . . . (Edith)

Breadth of Role

This is about the broad scope of their roles, what it is that they do and how they become involved in an expansive array of activities. The participants each describe a broad variety of functions beyond education. They speak of innovation and being able to translate innovative technology to improved products for caregiving.

Lara contextualizes her role in the clinical lab and tells how she relies upon her nursing perspective. She is the one participant who is based in her company's corporate offices within a clinical lab. Speaking about the breadth of her role, she identifies different aspects which include support of product development, coordinating 'Voice of Customer' and facilitation of customer education within a broad content area. She describes how she functions in product development and how she helps to represent sales from a nursing perspective, going out to visit nurses, participating in sales appointments to talk with nurses. Lara tells about how she can impact caregiving across the continuum of care by teaching in long term care and home care. These aspects of her role are integral to the process of designing new and innovative products.

I work technically in the lab and we are titled Technical Service, but we have one, two, three, four, five of us who are WOCNs and there's one Certified Wound Specialist and we really function in a variety of ways. We support product, if something has to change in our product insert we are responsible for getting it updated. We will help to coordinate Voice of Customer, Voice of Clinician . . . what do you think about this? Would you use it? What would you do different? . . . that whole realm of product development. We represent our sales force, so we will go on visits with them and we do a lot of education in long term care. I also right now am supporting the whole compression, edema management portfolio. It's wonderful, but in addition to that I support our extended care business. So long term care, home health, whatever that is. I do a lot of teaching. Now with technology changing so much and it's hard to get everybody in a room, we're doing a lot of live webinars and archiving them. Yeah, that's what I do (laughing). (Lara)

Lara talks about her nursing perspective and how it facilitates her ability to offer clinical insight and feedback through the entire process of product development. She helps develop the Indications for Use, which are the formal list of ways that a product can be used, as approved by the Federal Drug Administration (FDA), the regulatory agency in the United States. She lends valuable input to this process by offering the nursing perspective and her clinical expertise. She describes how important product development is by talking about how a product is more than just a tool to help in wound care. It is part of an approach that includes the nursing perspective and skill set. She goes on to share how she gets to apply her special skills and expertise in a new context. In her role she works in an area where industry and clinical nursing meet. Being involved in the scope of product development broadens her role in industry.

We bring the perspective of the nurse and patient into the whole manufacturing, development, new product information and so we help to look at the IFU (indications for use) and say, no that doesn't make sense. We also sit on product development teams. Again we bring that

perspective of the nurse, family whoever is going to be the end user. It's more than product, it's more than the bed, it's more than the support surface, it's more than the foam dressing . . . those are just tools. We still get to use all of our knowledge, the things that we learn . . . we're just doing it in a different way . . . Like I said before, one thing that I really do like is the education and educating nurses. They don't get it any other way, they're getting it from industry. That's where they're getting it from. And it's such an important role . . . (Lara)

Each of the participants sees education as an important part of their role but they describe a broad role beyond education, such as being involved in new technology. Lara sees her most important contribution as being split between two things, education and innovation. Her passion for technology is evidenced by her engaged facial expressions, forward posturing and the tonality of voice, as she admits to having fun in the process. She shares her excitement about working on new ideas and innovative technology. She talks about the pace of new technology and how it has the potential to change the way that care is delivered, to improve health care outcomes. She illustrates her point by commenting on the Exhibit Halls at conferences and how much technology is present there. She feels that her experience here is rewarding and fun.

I think the help that I do in long term care is education . . . education, education, education. We can teach about skin care, pressure ulcer prevention and topical management. You can teach about all those things, because in those settings it's just get out there and do the work. The other side to that is being able to work on new ideas. In this day and age, new technology, innovative technology that potentially changes the way that care is done, healing rates, you know whatever the case may be and I think that they are just coming faster and faster and faster. You look on the Exhibit Hall floors and it's like . . . advanced technology and it's very rewarding to be a part of that. It takes a long time sometimes, to prove it and bring it to market, but when it works and you see somebody who's

happy about it and it changes their life and all of a sudden they see progress in their wound . . . and it's fun, I'm having fun! (Lara)

The way that the participants perform their roles is reflected in the way that they see themselves as being a nurse. That part of their identity contextualizes and enriches their role. As Edith explains, for her the role is grounded in her experiences as a bedside nurse, which allows her to look at systems and solutions through the nursing process; very different from the non-nurse approach. She describes the approach as being patient centered, whatever is best for the patient. When it comes to performing her role, she feels her broad skills differentiate her. Sharing her story about interaction with her colleagues in industry and with her customers, nurses who have bought her products, she is laughing intermittently as she considers the two perspectives. Listening, offering solutions, training, time management, prioritizing is all a part of how she performs within the broad scope of her *role*.

And I think that we bring many skills to the table, I mean the relationship piece, half of the relationship is being able to listen. I think nurses are good listeners, I'm a good listener in particular so when the customer is saying, this is the problem, I'm trying to listen and help with a solution, whereas the sales people just tend to be very, like O.K. you have a problem, use this widget to fix your problem. There's a lot more to it than that, I mean we have the ability to look at process as well. And so the CNS role in particular, the training is looking at systems and processes. It's just whatever is going to be best for the patient in your system at the time. So obviously the relationship piece of it, the listening piece, organization, I mean, time management, prioritizing all the crises, putting out fires and I laugh because my colleagues who are in my peer group is actually the Marketing Department and our training department, that's who we all report up to and so they tend to get pretty excited about things that don't happen . . . and I'm like, at the end of the day no one died (laughing). It's different how we see the world. When I left my shift as a floor nurse, if all the IVs were running and patients were breathing and I gave all the meds

that day, I had a good day! And in this job, if the patients get what they need and we didn't kill anybody, it's a good day and so I always get the comment, you're so grounding and you're so calming, and that's because there's really no Marketing emergencies (laughing). (Edith)

Wider Vision of their Role

Some of the participants spoke about how they feel that their position in industry has opened wider opportunities that they might otherwise not have been exposed to. They share how they feel that they are experiencing new growth potential in their specialty areas and new ways to enhance their own learning. As Edith states, she feels that her position in industry opens avenues for her individual growth and learning by allowing her to allocate time and resources to review literature, attend conferences and participate in interdisciplinary meetings. She compares how her company encourages her to attend educational activities, whereas bedside nursing often does not have that type of support. In her enthusiasm, she claims to have forged some of her strongest relationships since entering industry. She describes her experiences of networking and her collaboration in professional activities and the passion that is generated among professionals in those groups.

I think I have more opportunity for professional growth. Learning, it seems like I have more time to read journal articles, attend conferences. My company is very supportive of any continuing education that I would like to do, whether it is at the University level or conferences. I know it's hard for WOCNs in hospitals to even get to a conference. There's no money, they're paying their own way so to be able to take advantage. I have to say some of the best networking and friendships I built have been since I've been in industry. Meeting other industry nurses, professional groups like the NPUAP, S3I, I've met such wonderful people. People who are passionate, who are either doing research, it's been fabulous, just the resources and networking that's been available. (Edith)

Nursing is described as 'opening doors' and their role in industry is optimistically described by the participants as being able to open the door to even more opportunities for learning.

Gwen shares how she feels the perception about nursing in general is associated with a 'can do' attitude. She describes her experience of living and working around the world and how nursing opened doors for her. She shares how her social interaction globally caused her to become increasingly aware of how adaptable others saw her as a nurse and how capable others considered her to be. She found that other people saw in her, skills that often she did not realize that she possessed. Their vision of her extended the vision she held of herself.

Nursing in general is a wide open field. It always amazed me that no matter where I went and remember I told you that I lived all over the globe. When people found out I was a nurse, then the most common thing they said was . . . Oh then you can do this, people see, it's their perception of us. I never thought I had all those skills. They see us as being highly able, committed and you can figure it out, you're a nurse! And so that opened the door. (Gwen)

Nursing continues to evolve as a profession that offers new areas of practice far beyond the traditional pathway to the bedside. Gwen describes herself as being unlike the stereotypical Florence Nightingale nurse, but rather as being true to herself and who she is. She shares how her nursing degree has enabled many choices for her over the course of her career. She describes how she was able to find positions that complemented her own identity while building her own confidence and enhancing her learning.

I could feel depressed that I'm not one of these . . . you know, I didn't end up being Florence Nightingale. You know, I'll slit my wrist, anything for my patients . . . I never was that personality. The door did not close and I can still be who I was and find something like industry that benefited what my personal needs were, my feelings. Just encourage other people to take their nursing degree and put it in front of people and I think they'd be amazed at what other people will say. You can do this, you can do that, take a stab at it! I learned from everything I did, so. (Gwen)

Participants point out the ways in which industry offers the chance to explore new roles within the realm of nursing. Nursing unlocks doors that may launch professional roles previously thought to be far from the boundary of nursing.

Between Two Worlds

This theme is about how the participants have described their roles as enabling them to see the bigger picture from where they are positioned between nursing and industry. The participants have contextualized their roles in industry and they describe how they feel that their careers are grounded between the world of business and clinical at the bedside care, as if bridging the gap between those domains. They share how they are able to view patient care in the larger context, to acknowledge the full scope of delivering patient care and what the account needs to deliver care to patients.

Gwen talks about the way that she frames her role, she calls it a global or an account focus, as opposed to the patient focus that frames the world of bedside nurse. She is concerned with the broad needs of the account; their need for education and teaching about products and being able to help them to achieve their goals. She describes how being focused on the account helps to achieve the mutual goals of both her accounts and her company. This is an expression of her position between the world of nursing and industry. Like Lolly who used the descriptor of being at a bird's eye view, Gwen talks about seeing the bigger picture while she views education as part of her role. The bigger picture is removed from the bedside, at a distance to observe patient care delivery through the filter of her nursing perspective. Part of that is ensuring the safe and comfortable use of products by nursing.

There's so many differences. They're worried about patients. Direct patient care, whereas I'm not so much worried about individual patients, I'm more worried about the account. Are they feeling comfortable with our products? Do they need education? It's just a very different approach. They are patient focused and we're more globally focused on helping them achieve their goals at the same time helping my company achieve it's goals. It's a different approach. . . the bigger picture. It's not patient focused, I call it account focus. And what do I have to do to help this account help their patients. What role . . . how can I do that? How can I

give them something that relates to or aligns with what they worry about all the time? You're a step back, I guess. How is it all working out and what do they need to make it easier on them? (Gwen)

Jane describes her role as unique. She functions at a corporate level of her company and attributes her value to the recognition of her ability to communicate what she calls the clinical story. She shares how she feels that she is 'really important' to her company. As she expressed earlier when she talked about being 'the voice of nursing', she sees her role as listening to the needs of clinicians and bringing the clinical story back to her company. She describes herself as working for both her company and for the nurses at the bedside, acting as a liaison. Her role is in helping to bridge any gap between industry and the nurses who use their products. building evidence and doing education, while facilitating communication at the tipping point of two worlds. In her case, she helps her customers to share their work by demonstrating the evidence of their patient outcomes through posters or publications. She describes how her company supports this because the patient outcomes may be associated with the products that they have purchased from Jane's company.

I would describe myself right now, my role is rather kind of almost unique within the wound care industry. I don't know how many other companies have a WOC Nurse that's going into the corporate level, GPOs. I think I was one of the first ones, my boss at the time, recognized that the clinical story is the most important message that we need to provide. I'm probably, in some respects, really important to the company to make sure they're providing sound clinical information . . . you know they (direct care nurses) need somebody who can hear what they are asking for and take that back to the company. And I'm almost working for both people (chuckling aloud). You know, I'm trying to work for the clinicians while I'm working for this company, which is really kind of interesting. I often say I feel like I'm a liaison, I function as a liaison between the clinical activity that is going on amongst our customers, the successes that they're having through posters, through articles, whatever. The building of evidence that's being done where ever it happens to be. So our partnerships with

GPOs they need to know that whatever vendor they're partnering with is not only going to try to just toss a product their way, they're also going to support that with value added. So I still do teaching and I still have that role of understanding and appreciating what's going on at the clinical level, to share that story. (Jane)

For the participants, their position and their nursing legacy facilitates their credibility with customers who are clinicians using their products. Candice feels that her customers perceive her role as credible because she is a nurse and she can speak the language of the clinicians who purchase her company's products. She describes her ability to speak on the level of nurses, as one nurse to another nurse. With a history of being a nurse at the bedside, she feels she is able to know what is important to nurses using the products that her company manufactures and distributes. Positioned as she now is within industry, she calls upon her embodied nursing skill set and experience to help her to connect with other nurses who are giving direct patient care. Candice feels that she can project that feeling of being credible when she is face to face with other nurses at the bedside.

I see myself in my role as being more credible than the Account Executive or the Sales person. Being able to speak on their level, knowing what's important to them. You've got to know your audience, who you're talking to. I see us as being more credible, being the ones who can bring them the value added, you know bring them the little extra Plus the educational programs that we can offer. (Candice)

Gwen elaborated on her role with her observation of how she blends clinical objectives with business objectives and how by doing that, she creates a mutually beneficial position for both the nurses she works with and for her company. She has integrated her clinical nursing skill set with her business goals and objectives to construct a role that is positioned uniquely between the world of the nurse at the bedside and the world of the nurse in industry. She shares how she came to learn that skill over time and she admits that not all every nurse who goes into industry can succeed in building that career perspective.

. . . I had good interpersonal skills and to me that was probably the crux of it and I was a psych nurse, so I think some of that helped a great deal.

How do you talk to people, how do you encourage people? . . . So good time management, good self-direction, good interpersonal, in a sense which I had to learn, I didn't start understanding it, but I had to learn how you can blend business objectives with clinical objectives. So I have, you could after years you could figure out who is too connected to clinical outcomes that they're never going to get the fact that, it went like this, when you're a clinical nurse consultant, you would say, but that staff really needs an inservice on pressure ulcer prevention, that's what they need . . . understood. Are they going to use our product? Well, no but . . . you have to understand the marriage between the two. And that took me a little while to learn, but once I got it and I really felt good and I really could marry what the company wants with what the facility wanted, then it was a really good fit. You know to develop business sense if you will. You can't give it away for free, which some clinicians really wanted to do. Unless you get it, that this is not an altruistic scenario here, we also . . . one hand will wash the other, if they'll work with us, we can help them. (Gwen)

Lara spoke about how her relationships with other nurses are key to how she performs her role. She feels that she has very good working relationships with her nurse colleagues and she reflects on how she can collaborate with them on product development. Lara feels that her company is well respected and that helps her to foster trusting relationships with other nurses. She talks about the satisfaction she feels from collaborating with other nurses and the respect that evolves through trust. Because of the relationships that she forged when she was in home care, she is now able to reach out and call on those nurses from where she is positioned in industry. For her, those relationships that began when she was in home care transferred as an asset in her new role, she is positioned to connect as a link between nursing and industry.

It's a very good working relationship, they can call us and we call them. We even, because of those relationships that were built first, we can call on those WOCNs who are still working in the practice and say, you know we need to talk to a clinician, can we meet with you? Let me pick your

brain, show you a concept. People are very respectful of my company and what they have and so they're very willing to sit down and listen and hear about it and just be involved in that role. Because I think what that does is it gives them an ownership into what might be on the horizon. This is something that we need, can you help with that? This is something that we're seeing, or maybe we bring them a concept and they say, no way you're way off . . . but if you did this . . . It's a very respectful, very good relationship. (Lara)

Thoughts on the Future

Some participants shared their thoughts about what they feel the future holds for CWOCNIIs. Gwen talked about the change she would like to see within industry. She feels that despite the influx of nurses within industry, there remains a lack of direction on the part of industry about how to best leverage the clinical skills that nurses bring to the table. She feels that nurses in industry are thought of by others in industry as being an 'enigma'. As a phenomenon that may still be surrounded by a degree of unknown, Gwen describes how she thinks that it might take a nurse in industry to lead the way to a better understanding. Formalizing professional roles of nursing within industry is a long-term goal that she would like to see happen. In her opinion, she feels that nurses are best equipped to take leadership in strengthening nursing careers within industry.

One thing that I'd like to change is for business people to figure out what to do with us. Cause I never felt like they knew what to do! We were like this enigma, and I never met a company who did know, how to incorporate what we do into the flow of the business. They can't figure out how to assign a number to us. In other words, well every rep in their location has to increase sales by ten percent a year and metrics, you know . . . they never could figure how to pin that, that's the story. I don't know what it's going to take. Some enlightened leader, someone like you or me, to be the business person at the very top! Maybe that's what it's going to take. Then, now we're running the show! And we'll tell the business people, this

is how you should be using us folks. Maybe that's what it will take, one of us. It won't be me, but someone who's walked in our shoes. (Gwen)

Overview of Role

These participants appear to have strong opinions about their professional roles. They speak of their work as career, not as jobs and they use terminology that expresses the distinction while making a conscious decision to make their life's work a career. Participants express themselves with confidence that they perform in a way that is satisfying to them, facilitates contribution to their profession and has the potential to deliver on making an impact in patient and caregiver outcomes.

The functionality of the role encompasses primarily education and research, along with the full scope of product development. Each participant expresses and shares a passion for their own education and for educating others as part of a mentoring process. They feel 'privileged to be exposed to learning opportunities' in their role and they consider it to be a responsibility and an obligation to mentor others by their knowledge and to communicate, facilitate and translate those opportunities as part of their performance.

'Making a difference' is a term used by participants to describe the way that they function. They see themselves as competent leaders and as risk takers and making a difference is a source of validation. Making a difference on a broad platform was echoed by each participant. Rather than impacting a single patient in a single care setting, these participants speak to impacting care in multiple settings from their position within industry. They see their role as a way to contribute to their profession by making a difference through education and research while enabling their opportunity to mentor others from a position within industry, ultimately providing quality products for patients and caregivers.

Their professional identity is contextualized within industry. They embody their skill set and apply it at a pivotal place across a large domain, at the intersection of nursing and industry. The breadth of their role encompasses a wide range of activities including 'voice of customer,' education of nurses, disseminating research, gathering evidence for product development, surveying healthcare trends, keeping current on technology and best practice, all the while communicating among diverse groups on a landscape that crosses boundaries. The participants describe a wide vision of nursing and this non-traditional role that they

perform. Their roles are described as opening doors to new opportunities for professional growth as they continue to experience an evolution of those roles.

The participants describe their roles as being juxtapositioned between two worlds, nursing and the corporate world of industry. They often express how they feel as if they bring the voice of nursing to industry. While acting as a liaison between the customer and the organizations that they represent, they consider themselves as advocates for the voice of nursing, bringing forward the insights, the needs, the recommendations of the customers and translating those into actionable scripts for their companies' life cycle project teams. They have transitioned to a position that blends the two worlds of nursing and business.

Speaking about the future of nursing in industry, the changes that they would like to see and the prospects of those changes, they describe how they envision an evolution of their role over time to reflect the diversity of a changing healthcare system. It may take nurses to lead the way in determining the path forward. This is new territory for nursing and for industry and these nurses positioned between the two will navigate the territory. It is a process about integrating two skills sets of nursing and business and merging them into a role that is positioned to facilitate communication to collaborate on a vision for improved patient outcomes.

Impact of New Role on Professional Identity

The theme of impact of new role on professional identity is about the way that participants perceive their role to have an effect on their professional identity. This section will describe the association of role and identity and how and why the participants feel that their role limits or enables their professional identity. This describes how they may experience 'feeling disconnected' due to their small professional network. They also describe 'feelings of exclusion' that may arise. They tell stories of how gender and stereotyping have influenced and sometimes complicated their role performance. Participants describe how they feel that their credibility is in question and how issues of trust can disrupt their relationships with other nurses. They describe how their role may feel invisible. They go on to describe their resilience and how they are working to establish the credibility of their role in industry.

Feeling disconnected

Feeling disconnected is about the lack of a robust daily connection with other nurses in industry, while acknowledging the support and camaraderie that they experience when they do come together. They have limited face to face contact with colleagues and with members of their professional network and they describe how they feel about being disconnected from one another. They share that they still feel a sense of community, despite the lack of face to face contact.

Their professional network of CWOCNIIs, although growing over the past two decades remains small in comparison to other more traditional networks of CWOCNs, for example those who work at the bedside in hospitals or in home care. Edith comments on the small number of CWOCNIIs in her professional network but she describes how she seeks out support from other CWOCNIIs when she attends general professional organizations and committee meetings. She describes how she feels as if those face to face meetings expose her to others who work in positions similar to hers and that is comforting to her. Feeling that there are a growing number of nurses in industry like her is also a source of support for her.

I think what surprised me with the role, not that there wasn't support, but I didn't have a big peer group, you know and I missed the nurses in industry session yesterday. But even though I missed that one, I go to other things, like NPUAP and I'm running into more nurses in industry and that's always wonderful to know, hey there are other people who are doing my job.

(Edith)

In contrast, some participants describe how limited face to face contact may also be compounded by a sense of competitiveness that may impact their professional network, challenging feelings of being close to one another. Lolly shares how she feels that a degree of competition frames the social environment of her professional network of other CWOCNIIs and the commercial industry impacts her ability to build relationships with them. She describes how the discreet sense of competitiveness is felt by her as being a barrier to full camaraderie between herself and other CWOCNIIs. She feels that experience is unique to nurses within industry.

In industry, we don't have the avenue, because of competition, or the environment to create those relationships. I mean I have relationships, strong years long relationships, with some nurses in industry, I have to be, I'm very aware of, we can't have a conversation about some of this stuff. That's unique to industry nursing, you have to be mindful of that. (Lolly)

Feelings of Exclusion

The participants express a feeling that their position in industry has led to them feeling as if they are being marginalized by the larger WOCN Society, in ways that are sometimes discrete and sometimes not so discrete.

They perceive limitations on entry into nursing leadership of the WOCN Society, at the national level. They describe the inconsistencies of the criteria for entrance to leadership positions and how they are interpreted as inequities. For example, CWOCNIs may run for and be voted into leadership as President on a regional level, but not at the National level. By implementing inconsistent criteria for eligibility into leadership positions, the participants feel that their roles are being challenged with the intent of restricting certain nurses from national leadership positions.

Two of the participants have held positions as officers at the regional level, yet the same positions at a national level is not open to them, if they chose to pursue such an office. As Jane shares below, she feels that being eligible to serve in certain capacities, but not others, fosters a gap between members based on their employment rather than their professional identity of being a nurse. She speculates about the rationale for exclusion, stating that she feels that others think she may have 'some crazy influence over people'.

I know, I think it's the fact that industry nurses cannot hold certain positions on the Board. I guess because you're supposed to have some crazy influence over people. . . I don't know, you're not, you might talk to somebody and sway them . . . people can't make up their own minds it's just a real sad state here . . . you can serve in this capacity, but you can't serve in this capacity. . . that's probably what it is as much as anything. (Jane)

Feelings of exclusion were also experienced as a result of more discreet practices and the participants described how this played out in less obvious ways. Lara told a story of how she felt that she was denied a chance to share her expertise. She tells how she responded to a call for presentations to be submitted by vendors at a national meeting and she was accepted. Vendors are commercial industry organizations, either manufacturers or distributors of medical devices. Use of the term vendor implies a lower status as opposed to being considered an industry partner. This is the first time that a participant has mentioned the label of vendor as associated with their role. During her story, she commented twice about how vendors were welcome. However, she tells how her opportunity to present was ultimately denied due to restrictions placed on her presentation that she was not made aware of until the last minute. Shaking her head and with a trembling voice she stated that 'there are many of us who have really good knowledge'. She feels that this is about an intent to silence nurses in industry. As she described the details, her frustration became apparent, as she leaned in, with clasped her hands and spoke with agitation in her voice.

There was a call for presentation and I'm not going to say what organization it was from, but it was a call for presentation, vendors welcome to send in an abstract to speak. Vendors welcome . . . I got into the whole process, spent a long time on the whole process and then the bottom line was that you had to also do it with somebody that was in clinical practice. So now all of a sudden I had to find somebody who was in clinical practice that would want to do it with me. It left twenty-four to forty-eight hours to get it finished and submit it and ultimately they ended up turning it down. It was like . . . why are you advertising vendors welcome if vendors really aren't welcome (laughing)? There's a lot of us who have really good knowledge . . . (Lara)

Participants shared their feelings that some professional organizations are more open and accepting of collaboration among disciplines and nursing specialties, than are others. Jane feels that some individuals who she calls 'mentors' have always been open to the need for collaboration, but she feels that there is bias associated with one particular professional

organization and she feels that bias is routed in their leadership. Jane expresses little hope for change with the current leadership.

It depends on the person and it goes right back to the old nurses, nursing types. The mentors, the Dorothy Dougherty's of the world are, 'come on in, we need everybody, we need the bedside nurse, we need the treatment nurse, we need the WTA, we need the EMS, we need the industry nurse, we need the researcher, the bench researcher, we need everybody that's going to . . . come together to drive really quality outcomes for patients. And then you have people who look at credentials, which is . . . it's credentialing, are you a nurse or not a nurse, are you . . . I think this group because it's interdisciplinary, has a different perspective, really . . . On all things . . . come together, cumbia . . . much more so than I think the other organization, but I think it's more really within the leadership of that organization than it is the membership. So, the leadership doesn't ever seem to ever change. We're stuck, been stuck and we'll be stuck as long as certain people are still at it. (Jane)

Gender and Stereotyping

Stories about experiencing the impact of new role on professional identity were sometimes framed by participants as gender issues at various points along the continuum of their career. Their stories spanned from early in their careers to the present day. All were told with a passion and described their options being narrowed to what they called 'roles for women'.

Lolly shared her perception that the pursuit of an education was not considered so necessary for women in the context of her youth, the mid-1970's.

So, six kids, brothers in school, the boys, it's more important for them to have a career, than women at that time. Does that sound a little bit familiar? (laughing) It's not so much anymore, but it was back then certainly, when I was 17. (Lolly)

Jane described her observations about the roles that were open to women, at the time that she was embarking on her career. As a young female during the mid-1970's, she described her choices as being limited to four options; teachers, nurses, secretaries and wives, which at the time were considered a traditional selection within the scope of female careers.

How did I get into nursing and why. I am 65 in a week and when I was coming through school, my formative years of school, there were some roles for women; they were teachers, nurses and secretaries and wives. And so you didn't always . . . you might have become a wife right out of high school, but you typically went to college or post-school for one of those things. (Jane)

Because of her mobility and her access to diverse environments, Lolly is in a position to observe how nurses and physicians interact and describes what she calls a medical and a nursing model. She observes the dynamics of professional interaction and cites how she feels gender is associated with the balance of power. She describes the roles played by men and how she feels that they differ from roles played by women in nursing.

I can tell right away when I go into a facility or an institution, if it's a medical model or a nursing model . . . by the demeanor, even the demeanor of who runs the meeting? Who's outspoken? Who makes the decisions? Who can even voice their opinions? Who is empowered to make changes for patients for improvement? . . . and some nurses, not all nurses have that, not all nurses have that. And part of that I think is because so many of us are females. Male nurses just don't do that, so what I think is still missing in the nursing curriculum? To this day and age, is some kind of business. Healthcare is a business. I don't know what the ratio is right now. Men to women in the field. But typically the men who do go into nursing, go into leadership, management roles. They are visible . . . they're in leadership decision making roles, most often. Or they're in a high impact OR or ED situation. You don't generally see them up on a medical-surgical unit. So, and till that changes, I don't see that gender thing going away. (Lolly)

Edith describes her pursuit of advanced degrees as an enabling experience when she was practicing at the bedside, but how that changed and became a source of tension for her, tension which she perceived as stereotypical gender-based bias. In her experience, Masters preparation was encouraged, while her pursuit of a doctorate was not encouraged and not supported by her direct leadership. Edith referenced a cliché, that ‘nurses eat their young’ and that the lack of support she received for her PhD studies made the cliché a reality for her. She linked the lack of educational support to the competitiveness of women within nursing. During the telling, her facial expression changed, and the pain appeared to be fresh as she spoke to gender. Her experience with lack of support triggered a thought process about her career options and served as a springboard for her move into industry.

. . . so I loved my Masters program, I'm a clinical nurse specialist in med-surg and it was just a great experience and they paid for all of my tuition. I was very fortunate in that sense. Then when I started on my Ph.D. it became, why are you getting that, why would you get that degree? What's the point? What are you going to do with that? I'll never forget the times that it happened, I can picture as if it was yesterday and I had two managers on two separate occasions say, it was a huge waste of time and then it was, well I can't do my Ph.D. because I have a young family and I was like, that's really not my issue, I can't help it if you aren't getting your Ph.D. . . in the old days we used to say that nurses eat their young. That they were not supportive of new grads. I never experienced that so I didn't really know what people were talking about, it was only later on that I realized that women and it's a stereotype and maybe it's true or not, but they can be so unsupportive and so petty about other colleagues doing better than them. It's hard, it's a lot of work and I never wanted children and so I threw myself into my education and I've always loved it. I've been a life-long learner. So to have those colleagues say, well you know, it's a waste of your time and why are you doing this? That was hurtful, there was no peer respect or woman respect to say that . . . It was all very positive until the time that those comments were made and I decided that

this wasn't a good fit and that's when I started exploring other options.

(Edith)

Questions of Credibility and Trust

A question of credibility and trust is acknowledged as sometimes having an effect on their professional identity. Participants share stories about how they feel that they were trusted and deemed credible by their colleagues prior to entering industry, but after transitioning to industry, they feel that their credibility was questioned. Those qualities of trust and credibility may not be automatically transferred when a transition of practice venue occurs. These participants share stories about how they sometimes feel like an outsider, how they feel that others may label them as a 'traitor'. Participants describe their feeling of being marginalized based upon an issue of credibility and trust.

One story that Lolly told, describes how she felt that her professional credibility with her former nursing colleagues was impacted. Lolly's story was about a conference call. With a pained facial expression, she described the mistrust that she experienced on the conference call and how she felt hurt that other nurses thought of her as being jaded. As she put it, 'they looked at me as going to the other side'. She had mentored those nurses on the call, prior to being employed by industry. She described how it was difficult for her to understand that given her legacy of leadership within her nursing organization, she could now be viewed with distrust because of the context of her practice. She described how it was a struggle for her to experience the distrust of other nurses she considered colleagues.

Well, I'll tell you, I struggled. In fact I was very hurt, when I had colleagues and some nurses I had mentored even on a part-time basis to become a certified wound nurse, certified wound, ostomy nurse, and then I was, I got the feeling I was treated as jaded and actually, it became really evident about a year ago, on a conference call, and this was a big IDN and we were trying to do some sort of metric study . . . At least six of them I knew fairly well and some of them I had mentored, and I couldn't get them onboard. I was jaded . . . they looked at me as going to the other side and actually on this phone call, at the very end of this call when we were struggling with trying to implement tools and I said, 'Use me as a resource, I don't have to

deliver direct patient care.’ And actually one of the lead supply chain people said, ‘Liz, it’s an issue of trust . . . an issue of trust.’ And I didn’t have much time to address that but I addressed it later with my boss and some of my colleagues and I gave it a lot of thought because that’s really what it boiled down to, my credibility that I had established as an officer of the Region, my activity at the National Level, all of that, really didn’t transfer to industry. It was there, but it was now jaded. (Lolly)

Lolly elaborated on the issue of trust, speculating as to why other nurses may distrust her. She feels that part of the issue has to do with a fear of unethical disclosure, compounded by a potential threat of ‘upstaging them’ with her display of knowledge. Lolly shares how she interacts with other nurses who are her customers by being aware of these sensitive issues. She admits that she might have initially feared that she had ‘gone to the dark side’.

. . . again, we get into that nursing territorial thing and knowledge is power and if, it’s sort of getting back to that nurse manager who didn’t want me looking under the sheets on their unit. And even though I’ve signed a HIPPA agreement, I’ve learned to reassure customers and my colleagues that I’m not discussing their business because I can’t. That would be unethical of me. But there’s that, I guess that threat of upstaging them, that’s the other thing. You come in and you have to be very mindful, because knowledge is power. And you come in and you do a program and you’re more knowledgeable or you’re more . . . maybe they feel like I’m delivering the same knowledge in a better way or maybe they got it because a different face is telling them. But they don’t always see that, so it’s threatening! Now, I work real hard to turn that around, I’m very mindful of that. I wasn’t so mindful of that in the beginning. I thought maybe I’ve gone to the dark side . . . (Lolly)

Edith states that when she first transitioned to work in industry, she heard the phrase ‘gone to the dark side’, but not so much now. She feels that the phrase was not meant to be malicious, but she speculates that it may have been used as a term of endearment. She describes how the use of the phrase ‘gone to the dark side’ may stem from a lack of

knowledge about the CWOCNII role, framed as curiosity. Edith goes on to describe how there are nurses who are just curious and want to know more about a career in industry.

The first year it was funny, it was kind of like, oh you went to the dark side (laughing) . . . I would hear that, you went to the dark side because the expectation is . . . oh you're going to be a nurse and you're going to be a nurse until you're eighty and you're always going to be able to do it. It's not always realistic or possible. . . No, I don't hear so much about the 'dark side' any more. And it was always kind of, I don't know if it was just kind a term of endearment . . . I don't know that they meant maliciously. I never really had anyone say 'You're a traitor, you sold out' (laughing). I think there's a small percentage that think that we kind of sold out and we're not nurses anymore. You know, you can live the high life (laughing), glamorous life of travel and . . . which could be true, I don't know and then the other group is like, wow you have this skill set and you use it somewhere else and that's really cool. And some of them are like how did you get into that and how can I do that? Yeah . . . it's again, the curiosity, well how did you get there? What do you do? Do you enjoy it? Does it pay well? Do you travel? I tell people in all the interviews for the position, you can't just tolerate travel, you have to love it, the whole experience. If you don't like being in airplanes and airports, this is not the job for you (laughing together) . . . (Edith)

Invisibility

The lack of visibility impacts their professional identity. Participants reflected on how nurses in industry do not share enough or give voice to what it is that they do. Some participants feel that their specialty group has not been vocal about what they do and how they perform. Lack of knowledge about the role of the participants in industry may hamper their face to face encounters with other nurses, ultimately impacting their role and creating a challenge to their practice.

Edith shared her observations on how others see her and her role. She describes how others respond to her, but in any event, she feels that everyone who talks to her about her

position in industry expresses a sense of curiosity about her role. They have questions about the role and she feels that addressing those questions is one way to spread the word and raise awareness about roles.

. . . the other group is like, wow you have this skill set and you use it somewhere else and that's really cool. And some of them are like how did you get into that and how can I do that? They're curious about what the role is like and what the pay is like and what are the opportunities. I mean I will still get WOCNs who will say, what do you do? They're curious, what's your role about and can I get into that? Are you hiring? And I'm always happy to say you know, this is how I got here and if you like, for example, if you like traveling and living in hotel rooms, you know, this could be an opportunity for you. If you love to teach, this could be an opportunity for you. I mean it's wonderful to go to a community hospital in the middle of nowhere and get twenty-five nurses in a class and give them whatever new information you have and share it and they're super appreciative of it. There's nothing more rewarding than talking to a nurse in California saying I have this problem and I'm able to say I met a nurse in Boston who had the same problem, why don't you guys talk together, connect. So that's been rewarding. (Edith)

Participants describe how they feel that other non-nurses in their companies do not understand their role. By making people familiar with what they do, they feel that they can gain credibility to establish their professional role within their respective companies. Edith describes how raising awareness about how they function, within their companies is vital to establishing their roles. She describes how the professional labor of raising awareness begins within industry and the companies that they are employed by.

I think in the beginning of my role it was hard for other departments within the company to understand what we do and how we did it and what was available, so I think even within our own companies just getting non-nurses, the owners of the company to say this is what we can do for you.

This is how you guys need to use us and so it's a lot of spreading the word.

(Edith)

Being Resilient

Participants describe how they might proactively impact their status by raising awareness of their role within industry. By being transparent and offering information about what they do in their role, they feel that they can educate other nurses who are curious and make them aware of the possible roles open to them. They describe how and what they could do to spread the word about their role in industry, what it is that they do and how they perform their role.

When Lolly was nursing at the bedside, she demonstrated and proved her expertise, as a way to gain acceptance among her nursing staff. That was her way of resolving a problem of credibility. When she transitioned to the position of nurse specialist in ostomy and wound care, she perceived an issue with trust among her staff. She felt that she was perceived as someone who did not want to get her hands dirty. Determined to resolve the issue, she recognized that it was about territory and the transition of her role within the larger group of nurses. She shares the story and implies that this may be a strategy for gaining credibility within industry.

I was somebody else, I wasn't going to get my hands dirty that they were doing all the work and I was going to come in and tell them what to do. So it was territorial, it was sort of an ego thing, where I don't want this nurse . . . Who is she? What is she credentialed in? We don't need her. What could she possibly do? We can't figure this out . . . she's going to figure this out? That was . . . no one ever really challenged me with that, but I had to win them over with the difficult cases. Bring it all together. So I did that, so I established my credibility with difficult ostomy patients, fistulas, big complex abdominal wounds and they loved that. So they responded well to that. And then I started going into wound care. (Lolly)

Lolly expressed that it is disturbing to her to have her reputation *jeopardized*. She has worked hard to establish her career and she feels that a change in her practice venue should

not jeopardize her legacy. She describes how she wants to get the message out about what it is she does and how her work contributes to her nursing profession.

. . . about this phenomenon of nurses that go into industry and being thought less of or jaded in some way because, I really, it really disturbs me I really want, I want to get that message out there because it disturbs me that I've been a nurse for a long time, 35 years or more and I've been a Certified Wound Ostomy Continence Nurse for 20 years and I've worked hard to establish credibility and I had that absolutely and I don't like that being jeopardized just because I switched my job venue, my career venue. And where would we be today without industry, who has the money to finance research? I just want to be able to shed light on that and not think that just because I work for industry . . . I talk with a forked tongue. (Lolly)

Like other participants, Jane feels enthusiastic about how nursing in industry has opened doors for her and she comments on ways to raise awareness with some suggestions as to how that might be accomplished. She talks about her perception that other nurses may have some misconceptions about the role or they may be unaware of the role. She feels that educational offerings about the roles that nurses play within industry may raise awareness of the opportunities available in industry and open paths for communication.

Sometimes our colleagues think we just want out, we just want something easy and we want to not have to do the hard work anymore and leave the laboring to them and I don't believe that any of us are really that way but I do believe sometimes that people might feel that way, that we've got it easy . . . And how hard it is. People don't know that. It would be nice to see if we could kind of offer it at some of these meetings . . . what does it take to become an industry nurse? Or industry anything . . . a lot of them would like to do it probably . . . Yeah, we really, it opened up doors for me that I never even knew existed. We don't share enough about industry nurses. (Jane)

The participants described feelings of responsibility to share their experiences in industry, what it is that the participants do and what differentiates them. Their skill set, comprised of

a knowledge base rooted in clinical experience, certification and education, complemented by networking skills enables their role performance and strengthens the resilience they share as a common bond. They describe how their resilience enables them to perform in a way that is satisfying to them and substantiates their professionalism. Despite barriers, they share a passion for what they do and the role that they play, and that passion is a source of their resilience.

Overview of Impact of New Role on Professional Identity

Establishing new territory is professional labour that may deconstruct existing boundaries and establish new borders. These boundaries have to do with identity, self-perception and interpretation of social interaction. Social interactions or face to face encounters impact new roles in a myriad of ways. Personal meanings associated with experience are interpreted by participants depending upon their contextual framing. Roles are impacted by participants' interpretations of their experiences and the meanings attached to them and they may influence professional performance.

Participants shared that they may feel disconnected from one another without the benefit of a strong network of support due to the small size of their professional network in addition to their mobility. They may not have the opportunity to be face to face frequently with colleagues; either with non-nurse colleagues in industry or with nurses from other companies, while their opportunities to be together face to face with their peers in industry may be limited to professional meetings, conferences or communication methods such as email, instant messaging, WebEx or phone. Real time experiences can serve as sources of support, as can maximizing alternate methods of communication, which they take advantage of. An underlying feeling of competitiveness may impact networking and may serve to distance them from each other. Despite the limited network and face to face interaction, the participants are resilient and take pleasure in knowing that they are part of a larger geography of nurses who share common bonds regardless of their numbers or their physical geography.

Some participants described feelings of being excluded. Both discrete and more overt actions were described by the participants and included restrictions to positions in national

leadership. Speculation that 'vendor status' may impact access to positions of leadership and education is a potential source of tension.

Stories associated with gender issues, revealed an impact on their role in industry.

Generational issues related to traditional role choices impacted some participants career decisions while gender may influence the balance of power between disciplines. In some cases, pursuit of higher education may be a testimony to gender stereotype of nurses 'who eat their young' by failing to support, mentor and nurture.

Roles may be impacted by issues of credibility and trust between themselves and other nurses. Credibility may be associated with the lack of knowledge about roles that this group of nurses perform in industry. The participants speculate that the unknown aspect of their role in industry may cause other nurses to fear them or to feel threatened by their presence, which may shed light on some phrases like 'gone to the dark side'. Ethics also come into question, impacting the professional and personal identity, causing a disconnect with their self-perceived image and the way that they are perceived by other nurses.

Participants described ways that they felt as if they could raise awareness about their role by proactively disseminating information about their identity; who they are and what it is that they do as nurses in industry. By leveraging credentials and their specialty knowledge base, participants can be transparent about voicing who they are and what they do, to establish professional territory of nursing in industry. These actions build resilience and positively impact role and sense of identity.

In summary, role can impact professional identify while the work of establishing boundaries for any professional group may be enhanced or challenged by a variety of factors. Role may be impacted along a continuum and identity is dependent upon context and the meaning that they interpret as part of their social interaction. Factors such as feeling disconnected, feelings of exclusion, gender and questions of credibility and trust, can all influence the work of establishing professional boundaries. Working to gain credibility builds resilience to balance feelings of being marginalized due to restrictions perceived as being exclusionary, issues of credibility and trust and working to gain credibility.

Independence and control

Personal and professional style focuses on how the participants feel about their work style, from a perspective of flexibility and independence, which is enhanced by the mobility of their role. It is all about how the participants feel that their inherent flexibility and sense of independence is complemented by their role. The themes that emerge are critical moments of transition, flexibility and independence, being a self-starter in control and working remotely. The stories begin with an introduction on how they remember the critical moments surrounding their decision to transition to industry. Each participant shared memories of how and when they made their decision. They describe how their flexible and independent life style complements their professional role. Being a self-starter and having a sense of being in control is an important aspect of their role. They describe how working remotely and being mobile suits their lifestyle and offers them the opportunity to be flexible and independent, while being receptive to change and to meeting their professional and personal needs. This is the future of their work.

Critical Moments of Transition

The triggers for career transition to a new role are remembered by each participant as critical moments in time that opened up new opportunities and provide the realization of unmet professional needs. These are moments when they made the decision to move from their traditional role working at the bedside to the non-traditional role of working in industry. Recounted vividly, some participants were pursued by professional recruiters, while others realized that the time for change had arrived and it was 'just time to move on to other options.' Each one shared their critical story with passion and in every instance, these participants claim to have career satisfaction associated with that transition. Career satisfaction is perceived as a source of strength and support for what they do. Stories are told passionately as participants lean in; with voices that modulate to express the thrill of opportunities to look beyond what they were doing.

Lolly's transition to industry came out of a pursuit by a professional recruiter. She shared her story about her decision to change the course of her career and came back to reflections on her career throughout her interview. She was expressive in the tone of her voice and her

body language when she shared that 'he wouldn't take no for an answer'. She feels that she is now at the end of her career and wants to make a difference on a larger scale.

I had a head hunter actually track me down and just wouldn't take 'no' for an answer. I said, 'O.K., I'll throw my resume in', I should update my resume anyway, it's been a year and a half, so I did. And it was a long process. I decided I'm going . . . I'm at the end of my career, I like the idea of really making a difference, not for just one patient, the one on one, a large, and I feel, I was just talking about this last night, I feel like in this current position, I impact care on a very large scale. (Lolly)

Lara's entry into the specialty of WOC Nursing was a segue to the present phase of her professional life in industry. Like Lolly, Lara was also pursued by a recruiter for industry. She found it appealing enough to want to give it a try, knowing that she could always go back to bedside practice. She was willing to try something new, knowing that she could always go back, if the position did not suit her. Her body language, the look on her face and the tone of her voice, told me that she still feels the thrill of this opportunity.

And I'm like, well I've always wanted to go to school to be a WOCN but I never knew how to do it, I never looked into it. And so the agency I was with was going to put somebody through and so they selected me and I went through the Web WOC Program and worked there for another three years and low and behold one day I got a call and I was all over the place. I was doing ostomy visits, wound care visits, all that and sometimes driving 150 miles a day because I covered the way northern part of the state. And I got home one day and there was a message from a recruiter . . . who somehow or another he had gotten my name from other colleagues within the metropolitan area that I still don't know . . . he said it was from X Company but I didn't know any of the people there . . . but anyway, I ended up interviewing. They offered me the position, that was in and of itself an experience, but they offered me the position and I thought, I can always go back to clinical practice. I may not ever get the chance to do this again. So I said, O.K.. (Lara)

When questioned about their transition to industry, participants shared stories framed by timing that was a trigger for transition. A contextual experience of being at the right place in time acted as a stimulus for change. Edith talks about becoming aware that her skill set was valuable in other practice settings beyond the bedside. Like Lara, Edith described how she was willing to take a risk and try something new. Edith describes how she felt that her manager in hospital was unsupportive of her professional needs, and that lack of support drove her to rethink her skills and how she might use them in an alternate environment. For Edith, a challenge to practice in one setting triggered passage to another setting. The timing was right for her and she realized that her skill set was transferable to a new context of practice.

I loved my colleagues, I loved my facility, I just had one particular problem with my manager. And so I knew that wasn't going to change and so sometimes, it's time to move on. . . Yeah, so nursing can be particularly bad about again supporting people and making sure that they're not going to fail. Based on that, my experience, this manager is not going to support me, I need to do something else. I hadn't really thought about industry, but when I realized that there was this skill set that I had that could be used somewhere else . . . it was like wow, you can do something else. You can be good at it and you can enjoy it. I didn't really know what an industry job looked like . . . you know there weren't a lot of job descriptions out there at the time. So I thought, well I have nothing to lose. And I was really looking for something that would help me learn more about research and be able to do research because that's where my passion was and so it was a good fit and I was offered the position and so here we are, six years later. (Edith)

When questioned about her transition to industry, Gwen shared her story. With a pained facial expression, she described that she had been in a position that was not meeting her professional needs and she responded to an opportunity that presented itself. Like Edith, as Gwen explained, it was a matter of timing. She recognized that her needs were not being

met and she was open to change. She shared that she was recruited by a nurse who she admired and who was already in medical sales. Gwen talks about seeing that other nurses walk out the door, while she herself described that she was not in the position to do that. In her own words, she said that she felt like she never got to leave the place. She described how she wanted to be able to perform work, give one hundred percent and then be able to move on. She described feeling like she couldn't resolve basic issues like staffing and she wanted to meet her own needs for success. She admits when she received the call asking if she was interested in the position in industry, it was a matter of timing for her and the timing was right.

Well, there was a nurse who called on my facility for Santyl. And I just admired her, she would come in and she'd teach us, she'd help us, she was there if I needed her, but I'd watch her walk out the door and say, I never get to leave this place. I needed something where I could give it 100% and then leave it behind. I'd never had the personality that enjoyed getting woken up in the middle of the night, having to come in on weekends when the staffing was short. It wasn't working for me, was what I'm saying . . . personally. So I got a phone call one day, while I was the DON of the nursing home and it was that nurse. She said Gwen, I am leaving my current position, my boss asked me was there anyone that she could identify that could do my job and you're the only person that came to mind. So I'm calling you to wonder if you'd be interested . . . and the timing was right. I was saying to myself, I can't hang on here forever, I'm not enjoying it, I need something different. That's how it happened. It was from another representative nurse sales person in the field who approached me asking me if I was interested and from that moment on, except for one year I've spent, I think I calculated the last eighteen years in industry . . . truthfully being the good team we were, we made a difference in the lives of staff and patients everyday, but I wanted better, I wanted the staffing issues to go away and I couldn't get it there. So by the time I entered my first industry position I was ready for something different. My

position wasn't meeting my needs for success if you will. So that's how I got started, wanting something different. (Gwen)

Unlike the other participants who expressed surprise at being pursued, for Jane, her experience was different. She expresses a love of her nursing specialties, but she always wanted to pursue sales of some kind. She describes how she has thought about becoming an entrepreneur. In her descriptions of sales, she talks about her belief in a product, what she liked and what worked for her. She says that she must have passion for what she does. When her life circumstances changed, and she and her husband relocated, she describes how she had industry in the back of her mind. Like the others, she remembers the moment that the opportunity presented itself and she took it. The transition to industry took her into sales, although she describes her role as 'consultative selling'. Rather than simply selling products, she describes selling her services.

I mean I love the ostomy stuff, I loved it all, but I wanted, I always wanted to be in sales of some kind. I wanted to be a realtor, I wanted to, I've come up with a lot of different companies I thought I could create. . . cottage industries I thought I could create. And so I knew a lot of sales reps, very close to them. I didn't really see a lot of clinical, a few times I would see clinical people, and so I sort of paid attention to products, is what I liked. What I could believe in, because I knew if I was to get into an industry position, and after you set up a seven county home care agency and you teach everybody in the whole community and you set up parameters and you set up education and you set up policies and procedures, get all that . . . I was busy! You know, and I was pulling people into negative pressure and teaching them, nurses and patients and I said . . . I'm not taking a patient. (Her speech became so urgent, fast, jumbled together, very difficult to discern with clarity) But I will go with everyone in the organization and I ended up teaching, teaching all these nurses how to do wound care, it was fabulous. So, I just sort of starting moving toward that direction of industry and then my husband and I decided that we were kind of tired of being pushed around the United States based on jobs so we

wanted to go and live where we wanted to live and so I, industry still in the back of my head, companies were in the back of my head because I have to have a passion about what I do. We wanted to move back to the mountains . . . so I got a job, after I was there for eleven months, the clinician who, the rep from a certain city called me and said we have a job opening for a clinician, a WOC clinician that is in a certain state. And I said, O.K. then, and I applied and that was eleven years ago. . . I like the idea of, I liked sales too. I think, it's not, it's not like pushing paper, it's consultative selling. You know, I tell people, they say how do you like sales? I tell them, look preachers are sellers, preachers sell, the concept that you can't even see. You think they're not salesmen? (laughing) And so I've been selling my services and I've been convincing physicians to change the way they practice for several years and that's a sales opportunity right there. (Jane)

Flexibility and Independence

Positioning of a role can impact the quality of both professional and personal life. For these participants, their professional environment is loosely structured, home based, supplemented with business travel and extremely mobile. They feel that they are comfortable in their home office place, with a blending of personal and professional environments. The participants admit that the flexibility and more loosely structured environment at home fits their lifestyle, both their personal and professional needs and the way that they see themselves working.

Jane offers an insight to her identity and how she feels this impacts the quality of both her professional and personal life. Her feelings about liking change and wanting something new to experience is accommodated by her flexible work platform, she has a mobile life style. She shares what for her may be a daily routine at home and then goes on to talk about how she manages the logistics of travel. Both appear to be compartmentalized to some degree as she puts it, 'never the twain. . .'

I don't like structure, I like change. I like something new all the time. I travel, I have my office in my house, I jump up in the morning and take a

shower, I want to get dressed and whether, I might have my tennis shoes on and my workout pants because I might want to walk later on that day but I'm working all day long, dressed, showered, coffee in hand, breakfast done, ready to work. I'll take my suitcase, I've got everything ready to roll. I've got my home stuff, my travel stuff and never the twain . . . fill up my things, run off and go again. So and my mother complements me all the time, she'll say you never complain about travel, you get delayed or you don't get delayed. Your flight gets missed or whatever, your hotel something or other, so I just don't mind, big deal. (Jane)

Candice also talked about the flexibility of her home-based work environment and how it facilitates her ability to perform. She talks about how she is able to plan out her day according to her business needs. Candice described how she would not trade spaces to go back to the bedside, while at the same time admitting that her life style is not for everyone.

Where in the job I'm in now, if I want to do something at eleven o'clock at night I can sit at the computer, but I'm sitting at home, working so there's definitely more flexibility in the role . . . unless you have to be somewhere. Flexibility in the role . . . if I want to do a powerpoint at one o'clock in the morning, I can. I wouldn't go back to the bedside . . . the fact that we travel so much. It's definitely not made for everybody. (Candice)

Gwen spoke about the diversity of her early years in nursing and how the roles she took on were a reflection of her geographic location. Her mobile lifestyle over the long term, set the stage for her flexibility and drove her to consider the local needs of where she happened to find herself, to apply her nursing skills. Over time, the context of her geography framed her selection of career choices. Her work depended on what was available where she was living and she her flexibility enabled her choices.

Yes, well about forty years ago I married a gentleman who had been prior armed services and a year later I went back and joined the Reserves so my path through my early years was colored by the fact that we moved every couple of years. We were in various countries and then we were in the States, we moved as the armed services required us, every two to three

years. And so the types of things that I did, more reflected the location I was in. (Gwen)

Being Mobile

Working remotely is integral to the role and these participants feel that it suits them well, while flexibility and being able to adapt is not only an expectation of their role, but the way that they prefer to function. Offices are remote, home based and mobile, but often those offices are set up in hotel rooms, airports and where ever the participants happen to find themselves. As Edith shares, she has learned to work anywhere at any time. Edith sees the ability to set up her office and work where ever she happens to be as something that she can do comfortably and with ease. One of the reasons that she took her present position was because the company allowed her to work remotely and to be mobile, depending upon the company needs.

Yeah, obviously when you travel a lot you work remotely and so you have to be able to open the computer and work anywhere at any time. I mean I do email in the airport on the plane, in the cab, technology has been wonderful. My manager worked remotely in her previous job so she is very supportive. When I started with the company, there was an expectation in my interview . . . would you move to corporate? I said no, but I am happy to come in as needed. So that was the arrangement that we made. I'm comfortable working mobile. (Edith)

All of the participants except for Lara work from home, and they feel that a corporate office is often not necessary due to travel inherent in the role. Home office does come with life on the road or in the air. Candice describes how working remotely from the corporate office was one reason that she decided to take her current position.

I asked them, who is the manager and they said they hadn't hired anybody yet. It's going to be a corporate based position. I don't understand why it has to be. They're going to cover the whole country, why do they need to be in a specific city, they're going to be running after their consultants. Oh no, it's got to be a corporate position . . . I said, O.K. but if you change your mind let me know . . . when they called and offered me the job, they said,

we've been thinking about what you said and you can stay where you're at. (Candice)

When asked about the difference between working within industry or working in a hospital, Lara responded by saying that the only difference she sees is their work setting; all nurses are working toward a common goal, regardless of where they work.

(Comparing industry to acute care setting) . . . I don't know other than the fact that we're in different settings . . . we still are working toward the common goal. . . we all have a common goal and you have to figure out where your setting is. (Lara)

Being in control

These participants describe themselves as being self-starters, having the initiative to be self-sustaining, motivated to drive progress and to be in control of their lives, personally and professionally. Strength of conviction in what they are about facilitates them to identify priorities, set goals and objectives and to be in control with minimal level of supervision. Being able to organize their time, their schedules while being comfortable with a level of independence and flexibility, complements their life style.

Like four of the other participants, Gwen's professional work environment is home based. She feels that this arrangement makes her happy because she is either working at home or traveling for a week at a time. Going into some detail about her responsibilities, she comments on how she likes the diversity. She describes how not having to go to an office is what she likes and how working from a loosely structured space seems to suit her need for diversity. Gwen describes herself as a self-starter and her autonomous sense of control is complemented by the flexibility of her mobile work environment. Elaborating on how she feels about working from home, Gwen admits that she is too far removed from a corporate office to ever go back there. In a voice filled with enthusiasm, she describes how her work environment fits her needs at this time in her life.

Well I'm very happy. It's because I'm either in my home for a week at a time, working on my computer, I manage our company's hot line. And I do projects. I write educational programs and whatever the company owners

need to have done from a clinical perspective. Once or twice a month I am sent to teach somewhere. Generally for a week at a time, . . . so I like the diversity, I totally love not having to get up in the morning and go into an office. You know, I just . . . I'm too far away from that. It's been too many years, too many decades. Because I'm self-motivated, I get . . . I can sense what my bosses priorities are and be sure to meet those. It doesn't mean I have to be in this office all the time. I can go to a doctor's appointment in the afternoon, work until 7PM or so, I love the flexibility. It works for my needs . . . (Gwen)

Lolly speaks about her relationship with her supervisor, who is not a nurse. She describes herself as being self-directed and having integrity. Within that framework, she feels that being a nurse strengthens and lays the foundation of her code of ethics that she feels enables her to function credibly with guidance, but without being micromanaged. Lolly describes how being confident in her ability to true to herself and to be self-directed is important to her. She describes how much value she places on her professional integrity and how she would not jeopardize her ethics in any situation for any reason. She has worked hard to establish her position. The ethical code of nursing and her identity as a nurse means that she has the strength to keep her integrity and power in industry.

. . . what I told this company too is that 'don't try to micromanage me, you will never get the product from hiring me if you want to micromanage me.' I am self-directed, I'm going to assess things . . . guide me, absolutely, guidance. And he does guide me, he doesn't micromanage me. He knows I'm going to do the right thing. I have integrity. I am going to, in fact I've told him, I am not risking my professional career integrity for any employer. I never have, never will. If I feel that I'm at risk, that my reputation, as a company, as an industry, you can take advantage of my credibility and my ethical standing in the community, like I can't let you jeopardize that, I won't. So, I think . . . and that's an O.K. relationship and it's O.K. to be frank about that. I don't think nurses are confident in that and therein lies the problem. (Lolly)

Overview of Independence and control

Each of the participants describes with clarity the time preceding their decision to transition to industry. They recount those moments with engaged narrative, leaning into the investigator and sharing their stories with passion. Each of them speak to a sense of timing that so moved them to make a change. They describe their feelings of becoming aware that they were positioned to move, to meet their needs for a more non-traditional, unstructured career style. Recognition that their special skill set is applicable to a new professional setting where they can continue to make a difference and contribute to patient outcomes appears to be a momentous event that is recalled with nostalgia.

The participants' practice is loosely structured and non-traditional, unlimited by structured physical boundaries where space such as business travel may be considered the unfamiliar and represents open potential, while place is familiar and may be symbolized by home. Home may be a symbol of familiarity, comfort and unstructured environment for performing a role that allows them a degree of flexibility and autonomy that they feel fits their life style. Bringing work and home together in the same place is a blending of two environments, personal and professional. Being mobile is essential to their role, responding with flexibility is part of their professional life style. They travel frequently and across broad geography, regionally, nationally and often internationally, which impacts their potential for influence and learning. Diversity, flexibility, change are all personal modifiers that they claim, as is their preference for the loosely structured home-based office. The boundary of a single building or organization has been left behind and geography expands to offer them diversity and something new.

Without the physical boundaries of the work place, they describe how they experience a professional style that they feel fits their personal style of being flexible, independent and in control of their life. Being in control, leveraging autonomy and being a self-starter are realized within a non-traditional work style. Wanting something new and different, taking on challenges, comfort with diversity, less comfort with structure and liking change while being flexible describes their personal style and fits their professional work style. Contextualizing the work environment is a cultural preference and personal style.

They share stories of being mobile and working remotely. Their perspective on the world of healthcare differs from that of a more traditional role due to their spatial orientation, while their perspective is a blend of clinical and business. As Lara puts it, being a nurse is the same regardless of the work place, she feels that they all have a goal of delivering quality outcomes, they simply do it from a different place. The participants feel that their loosely structured environment is adaptable to suit their life style, while offering them the opportunity to contribute to nursing outcomes.

Temporally, their approach to practice is enabled by their historical legacy of clinical experience and special skill set that they bring to industry. Their work style reflects their personal style and enables them to construct a professional mobile platform that blends their approach to life and career as a unique nursing role.

The four primary themes that emerged from analysis of the interviews were each rich with nuanced subthemes. The participants see themselves as nurse leaders, feeling passion about making a difference through a career that is impacting their professional identity. Gaining a perspective that frames a broadened scope of practice while establishing new boundaries is facilitated and challenged by the context in which they have positioned themselves.

This chapter has presented analysis of the themes and subthemes that emerged from the six interviews. Chapter Five will frame a discussion of thematic analysis from an integration of both methods, the focus group and the interviews.

Discussion

Chapter Five

The data collected from two sources, focus group and one on one interviews, will now be considered as one large pool for interpretation with implications of findings to inform the identity of the participants and the role they perform. Combining the two sources of data collection offers triangulation of data for a rich narrative on the experiences of the participants. This chapter addresses points for discussion surrounding the overarching thematic conceptual framework.

Overarching concepts

The overarching concepts that have framed this interpretative analysis are Identity, Role, Boundary Work and Human Ecology.

Over Arching Concepts – Framing the Investigation	
Identity	Image of oneself as a composite of social interaction
Role	Image of oneself as an evolving professional nurse
Boundary Work	Labor to establish new geography distinct from larger cohort
Human Ecology	Analysis and Investigation of individuals and their environment

Identity is defined here as the image of oneself that defines the individual and is a composite of and grows out of symbolic social interaction. Identity is the prominent and the grounding theme of this study. Who they are, how they see themselves, their role, the space, place and time in which they exist and the barriers and enablers to their practice are all mediated to some degree by their identity. Every theme that arose within the study sheds new light on their identity and informs their role.

Role is closely integrated within identity and reflects the professionalisation of the individual as a nurse engaging at the periphery of established territory, for the purpose of this study. Role refers to the performance of the professional facet of an identity, impacted by the social mechanisms and role sets implied by the space and time of their practice.

Boundary work is the labour to establish new geography as distinct territory while nested within a larger cohort with similarities that bind the two together. The labour may be consciously performed or may be acknowledged as reflection retrospectively and in the moment.

Taking the discussion to the next level, how is this framework situated within the larger scope of human ecology. Human ecology has been defined as analysis and investigation of individuals and their relations within their environment. The environment encompasses all objects, their meanings, the spatial and temporal relations of objects to participants and their social interaction. This body of work is a study in human ecology, how one subculture of nurses is constructing a new role through the active work of defining applications of a special skill set in a way that sets them apart from their colleagues. Each of the themes that have surfaced through descriptive and interpretive analysis contribute to the professional identity of this sub-culture of nurse specialists as an authentic representation of themselves and their practice.

Identity and Role

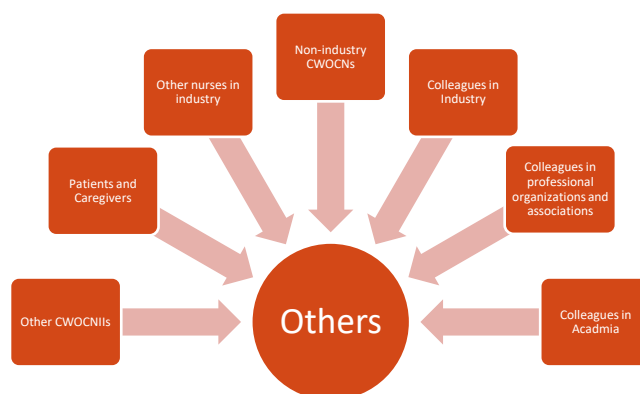
The way that the participants see themselves is a broad theme and encompasses a number of subthemes. *Being a nurse* was prominent within both the focus group and each interview. The participants each consider themselves first and foremost a nurse. They see themselves as nurses who practice in an alternative setting. For them, it is a matter of context for practice.

They express a desire to not only be the teacher but to be life-long learners themselves. The process of education is a continuous loop that is dependent upon lifelong input to have a valuable and meaningful output. A more precise descriptor for what the participants do in their role, is facilitator. They acknowledge that they consider themselves to be in a position that allows them access to the most current information, the most relevant clinical trends in healthcare, while indeed their proximity to information enables their functionality. While the current healthcare climate places a premium on education of bedside nurses to be able to engage in best practice, continuing education for CWOCNIIs is a part of their role. They are expected to attend conferences, participate in continuing education and engage in collaborative work with professional organizations, this activity fosters learning and expands

their network exponentially. It is then an expectation that the product of their activity, an expanded knowledge base and skill set, will be transferred to other nurses who may or may not be customers. Inherent in this position they express a responsibility, an obligation to transfer information to others who might not have access to information. This need is accompanied by a feeling of being responsible to share knowledge with others.

Participants consider their role and their practice within industry to be a career as opposed to being a job. They are vested in their roles and they are passionate about their mission to establish their professional role as legitimate. Their special skill set of clinical knowledge, expertise and the legacy that they share contribute to their life work as a career. Career implies a commitment and dedication to furthering the profession, rooted in historical relevance whereas the term job implies a mechanical set of duties that are performed in a rote fashion to fulfill a set of expectations. Their unique core body of expertise, knowledge and skills sets them apart from others and positions them as empowered, which is another way that they see themselves. Their role enables the way that they see themselves as empowered leaders.

All participants express a similar image of themselves as leaders and risk takers. The way that they see themselves is a product of their interaction with others. Their self-perception is a constantly evolving image that has everything to do with their professional interfacing with colleagues, their roles sets and their interpretation of the meanings they take away from their interactions. The diagram below illustrates the members within their role set.



These are the individuals with whom they engage in relationships with, as the occupant of their role in industry. They are immersed in a continuous feedback loop that engages them proactively. This iterative action of reciprocity is determined by constantly evolving perception changed through personal interface with members of their role set. They see themselves as configuring a role that is autonomous and empowered, while being an advocate for both patients and for other caregivers is a primary consideration.

Participants each expressed barriers and enablers to practice in industry. These barriers and enablers are realized through professional interaction with others and their meanings are influenced within the context of space and time. Barriers are experienced as challenges to role performance that the participants acknowledge and perceive as sources of tension, while at the same time, they are perceived as opportunities for growth. Each participant expressed feelings of tension related to a fear of being misrepresented by others who are not CWOCNIIIs. This tension is sourced to a deficit related to what is known about their role by others. They sense a lack of visibility about who they are and what they do. Relational identity can impact social interaction either positively or negatively. There appears to be an association between being in a role that is an unknown entity and a level of tension that they interpret from others. As counterpoint, if their identity and role is known through professional experience in the work place, they do not feel tension associated with others but rather a professional acceptance by others as a colleague. For example, they feel that customers who know them through a professional work network, know who they are and what they do, interact with them in a mutually respected collegial relationship. Exposure and awareness often leads to acceptance. Barriers that participants shared included feeling disconnected, feelings of being excluded by others, issues of credibility and trust and issues related to gender.

Their practice setting is a new one among many established contextual interpretations of practice. Although they are unaware of the formal label of what it is that they are doing, they are in the process of performing boundary work to construct a non-traditional role that is currently situated on the periphery of established practice. They form part of a complex network that reaches out indirectly to large numbers of caregivers and patients over time rather than a limited number of patients on a daily basis. This extended network or role set

now engages professional caregivers, their colleagues, every bit as much as patients. Their network for making a difference multiplies exponentially when they transition to industry.

Boundary work

Positioning themselves within this specialty WOCN Society, the participants reveal that they feel that they are now engaged in establishing territory as CWOCNs in industry, a non-traditional practice setting on the periphery of practice, that is a relatively small yet growing niche area. They do not label this activity as boundary work, but they feel the effect of what they are doing.

Traditionally, patients are the materials for performance of nurse's identity, while the zone of performance is at the bedside. Broadening the boundary of practice demands investigation of new geography, new context to enable an understanding of who nurses are and what they do and new social capital. The question becomes when the bedside is no longer relevant, and practice is expanded to other fields and area, what then becomes the material for performance and how is the new geography identified. That is the essence of this study, now that a new zone is identified, the future lies in the investigation of this zone of relevant practice. This study shows that the zone of practice has evolved, broadened beyond the bedside to caregivers and entire organizations of providers.

Their perspective on the periphery of practice is a blend of clinical and business. When practicing at the bedside, the focus of nurses is on their patients. Moving away from the bedside, their focus changes and they are now focused on delivery of quality patient care through the provision of innovative products and devices for use at the bedside. They are now concerned not only with direct patient care, but care as it is delivered by the end users of their products and devices, the nurses who use the products and devices to deliver care at the bedside. Their scope of practice incorporates a wider vision, they feel that they can impact care delivery by influencing the quality through the design and innovation of product technology. Their focus is now on the organizational account and the global market. Their approach to their role is enabled by their historical legacy of clinical experience and special skill set that they bring to industry. I propose that these are their new social capital.

The same mobility of their role that may offer freedom from physical boundaries may also lead to feelings of being disconnected. Participants who work at a distance, often do not work side by side with their colleagues and subsequently lack the closeness of being with colleagues on a daily basis. They have more limited face to face contact with colleagues and with members of their professional network. This lack of face to face contact impacts their relational identity and their interaction with their role set.

These participants share stories about how other nurses carried out this boundary work. They sometimes feel like an outsider, how they feel that others may label them as a traitor. They describe how an element of unknown that surrounds their role may factor into this phenomenon and may be associated with fear or a feeling of being threatened as a response on the part of other nurses. Unfamiliarity with the role of the participants in industry may hamper their face to face encounters with other nurses. The participants describe how they feel that others may react to them by pushing them away, resisting them or viewing them as not credible, ultimately impacting their role and creating a barrier to their practice, based on issues of credibility and trust. These feelings of being marginalized are impacted by frequency of interaction with others. As others become familiar with the CWOCII, the relationships become personalized, the unknown transitions to the known and barriers are broken down. Familiarity paves the way for relationship building that is based upon credibility and trust.

Speculation that 'vendor status' may impact access to positions of leadership and education is a potential source of tension and may be an avenue of exploration for decreasing tension. Framing of a role to be perceived by others in the context of social interaction is instrumental to resolution of tension. A label can be symbolic of the meaning attached to a role. The potential exists to change the interpretation of meaning associated with labels such as 'vendor'. Use of appropriate terminology and increasing frequency of exposure to the blended role of clinical and business may all impact the relational identity. The charge becomes for these individuals to initiate conversations with language and terminology that they configure. They are leaders and leaders take charge of crafting conversations.

Building Bridges- boundary spanning

Throughout the interviews participants told stories about what it is that they do in their roles, while building a repertoire of activities to strengthen their roles. They have contextualized their roles as grounded in their identity as nurses. They describe how they feel that their careers are grounded between the world of business and clinical at the bedside care, as if bridging the gap between those domains. The analogy of bridging the gap is meaningful to this study in a number of ways, depending upon the frame of reference. Meaning lies in building a bridge of continuity to the periphery of practice and being a conduit between the worlds of clinical nursing and industry. They are in a unique position to mediate, at the *crossroads* between two worlds.

Risks Inherent in Boundary Work

Currie's qualitative interview based study (Currie et al., 2010) asks two questions that are relevant to this study. They have to do with how individuals respond to the opportunity to move into new less-bounded roles and how organizations support or do not support movement of individuals into new roles. Her findings involve two themes of moving into new roles and the way that individuals enact those roles. This interpretative analysis asks these same questions and the findings are the essence of this study. By seeking to explore an identity, the investigator went beyond identity to uncovering themes associated with spanning boundaries and investigating human ecology in nursing. This study is a model for boundary work that demonstrates a journey along a continuum of maturity, to professionalization of practice.

Human Ecology

The work of carving new boundaries is timeless and is part of human history as individuals and groups respond to challenge and assume the risk of forging new identities. Movement is a key theme in American history (Tuan, 1977, p. 99) and with it brings an awareness of spatial consciousness and spatial relationships that have the potential for associated power. That power is evidenced by new mapping of landscape to reflect how space that was once strange has become familiar. Brokering new space in and of itself can resolve tension and open opportunities for new choices and hope for the future, articulated by those with skills and knowledge (Tuan, 1977, p. 118). The labor of brokering new professional territory is not new, yet it is challenging for nurses who have in the past been

tethered to an image associated with an emotional script. Human landscapes change and those enabled with skills, desire and passion to seek new spaces are in control of their future. Intentional decision to socially construct new landscapes offers independence and control. The emphasis on study of work and organizations has a long tradition of social construction framed by symbolic interactionism (McCall and Becker, 1990, p. 197). The fluidity of human ecology is evidenced by social interaction and is demonstrated in nursing, by a greater understanding of these participants. Their world is a stable collective as they actively make their careers.

Implications of Findings for Evidence on Identity of WOCNII

As demonstrated by a gap in the literature, the findings of this study offer evidence to build a knowledge script that may inform the virtue script (Nelson and Gordon, 2006). The outcome of this research study provides the evidence to describe the professional identity of these nurses while contextualizing and legitimatizing their professional role.

My transition to Interpretivist approach makes sense of what evolved within the course of my study. For me, thinking of the themes that emerged, these themes are the “root images” (Blumer, 1969, p. 6) of this culture and constitute the framework of their group. My participants act and share patterns of beliefs and behaviors yet play out their roles and develop their professional identity physically isolated from each other. Yet when they come together, they find that they have these commonly held themes experienced as root images that bind them together. Their interpretative approach to their world is exemplified through their social interaction and the linkages individuals have to one another (Blumer, 1969). In support of this, symbolic interactionism applies to joint or collective action in addition to the individual.

Congruency between the work role and the self-concept are vital for successful professional employment. This study explores how the WOC Nurse in the world of business, seeks to answer the question of how the nurse marries a role in industry with the stereotypical image of the nurse portrayed as the nurturing caregiver (Goffman, 1969). There is no literature on congruency between the work role and the self-concept of this niche group of nurses. Part of the professional and personal experience of the CWOCNII is the subjective

way in which they integrate their role as a nurse within the context of industry. This study informs and fills that gap in the literature related to role congruency.

Investigation of this segment of the professional nursing culture nested within the larger organization is an examination of the complexity of their social construct and professional ecology and is instrumental in uncovering the cultural identity of these nurses (Allen and Boulton, 2011). Part of the jurisdictional conflict may be attributed to the effect of being nested, compounded by the unknowns surrounding their role.

Using the model of symbolic interactionism, it becomes the responsibility of the CWOCNII to increase their visibility through professional interaction. Consciously influencing the perception by others, of their social front, they have the option to portray themselves within the context of the world of industry. With the aim of deconstructing the virtue script and debunking the stereotype, they may impact authentic interaction with others by sharing what they do and the value of their role. By increasing reciprocity of interaction, they may increase their feelings of congruence associated with their role and decrease their feelings of incongruence as manifested by tension and conflict associated with marginalization. It would appear that a linear relationship exists between levels of reciprocity and congruence and that relationship may be leveraged by the CWOCNII.

The social cohesion that they describe as members of their group may be leveraged as a source of support and resilience as their role evolves along the continuum of maturity. The goal of experiencing a congruence of identity and role will become a reality as they strive toward greater visibility and awareness among their colleagues.

Relevance of Findings to Wider Boundary Work in Nursing

The current and future direction of the CWOCN role is the expansion to professional domains that are not directly associated and defined by patient care. Those nurses who choose to practice within the peripheral space, removed from direct patient care, are challenging the acknowledged nursing boundaries by applying their clinical expertise to fields that are outside the context of direct patient care, yet has indirect impact to the care delivery environment.

The literature search in Chapter One shows us that understanding nursing identity, the impact of changing roles, and the boundary work around nursing is important in understanding not only the CWOCN working in industry, but the greater geography of nurses who are working in roles framed within new contextual environments. The review of the literature identified that a small percentage of nurses' work in other non-health industries; specifically those in management of companies and enterprises (Employment and Earnings ANA Issue Brief, 2010). While the WOCN Society surveys of salary and employment have found that a small percentage of CWOCNs are employed in industry, over the past two decades, I have witnessed a steady increase in the number of my nurse colleagues who have transitioned from direct patient care to take a role within industry. This transition is happening in the United States because the value of the nurse in medical device development is acknowledged to enhance the clinical relevance of products and to improve patient and caregiver safety in the design of medical devices.

As referenced within Section Two of the Literature Review, it is not so difficult to expand this conceptual framework of identity to terrain that is professionally unfamiliar. The analogy of the flayed self as demonstrated by travelers might be just as applicable to those who are traveling in new professional territory. The concept of the flayed self is constructed around the incongruity of self expectation; whether self image is congruent with the expected image held by others can depend upon the context of the relational identity. My findings and their implications may be extended to application for nurses within the context of other new roles beyond industry. The relevance of my findings may also depend upon the uniqueness of the role and the role set and not necessarily the larger context of the practice environment.

Evidence in Section Five of the literature review on the theory of nursing work supports the concept of extending professionalisation beyond the zone of patient care, although there is currently a paucity of literature exploring this. Since social interaction is at the center of nursing practice, any professional space where nurses choose to use their skill set and their knowledge base, is an expansion of evidence-based practice. Attempting to place limits on nursing roles within boundaries of practice, hinders evolving professionalisation.

Emotional labour may be categorized as being collegial and the legitimacy of emotional labour as a component of the expert skill set is associated with practice beyond the zone of patient care, as demonstrated by this study. Unfortunately, emotional labour as a professional competency has been

historically tacit, but as nursing matures and claims emotional intelligence, clinical empathy and reflexivity as part of their skill set, there is an acknowledged need to make these skills visible. Part of the relevance of this study is bringing forward the value of these skills.

The literature also shows that evolution of professionalism includes not only changes to existing roles but also carving out of new roles in response to emerging needs. Examples of new roles such as the clinical nurse leader, although within the zone of patient care, demonstrate some of the same emotional labour that is experienced by the participants of this study. Acceptance hinges on the visibility and increasing professional interaction that can build relationships and foster trust. The nursing profession is on a journey and movement along the continuum of growth that encourages taking ownership of new roles, by claiming and making visible the skill set, builds competencies within new zones of practice. This study adds to the evidence base in support of the evolution of nursing practice and roles.

As posited by Everett Hughes, every profession documents the work that it does as part of the journey to professionalisation. My findings are part of the documentation on that journey to professionalisation of nursing and as such may be applied beyond the context of industry to other roles that extend beyond the zone of patient care. Boundaries are territorial, and they are contextual, as defined by the occupational setting, the time and the geographical space in which roles reside. The findings of this study are relevant to nurses who find themselves insulated from others, practicing in a frontier zone, an unfamiliar space with ambiguous boundaries. The relevance of my findings may also hinge upon congruence of the personal and professional role. The implications for the future, in my final chapter may prove valuable to other nurses who find themselves doing boundary work. Examining boundaries can only be done when those boundaries are recognized, acknowledged and shared with others by the occupants of those role sets.

Prompted by Latimer's call to frame nursing work in terms of socialness, my findings may be used to support other nursing boundary work, in other zones of practice. My findings support the identified need for self-examination of our profession. The model for boundary work is one that is relevant to other nurses who find themselves on similar journeys to maturity of professionalisation. My findings support investigation of boundaries by providing a precedence for the journey into new geography.

Limitations of Study

I address the potential limits of this study and identify them as the problem of familiarity and the nature of the study sample. Both of these potential limitations were addressed more broadly in the context of the Methodology, Chapter Three.

Problem of Familiarity

The problem of familiarity is addressed within Chapter Three but is also referenced here within Limitations, to acknowledge it as a possible risk to my study.

Risks Associated with Familiarity

I am intimately aware of the experience of this cultural group and the danger exists that I may *think* that I am hearing and describing the story of the participants, while my perception may be inadequate to filter out my own interpretation during the process of descriptive analysis (Bonner and Tolhurst, 2002). I may *think* that I am hearing their story, but I may unwittingly be hearing my own version of their story, that is the risk of 'going native' (Bryman, 2008, p. 412). *Knowing* what is going on, *knowing* what is happening can be deceiving simply because the mind is so entrenched in the everyday experience of professional life (Kanuha, 2000, 442). As I set out in this study, it became apparent to me that the risk exists that without realizing, I may miss something that would otherwise be seen by someone who is less intimate, less familiar with the context of the study; this may be a case of 'observational ennui' (Atkinson et al. 2003, p. 26). Being a stranger may in fact be considered advantageous, in that what is happening may stand out and become visible to someone who is less familiar to a situation, while it may go unnoticed by someone who is familiar.

In addition to thinking that my own interpretation is that of my participants, I may in fact miss the opportunity to probe further into some statements and lines of inquiry (Wolcott, 2009). On several occasions during transcription I found myself asking why I had not probed further into a comment or a statement. I recall reading a section and asking myself questions about what had been said or what was meant. I remember thinking to myself, that was a lost opportunity to engage on a deeper level. Reflecting on those occasions, I wonder if I indeed had been so caught up in the moment as I listened to what was being said, that I may have not even thought to probe further (Kanuha, 2000, 442). Then again, on at least two occasions, I do remember identifying with commentary in the moment and taking the opportunity to delve deeper, because what was said was relevant to me. Those were significant moments to me.

There are implications associated with being an insider when engaging with participants, indeed familiarity can be a problem regardless of the method being used, to the extent of being in danger of 'over rapport.' (Atkinson et al., 2003, p. 28). Because of the shared degree of closeness between myself as the investigator and the participants, it was often a challenge for me to recognize and to acknowledge the mundane because it is so much a part of my frame of reference that it may be missed because it may not rise to the surface for consideration (Atkinson et al, 2003). I may in fact be unaware that my own cultural knowledge of this group is directing or influencing what I observe (Spradley and McCurdy, 1972, p. 16). The participants may view me as leveraging authority at the risk of exposing them within the larger nursing organization. On the other hand, participants may run the risk of being judged for consenting to participate.

This problem of familiarity may be perceived as a limitation within my study, but within my Methodology chapter, I acknowledge and defend this problem, with a detailed transparent strategy of the way that I implemented it as a strength.

Nature of Sample

Because I am a colleague of these individuals or at least acquainted with all of them, an additional attribute that I used for my selection, was their willingness to share their stories and their passion for what they do. My position as an insider to the network afforded me insight as to which individuals would be generous with their stories. I acknowledge the potential for investigator bias here, but I knew who was more vocal and who might be more expressive and 'information rich' in their narrative (Polit and Hungler, 1999, 296). I was willing to risk that bias. By selecting those individuals as participants who I know to be vocal and willing to share, I may have eliminated some individuals who are quiet, but when I reflect on this, I realize that most of my colleagues who work in industry are adept at expressing themselves and are not shy about doing so.

This chapter has discussed the findings of this study in light of the overarching concepts that framed it and their implications as evidence base for the practice of nurses in industry. Relevance of findings was discussed related to application of a wide scope of nursing practice beyond the zone of patient care. The next chapter will present implications for the future of practice.

Implications for the Future

Chapter Six

The findings of my study contribute to the evidence on the identity of CWOCNII, but the greater question becomes where does practice go from here, and how does this study inform practice in the future. Nurses are now established within the context of business and their future legitimacy and jurisdiction depends upon a strategic approach to navigate their journey of professionalisation. Social interaction that positions them as leaders with the social capital of a unique skill set, enables them to broker networks, span boundaries and perform the labor necessary to transform geography that was historically considered a frontier, to a place that symbolizes the here and now of their clinical practice zone. This is their path to professionalisation.

Significance of the Findings

Demographic, social, political, practical and cultural aspects make this body of work important not only to the participants but to the larger society of the nursing society. The field of nursing can be influenced by this work because new qualitative research on a non-traditional nursing role lays a foundation for evidence-based practice, previously not documented within the literature. The members of this cohort of CWOCNIIs have expressed the need for evidence related to the roles they perform, since inception of the role more than two decades ago. This study was initiated with an intent to explore the identity of these nurses and to provide a foundation of evidence for initiating discussion on the territorial boundaries of this role. It is the hope of the author to stimulate dialogue and simultaneously trigger additional study into the boundary work that has been ongoing by CWOCNIIs. The aim of the author is to disseminate these findings via publication and presentation to share with the larger audience of other nurses and interdisciplinary health care professionals, giving a voice to a cohort of nurses who practice in a setting that is largely unknown to others outside of their group.

Agenda for the Future

An agenda for the future will address five areas to mobilize the professional journey along a continuum to sustainment and growth. Tasks related to each focal area are part of the boundary work that lies ahead for this nursing specialty. The findings of my study on identity and role inform the professional path and support movement along the continuum to a fully embodied identity of this culture. Based upon those findings and the literature review on identity, role and boundary work, the focal areas for professionalisation are below.

Contextualizing their role

A prerequisite associated with construction of a sturdy, viable nursing role lies in contextualizing that role, within both the culture of nursing and the professional context of the segmented society in which that role practices. The old cliché of '*location, location, location,*' holds significance in this context as it is a way to frame the journey, from inside and outside the experience on both sides of this boundary. Being positioned within the larger group on CWOCNs and again, within the larger group of specialty certified nurses, translates into a complex nesting of nurses. That nested position is then contextualized within the world of business with a role set that requires transparency. Being vocal about their identity and role and increasing the exposure within their role set leverages their position as brokering boundaries to expand practice.

Expanding their professional scope of practice within industry.

The scope of practice that was once applied to patient care is now applied to the world of business where the recipient of practice is no longer the patient, but is now a new spectrum of role set. Initial forays into business have been primarily within the area of education, but the essence of practice is encapsulated within being the voice of nursing and that skill set will expand to regulatory, quality, new product development, risk management, research and development and acquisitions.

It is a mandate for the future, that this niche specialty group break down the complexity of their practice and demarcate that professional ecology by being the voice of nursing within industry. Make what was previously unknown about their role, familiar.

Normalizing their identity – relational identity

Normalizing their identity means translating who they are and what they do in a transparent way with clarity. Manipulation of their social front to be the norm within the context of business is a mandate. Making relational development a priority is the way to achieve normalization. Building a formal professional network and advocating for their own identity and role will support normalization through authentic interaction. With an emphasis on relating to others in a way that increases social interaction, they will experience a congruency of role and identity among themselves and with others. The greater the opportunity for relationship building through reciprocity, the closer they become to normalizing their identity within the world of business. Location becomes established territory, no longer on the margins of practice. Increasing reciprocity will equalize congruency. Striving for congruency between the work role and the self-concept are vital for successful professional employment.

Building Social cohesion

The promise of resilience lies in their ability to build on the social cohesion that they already experience. They have been able to feel the sense of belongingness among themselves and their potential to solidify that sense of belonging, grow it and leverage it are implicated in how well they manage their social front. Joining together as a formal organization may offer them the opportunity to differentiate themselves and secure the group in a way that supports their unification. Taking on the accoutrements of their culture may include claiming a name for themselves that implies exclusivity and offers benefits and advantages to members.

Marketing their social front

This group could develop and use the marketing skills learned within the business world to leverage their own professional front, in order to become embedded within the context of business. Their love of life-long learning will be to their advantage in observing and becoming acclimated to the context of business. A variety of options are available to them, as they market their identity and their roles. They may disseminate their voice through

presentations, posters, publications, participation in conferences and meetings while focusing on ways to collaborate interprofessionally with their colleagues.

This author calls for further research on this role and the work of nurses within the context of industry and beyond. Contributing to evidence and examining one's own identity and role is part of the pathway to maturity for a profession. It is the hope of this author that these findings will generate conversation and dialogue and nurses and others within the professional community.

The exploration of the identity of this specialty group of nurses has been a journey for this author, personally and professionally. The potential growth in maturity of this group is slated to be exponential. The varying degree of success or failure is dependent upon the resilience of this specialty nested culture of nurses. This author has faith in this nursing specialty to become an ever-increasing force within industry, one which will be openly acknowledged as a professional contingent that contributes to quality production within the medical device world. The impact of this professional group will designate nursing as providers of healthcare in a way that frames quality and leads the dialogue forward in the realm of professional ecology.

The seventh and final chapter will explore my experience of this journey as I made my way from an experienced nurse and a novice researcher, to one who has learned a great deal along the way, but has uncovered more questions that beg answers.

My Professional Journey

Chapter Seven

This final section tells the story of my journey from being a nurse with the desire to tell a story as a novice researcher, to becoming a nurse who evolved to embrace the skill set of a qualitative researcher. When I began I was relatively naïve about the work that I was taking on. I had questions and I set a goal to explore the identity of one new role for nurses, but I was unaware of the scope of the story and of the broad landscape where it was embedded. At the outset, I had no appreciation for my role as an instrument of research and how my own reflexivity can contribute to the process. It is the realization of how my role and my growth as a researcher contributes to my identity as a nurse. The lens of my own perspective is a valuable tool. I will identify the milestones and share how each part of my program of study has contributed to achieving competence, concluding with my thoughts on my journey, at this point in time.

Milestones along the way

My journey has been informed by two formal elements of the Professional Doctorate Program, a didactic component of structured modules and a supervised component of performing original research. Each of those elements are complemented and facilitated by the expertise of the individuals who led them and the social interaction with my entire cohort. Each element supported activities that encouraged growth from being a novice to being competent as a researcher. I will share how those transpired over the course of the seven years of my journey.

Modules

The most influential module for me was about Qualitative Research Methodology. It made a lasting impression on me that was associated with the Professors who taught me and the relevance of the content for me personally. Dr. Sara Delamont and Professor Paul Atkinson brought qualitative research to life for me with stories of their experiences that sparked an enduring interest within me and personalized the textbook concepts through their expertise. The central traditions and the range of methods presented set in motion my own thought process about how best to initiate the

investigation of my research problem. Focus on the appropriateness of methods, strategies for how to approach data and regard for the classics, ignited a passion for this qualitative methodology.

Two projects from that module were relevant to my subsequent research, a life history and a paper on the problem of familiarity. I had never performed a life history and it gave me an opportunity to draft my first Interview Guide, which was most helpful to me later as part of my thesis. Interviewing was later to be one of the two methods used for my data collection, so this was an early opportunity to experiment with this method. This initial experience with interviewing was a foundation upon which I could build one of my two primary methods for data collection. It also facilitated my first engagement with managing electronic data collection which supported the data collection for my thesis. The assignment specified that the life history interview be focused on the career of the individual, that also supported the research for my thesis.

My paper on the problem of familiarity exposed me to the concept. Prior to that, I knew that as a friend, a colleague and a member of the group I intended to study, there were issues surrounding my exploration of the WOC Nurse in industry, but I had no name for the problem and no idea that there was a body of evidence surrounding it. I was driven to read the early work by the researchers of the Chicago School. It was during this class that I was exposed to the theory of Symbolic Interactionism, which became the theoretical framework of my research.

Changing Modes of Professionalism, introduced me to the complexity of professionalism that came to take on significance during the course of my study. I had been unaware of the significance of the concept, to the essence of my study. By initially exploring the identity and role of the WOC Nurse in industry, my investigation led me to emerging themes that yielded a model for professionalisation. The concept of othering in the formation of professional identity was introduced in readings during the module, for example, about new professional identity in the context of new working relationships. That concept became integral to my model when I examined the role set associated with the context of industry. Examining how roles and identity are deconstructed and reconstructed was something I had not given a great deal of thought to, prior to this module. The impact of interprofessional partnership and collaboration was another concept that emerged from within the readings of this module; once again, this was integral to my own research. Specialism, credentialing and elitism all became part of the dialogue. The work of this module took on a significance that I later reflected upon and helped to prepare me for my role as investigator.

The Work of this Study

My research into the exploration of the identity and role of the WOC Nurse in industry gave me the opportunity to implement the concepts, the framework, the evidence that I had become acquainted with during the modules. All my endeavors in my qualitative research study were guided by my supervisor, who I regard as a mentor and over time, I learned to be with her as a colleague and friend. The individuals with whom one interacts with socially during research are part of the journey and facilitate the competence gained by the research process over time.

Reading of the classics and the early works of the Chicago School gave me a respect for and familiarity with qualitative researchers who laid the foundation for the early work on social interaction and social and relational theory and boundary work. The discovery that the experience of my participants was an established route along the continuum of professionalization and that a body of evidence exists on boundary work, was a revelation to me. I came to realize that what my participants were experiencing was a normal process associated with constructing new territorial boundaries. There is an entire body of literature and a precedence for what they are living through and I had it at my fingertips.

I became more adept at interviewing with each participant. My level of confidence grew, and I found myself enjoying the process and anticipating the next conversational event. It became like an information game for me, to probe and draw out the stories of my participants. Reading about the techniques is a start, but the art can only be achieved by doing. Being sensitive to the balance of power is a skill I became competent in, when interacting with study participants.

I became skilled at the logistics of preparation that makes data collection successful. Consideration of time management over the long term, the logistics of coordinating the technical components of the audio-visual equipment to ensure that all recordings are captured, having the ability to plan events such as the focus group down to the most intimate details so that everything and everyone is comfortable, at ease and can go about fulfilling their roles on the day of the event; these are all skills that a researcher must hone. They are skills that must be learned by doing.

I had done significant reading about the problem of familiarity, but nothing can quite prepare an investigator for experiencing the problem, like constructing a strategy to fight it. As I describe in Chapter Three on Methods, over time I came to practice reflexivity routinely without being conscious of what I was doing. It became part of my process of immersing myself and thinking about what my

participants were telling me. Using the steps and the actions of my plan, I became adept at making what could have been a weakness into a strength. It is an internal thought process and can only be built up by constant self-awareness.

Thematic analysis is a skill that takes time. Regardless of the topic, what I did learn, is that it cannot be rushed. The skillful investigator must build in time to the research plan, for reflection, time for immersion into the data, time to come back to the data multiple times with fresh eyes. I also learned the art of patience. Performing descriptive analysis as separate from interpretative analysis is another skill that takes time and practice. Learning that to apply the interpretive lens is a skill to be engaged and to build upon a thorough descriptive analysis, is a lesson learned. Thematic analysis cannot be rushed, and one must learn to be comfortable with the chaos. The acknowledgment that a feeling of chaos is to be expected, is something that cannot be taught, it must be experienced.

Lessons Learned

The lessons that I learned were taught and experimented with as part of each module and experienced throughout my study. Looking back, I remember how each convener stressed the importance of choosing the modular assignment that might be most supportive of the topic for original research. Since I had chosen my topic of research prior to beginning my Professional Doctorate program, I always kept that in mind. Those lessons include learning about the problem of familiarity and the literature surrounding professionalisation of nurses' work. Being comfortable with and trusting in my ability to interact with my participants in my role as an investigator is a new skill for me. Building confidence in my own abilities is satisfying and offers a sense of accomplishment.

All my lessons learned throughout the research process could not have been possible without the guidance of my supervisor. Her wisdom kept me on the straight and narrow, even to this day, her mantra is slow and steady. Her advice overruled the voices in my head, I learned to trust in the experience of my mentor. One skill that I learned from her when writing is to consider the reader, first and foremost. Asking the questions, who is my audience, what do they need to know, what do I want to convey? The ability to sign post and facilitate understanding about what is being conveyed is important. The findings are of little value if they are not presented in a way that makes sense to the reader. As the investigator, it is my responsibility to convey meaning with clarity, to make the reader aware of what is coming and to summarize what has been said.

Being a researcher is an elusive quality and not easy to define, especially when the individual is oneself; here again, an example of being reflective. Overall, the skill set that represents competence as a researcher are those elements that facilitate my ability to tell the stories of my participants in a way that is true to what they have to say. This research study is the story of my participants and my ability to tell that story reflectively in a way that represents what they have to say. The findings are a way to evaluate my competence and my ability to make the familiar, strange.

I feel that over the course of the past seven years, my ability to perform as an investigator has matured to the extent that I have achieved interpretive authority and my goal of being authentic to my participants. I have answered the research questions that I sought to explore, and I have contributed evidence of the expanding scope of practice by constructing a model of a maturing profession through boundary work. I learned to choose the question carefully, passion for the work of research cannot be taught but must be nurtured.

Without passion, the traveler will miss the richness of the experience and may arrive at the destination without appreciation of the process. Learning how to reflect, immerse myself, question everything I think about and be at ease with the chaos, is part of what this journey has taught me. At the start of my journey I was a nurse whose experiences led to questions about being a nurse and I find that now I think of myself as a researcher who happens to be a nurse, comfortable with an expansion of roles and comfortable that I have performed my own boundary work. For as my participants echo throughout their narrative, I will always be a nurse.

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Informed Consent Document

Title of Project: Exploring the Identity of the Certified Wound Ostomy Continence Nurses *in Industry: An Ethnographic Study of Nurse Ecology*

Principal Investigator: Cynthia Sylvia

The Introductory Paragraph

I invite you to take part in a qualitative research study entitled “Exploring the Identity of the Certified Wound Ostomy Continence Nurses *in Industry: An Ethnographic Study of Nurse Ecology*” at Cardiff University/Cardiff Wales. This ethnographic study, which consists of semi-structured interviews and a small focus group, seeks to explore the professional role of the Certified Wound Ostomy Continence Nurse in Industry. Taking part in this study is entirely voluntary. I urge you to ask any questions about this study. If you decide to participate in either the participant interviews or the focus group you must sign this form to show that you want to take part.

Section 1. Purpose of the Research

You are being offered the opportunity to take part in this research study because you are a Certified Wound Ostomy Continence Nurse who works in industry.

The purpose of this research study is to explore the professional role to construct a professional identity for authentic representation of their practice.

Approximately twelve to eighteen people will take part in this research from the United States.



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Section 2. Procedures

This study consists of two procedures:

- Approximately ten to twelve participant interviews to be called participant dialogues will take place in the United States. Each dialogue will be of one-hour duration or less to occur at a place that is mutually agreed upon by the participant and the primary investigator. Each dialogue will be audio taped by the primary investigator for transcription, field notes will be taken.
- One face to face small focus group event lasting approximately one-hour in duration will be composed of approximately six to eight individuals and will take place at the annual Wound Ostomy Continence Nursing Society National Conference (2014). The event will be facilitated by a moderator who will lead the small group in dialogue about their experiences as CWOCNII. The event will be video-taped by a consultant, while the primary investigator will observe and take field notes.

You may choose to participate in a participant dialogue and the focus group or you may choose to participate in one of the events.

Section 3. Time Duration of the Procedures and Study

If you agree to take part in this study, your involvement will last approximately one hour in duration if you are participating in a participant dialogue and approximately one hour if you are participating in the focus group.

Section 4. Discomforts and Risks

There are no known physical risks associated with the research. However, nonphysical risks may include such things as potential anxiety related to the sensitive nature of the questions asked.



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Section 5. Potential Benefits

Possible benefits to the participant:

The possible benefit you may experience from the study is that as a member of the Certified Wound Ostomy Continence Nurses in Industry (CWOCNII) group you will assist with findings to contribute to the body of knowledge for this nurse specialty. However, there is no guarantee that you will benefit from being in this research.

Possible benefits to others:

Nursing specialty may be advanced through their contribution toward gaining a professional identity and an authentic representation of themselves and others.

Section 6. Statement of Confidentiality

Privacy and confidentiality measures

Your research records that are reviewed, stored, and analyzed will be kept in a secured password protected electronic file on the computer network of the primary investigator.

For research records, name, social security number, address or phone number will not identify you. The records may include a code number, your initials, and date of interview. The key that matches your name with the code number will be kept in a locked electronic file.

In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared.



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I will keep your participation in this research study confidential to the extent permitted by law. However, it is possible that other people may become aware of your participation in this study.

If you choose to participate, you are free to withdraw your permission at any time. You must do this in writing.

Section 7. Compensation for Participation

There will be no monetary payment to compensate you for time or expenses for participating in this study.

Section 8. Research Funding

- **Funding disclosure:** *There are no grants associated with funding of this study and no companies are involved in the research through funding or grants.*
- **Conflict of Interest:** *The investigator has no consultative or financial relationships to disclose.*

Section 9. Voluntary Participation

Taking part in this research study is voluntary. If you choose to take part in this research, your major responsibilities will include participation in an open ended semi-structured interview. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time. If you decide not to participate or if you decide to stop taking part in the research at a later date, there will be no penalty or loss of benefits to which you are otherwise entitled.

Section 10. Contact Information for Questions or Concerns

You have the right to ask any questions you may have about this research. If you have questions regarding your rights as a research participant or you have concerns or general



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questions about the research or about your privacy, contact Cynthia Sylvia at 703-371-5964 or via email at csylvia@nachos.net.

Signature and Consent/Permission to be in the Research

Before making the decision regarding enrollment in this research you should have:

- Discussed this study with an investigator,
- Reviewed the information in this form, and
- Had the opportunity to ask any questions you may have.

Your signature below means that you have received this information, have asked the questions you currently have about the research and those questions have been answered. You will receive a copy of the signed and dated form to keep for future reference.

Participant: By signing this consent form, you indicate that you are voluntarily choosing to take part in this research.

Signature of Participant

Date

Time

Printed Name

Person Explaining the Research: Your signature below means that you have explained the research to the participant/participant representative and have answered any questions he/she has about the research.

Signature of person who explained this research
Name

Date

Time

Printed

Only approved investigators for this research may explain the research and obtain informed consent.



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Interview Guide

Themes	Potential Probes
Tell me the story of how you came to be a nurse . . .	Nursing before industry – Why nursing? Conscious choice? Share one memorable experience.
Please share the trajectory of how you came to be where you are now, in industry.	Talk to me about your decision. Your motivation, transition and expectations? Insights on your new practice environment? Links to the past?
How do you see yourself in your role?	Describe your role and how you feel about it. How would you describe your reality? What are your competencies? Share some of your experiences
How do you perceive that others see you?	How do your colleagues perceive you? <ul style="list-style-type: none"> • those in industry • those not in industry Are their perceptions similar to yours? Any gap?
(Boundary Work) What differentiates you? What is yours? What do you own?	Describe your professional niche. Do you share it? What differentiates you? What do you bring to your role? Commonality with others? Describe the physicality of your environment – your space, your network Impact on your life?
Future of Nursing & Nurses in Industry	Describe your single most important contribution, your legacy. If you could change one thing about your current role what would that be? What is your prediction for the future of nursing and for the future of nursing within industry?
Closure	Is there anything that you would like to share with me that we have not touched on today?

Transcript

The following is a full transcript of one of the participant interviews.

Interview #1

This is the first of six interviews that took place on the 30th of April, 2015.

Participant Lolly / Myself as Interviewer CJS

CJS Thank you so much Lolly for willing to be my first participant in my one on one interviews. As you know I had a focus group last year at WOCN and now the second phase of my data collection is going to be with interviews, so thank you very much for agreeing to participate.

Lolly Happy to do it.

CJS First off, let's start with . . . I would love for you to share the story of how you came to nursing. Think back, way back and just share some of your thoughts about how and why and when you went into nursing. What drew you there?

Lolly What drew me there? Is my family, a family of multiple kids, (religious affiliation) and I was programmed. I was given nurse dolls, and my sister was the teacher and I was going to be the nurse. I had an Aunt who graduated from a hospital in a major metropolitan city during war time and she was a great mentor, and really wanted me to go into nursing. So, I was wait listed at that hospital and I

ended up at another hospital at a three year diploma program. So that's how I got there. I grew up in the state of _____ and I wanted to get out and get away. I wanted desperately to go to the city, I was only 17 and my father was from a city and he said 'No, you're 17, you can't go to the city.' So, and he thought being in another state near my Aunt and she was a nurse, that would be a good solution. So that's how that shook down.

CJS So it sounds like familiar influence . . .

Lolly Yes, absolutely. Family influence and I've had no regrets, I've loved it and it's been a great career. Love nursing.

CJS So, what were your expectations?

Lolly I didn't really have any. I remember being horrified when I went into the hospital initially and I didn't know what a bedpan was, a urinal, I'd never been a candy stripper, I didn't know any of that. It was really a reality shock and a culture shock too, for me because I had an accent when I came down at 17 and I got poked fun at a bit. I learned to adapt fast, but it was good. I loved being autonomous, being out there, nursing school was tough, it was hard.

CJS In what way?

Lolly It was . . . I couldn't even afford a meal ticket at that diploma program. So, uhm, six kids, brothers in school, of course religious affiliation, the boys, it's more important for them to have a career, than women at that time. Does that sound a little bit familiar? (laughing) It's not so much anymore, but it was back then certainly, when I was 17. So I had to work every weekend, I worked as a nurses' aide in the hospital and went to school during the week . . . shopped for groceries and did all of that. They were tough on us, they were touch on us at the diploma program. And there was lots of competition. The grades were posted and everybody could see them and see your name. That was the old style of that, you know to be successful, be competitive and we wrote reams of clinical reports and post-conferences, all those things that you do in the old style of nursing. All about the patient and we worked evenings even as students we took charge. That was the team leader model back then in nursing, so you had aides typically in hospitals which you have techs now, but it was a different style of nursing back in the 70's, it was team nursing.

CJS Are there any special experiences that stand out or interactions that you can bring to mind?

Lolly I remember that one of my first patients was a GYN patient and when I took off the scultetous binder (laughing), do you remember those?

CJS Yeah, (laughing) haven't heard that name for a long time.

Lolly And the patient actually told me I was killing her and I thought that perhaps I was (laughing). The first injection . . . we gave each other injections and all that stuff but first injection to a patient and I learned that you had to be confident with the patient and believe that you had enough information

that you could do the job and you went in there and did it and I had some great mentors along the way and people that believed in you and instructors included. So it was good, it was good. It could be very taxing, I remember the OR was tough. Eye surgery was the only surgery I didn't care for. Give me a good Whipple Procedure or whatever, blood, guts and gore (laughing) . . . that was fine, retractors, hold the retractors for hours, but eye surgery I didn't care for. Wouldn't you know, so my husband has had at least five eye surgeries (laughing). Of course.

CJS Of course.

Lolly Made good friends that I keep in touch with today (voice rising) today! It was sort of a sorority atmosphere when you're in nursing school. Those old diploma programs. We're all in it together. And many fell along the way, you know. But, I still keep in touch with people that I met then. . .

CJS Great.

Lolly Yeah. Oh yeah.

CJS Lifelong . . .

Lolly Yeah, life long friends.

CJS Now, let's move along to the . . . share with me about the trajectory, about how you made a transition from nursing specialty at the bedside to industry.

Lolly Well, the path has been convoluted . . . for sure, my path (laughing). . I uhm, I did a lot of med-surg nursing, I did some management, assistant nurse managers and that kind of thing at my hospital and then, I had a family, so I had to sort of negotiate what I could do. Actually, the philosophy at that hospital at that time was that if you were a part-time nurse, you weren't a professional nurse. And that was the undercurrent, the philosophy was that only the full-time nurses, so that when you had a family and became part-time, there were not even any benefits. The benefits didn't exist. So I actually changed hospitals at that point in time because I went to a hospital that would offer benefits for part-time work and then did part-time to be flexible with young children. From that point in time when I wanted to return to work full-time, I decided I needed a career. I wasn't going back to a job, I was going to have a career. So I had been taking some courses and I finished my Bachelor's in Nursing. It took me about ten years. But I did finish and meanwhile, I started working, I went into renal dialysis and became a dialysis nurse, because the schedule worked and I loved that and chronic care and really, I loved the chronic care because I saw those patients more than I saw my family, most of the time. I learned a lot but I also learned that, and when I finished my degree of course they wanted me to go into management and management at that point in time just seemed like conflict resolution every day all day and I didn't want to do that. Patient education was my thing, I loved it. I developed a video on how, if there was a fire, how to get out of the building and get people off the machines and all that stuff. I loved doing that, so the opportunity came up for a Wound Ostomy Continence Nurse in the hospital that I was at. Didn't know anything about it, hadn't done med-surg nursing for nine plus years but I knew I didn't want to go management. So I looked over the five page job description, I

thought I can do a lot of things with this. And the position hadn't been filled for about ten years . . . I mean ten months, ten months. So I said, well, I'll take this, pursued it and got hired and they sent me off to X Training Program and then I did my clinical training down at a hospital. So, that was three days a week, two days a week I was being the Wound Ostomy and Continence Nurse. Had to establish credibility with the ICU Nurses. I figured that out really quick. Tough, complex abdomen, complex abdomen that took the nurses hours, they couldn't manage the wound care, it was a disaster sort of zone. So I came in and saved the day, with doing saddle back pouching with huge wound managers that they'd never seen before. Special ordered them.

CJS Challenging . . .

Lolly And I was a nurse, back then that was (date of year), so I, my immediate boss was a great mentor, still see her today. I keep in contact with her and she's up at another hospital and she was a great mentor and she insisted I wear street clothes and a lab coat. So I did that, but it was really off putting to staff, because who do I think I am, coming in there, and remember I didn't work in a hospital, I worked in a separate building in the dialysis unit so I wasn't really a part of the hospital staff. They didn't know me, they didn't know anything about me, nor did the physicians, really. I only knew the renal guys and some medical doctors. So, I didn't know any surgeons.

CJS What do you think it was about the street clothes and the lab coat?

Lolly Because I thought that I wasn't one of them (a rise in her voice as if questioning). I was somebody else, that I wasn't going to get my hands dirty that they were doing all the work and I was going to come in and tell them what to do. So it was territorial, it was sort of an ego thing, where I don't want this nurse . . . Who is she? What is she credentialed in? We don't need her. What could she possibly do? We can't figure this out . . . she's going to figure this out? That was . . . no one ever really challenged me with that, but they, I had to win them over with the difficult cases. Same with the docs, same with docs, it was basically, when the chips were . . . and I really focused on ostomies, because generally nurses don't like taking care of ostomy patients, a lot of times. You got that preconceived idea with all of that and if they don't know how to use the equipment or don't have the right equipment, it's very difficult to take care of them. If you have all the right supplies and know how . . . they're actually quite easy.

CJS Bring it all together . . .

Lolly Bring it all together. So I did that, so I established my credibility with difficult ostomy patients, fistulas, big complex abdominal wounds and they loved that. So they responded well to that. And then I started going into wound care. And I remember, I'd been there about a year and a half and I wanted to do a pressure ulcer prevalence survey and so I laid out a plan, I was independent, I was going to get some staff nurses, there was a team that had been a part-time wound and skin team, so I revitalized that. We were going to do this. A nurse manager, a male nurse manager, said 'No, you can't come on my unit. I don't want you on my unit.' So I had to go to the CNO and I said, 'This is a problem. I'd like your advice on how to do it.' She heard me out. My opinion is that if a manager

doesn't want me on the unit looking, there's a problem. So I think I need to go there first. And I said, let me collect this data. And so she was, she spoke to the nurse manager. Lolly is going to do this, we want her to do this. So I started collecting data before we had any formal method of nationally collecting data. So what I caught was just trending, but it was . . . And I remember bringing the Braden Scale in and there was a committee, because we were looking at documentation. So I said I want a risk assessment tool for pressure ulcers. I think that's the way we should go. And here's the Scale, I remember the Braden Scale, the pages, it was like three pages long on the initial assessment, outpatient and admitting patients. They said, this is too big, we're not doing this, it's too big, you have to abbreviate this. So I went to again, now a different DON, and I said, she asked me, can I abbreviate this and I said no, this is a studied tool. If you want me to abbreviate this, then it's going to be a different tool and we're going to have to pilot it and that's going to take six to eight months at a minimum, for me to do that. So you tell me what you want to do, just let me know. And she came back to me and said, we're going to use the tool as it stands. I said, this is a researched established tool, I can't adapt it. I won't adapt it. They went on board and I'm proud to say that they're still using it today. So that hospital is a Magnet times four hospital.

CJS Wow . . .

Lolly And the first Magnet application had a lot of wound and skin team and a lot of what I did in it.

CJS How does that make you feel?

Lolly Feels great! I made a huge impact on that hospital and I'm very proud of it. I left very satisfied when I left that hospital. I felt like it was just time to move on! I had been there enough and I'd done all I could do and I couldn't change roles because I was so programmed, that it really wouldn't allow me to take on anything else. Like risk management and quality. They needed me and relied on me so much then that I just couldn't do it, so I had to make a clean break.

CJS So they changed their image of you . . .

Lolly Absolutely, absolutely

CJS . . . as you built credibility.

Lolly I actually had an educator come to my office one time, and say, chit chat, how, I want to teach new nurses how to get . . . how to be credible. I said, that's not something you really teach, it's something you earn. You have to be a risk taker, you have to be competent, you have to stay informed, keep yourself current. When you don't know something, say you don't know it.

CJS Now you mentioned something about making the distinction between having a job and having a career . . . talk to me about your decision to then move from patient care to industry.

Lolly So, uhm, there, once I left the hospital, I left the hospital and went to the state and worked for the Advocacy Office. And that was a small office, two attorneys, couple of social workers, couple of nurses, and we did a lot of, what we did mainly there was we took cases and with, we did Medicare too, but mostly commercial insurance, and denied reimbursement and we fought that and we had over an 80% turn around rate. And I loved that challenge and I learned the advantage, I only spent 15 months in the role, because I felt like I wasn't using my background and my clinical skills, I mean took any cases, psych cases, kids, adults, neonates, the whole thing. And worked those cases and I learned the legal, some of the legal part of health care.

CJS There's always something to take away.

Lolly They always say in healthcare, we have this language that no one understands and we do. We have our own healthcare speak. Attorneys have legal language and third party payers have their language and it's no wonder that the customer, the patient at the end of the line can't figure what their bill is because you got three different languages. And oh by the way, if English is not their primary language, they've got 4 strikes against them before they even begin. So, I love advocacy and I did that for 15 months, but I moved on, I still keep in touch with those people, I still see them and they'd love to hire me back, but again, that management, that conflict resolution, I'd rather put my energies into patient education where I'm making a difference. I did get involved along the way in helping to get a bill passed. I actually, while I was there for the state, I did give some advice, played on some state committees, and stuff which I love, that social policy stuff. But then, that was a, that position, that whole department was politically appointed and budget dependent. There were 11 people in the

department, I was the last one in, so when budget time was coming, I was in danger of losing my job. And I just couldn't live like that, I just couldn't live like that. Knowing that on an annual basis, and also for the first time in my nursing career I was unionized. I had to join this union and I didn't love that either, so I left. This opportunity, I left because the opportunity for industry came up.

CJS So you went from the state then, you transitioned hospital to state and then to industry.

Lolly Yes, before I left the hospital, I did look at industry and I was interviewed . . . I didn't like the sound of the job. That wasn't for me. I had a head hunter actually track me down and just wouldn't take 'no' for an answer. I said, 'O.K., I'll throw my resume in', I should update my resume anyway, it's been a year and a half, so I did. And it was a long process. I decided I'm going . . . I'm at the end of my career, I like the idea of really making a difference, not for just one patient, the one on one, a large, and I feel, I was just talking about this last night, I feel like in this current position, I impact care on a very large scale. I believe that you gotta have the right product for the right patient for have the right outcome. Now, this company hired me, they knew what I was, I was very clear what my ethics were, what my beliefs were, and what my strong qualities and what my weaknesses were. And I didn't even get through security when they called and made me an offer. And I didn't accept their first offer, no, I said, this is what I need.

CJS Good for you.

Lolly Basically even along my career as a WOCN at the hospital, I, there were very few resources for nurses to learn how to negotiate their salary, any kind of perks . . .

CJS Why do you think?

Lolly Because we were better unempowered? . . . because we could be controlled. And the medical model wanted that, they didn't want challenging nurses. I was a challenging nurse. I was confident and I'd go into surgical meetings and someone would challenge me and I would be the first one to stomp out of the door, slam the door. I'm not getting into a bee hive. I had a surgeon who wouldn't let me see any of his patients. I'm going to get you and you're not even gonna know that I've got you. As it ended up, he wouldn't do anything with his patient without me, you know, he's stop and hold the OR until I got in and marked the patient. But that was a complete about face. But you have to work at that, you have to be the risk taker. Be confident and not, sometimes you had to work long hours. And that was a bit of a sacrifice . . . on my family and on my husband. But . . .

CJS Let me ask you about that . . . you say it was a sacrifice on the part of your family . . .

Lolly It is, less time with them because I was doing . . . the first year of any job is tough but when you're in an autonomous . . . and at one point when I was at the hospital I covered, it was a community hospital, we absorbed a home care, I was consulting for their inpatient, the home care and I had contracts with five local nursing homes, the contracts said that within 3 days of them contacting me for

a consult, I had to be there. So that was . . . I got a cell phone for the first time when that happened because pay phones, you'd go there and they'd be ripped off, no phone to make a call. Remember that? (laughing)

CJS Yeah, yeah.

Lolly When you didn't have a cell phone? My husband bought me my first cell phone. He said you can't be out there driving around in these rural areas and you don't know where you're going. And you didn't have maps, you had town maps and Roast Meat Hill Road and go back by the pharmacy that burned down 5 years ago and take a right and when you see the horses on the left, take a . . . it was crazy out there. It was fun, it taught me a lot, I only did home care consulting, I never worked as a home care nurse in the traditional sense. I took students and mentored many WOCNs along the way. Proud to say that and it was all good. I love sharing, I'm not possessive of my knowledge. My recipes, some of them . . . yes (laughing).

CJS You're not possessive of your knowledge. Talk to me about the link between the nursing that you did when you were directly impacted patients and the nursing that you do now in industry and what's the link there in terms of that special knowledge that you have. Talk to me about that knowledge and how that transferred . . . what is it?

Lolly Well, I'll tell you, I struggled. In fact I was very hurt, I would say hurt, when I had colleagues and some nurses I had mentored even on a part-time basis to become a certified wound nurse, certified wound, ostomy nurse, and then I was, I got the feeling I was treated as jaded and actually, it became really evident about a year ago, on a conference call, when my boss was on there, my current boss and we were having, and materials management and this was a big IDN and we were trying to do some sort of metric study. And I was trying to get the nurses onboard with stuff and there were four of the hospitals had ten clinicians. Many of them, at least six of them I knew fairly well and some of them I had mentored and I couldn't get them onboard. I was jaded because I . . . they looked at me as going to the other side and actually on this phone call, at the very end of this call when we were struggling with trying to implement tools and me helping them and they couldn't get it done because they're so busy with direct patient care, and I said, 'Use me as a resource, I don't have to deliver direct patient care.' And actually one of the lead supply chain people said, 'Lolly, it's an issue of trust . . . an issue of trust.' And it was at the end of the hour conference call and that finally came out. And I didn't have much time to address that but I addressed it later with my boss and some of my colleagues and I gave it a lot of thought because that's really what it boiled down to, my credibility that I had established in my region, my activity at the National Level, all of that, really didn't transfer to industry. It was there, but it was now jaded.

CJS Why, do you think?

Lolly Uhm, I think that's because . . . again, we get into that nursing territorial thing and knowledge is power and if, it's sort of getting back to that nurse manager who didn't want me looking under the

sheets on their unit. If I've trained you or if I've worked with you or you're a colleague on this level, but it's more of a social level and now I'm looking under your sheets here. And even though I've signed a HIPPA agreement, I've learned to reassure customers and my colleagues that I'm not discussing their business or what's under your sheets anywhere else because I can't. That would be unethical of me. But there's that, I guess that threat or upstaging them, that's the other thing. You come in and you have to be very mindful, because knowledge is power, knowledge is power. And you come in and you do a program and you're more knowledgeable or you're more . . . maybe they feel like I'm delivering the same knowledge in a better way or maybe they got it, and maybe they got it because a different face is telling them. But they don't always see that, so it's threatening, it's threatening! I think, for some. Now, I work real hard to turn that around, I'm very mindful of that. I wasn't so mindful of that in the beginning. I thought maybe I've gone to the dark side . . .

CJS Remind me again of how long has it been since you've been in industry?

Lolly It'll be three years the end of June. So it's not a long time, but I've learned with some accounts, and the other thing is that, in the city, they don't know me, the larger area, they did. So in the city, it's kind of like a clean slate there. But that's a different culture, both in the city and outside the city as you probably know, and even upstate, it's a different culture there. What I've learned is that all hospitals are the same, but they all have that uniqueness, just like every patient does.

CJS How did that culture translate, that difference?

Lolly Uhm . . . I have a hard time in the geographical territory because of my . . . although it's an advantage to have pre-existing relationships, it's also a disadvantage.

CJS Mmm . . . Why?

Lolly a disadvantage . . . because preconceived notions about what you can do and what you can't do or what you may do, uhm . . . I'm strong, I'm outspoken, I have opinions, I'm a risk taker, I can present, an informal leader, a formal leader . . . all of those things and I think that, I've gone into hospitals where there have been clinicians that I think, 'Wow! I just stepped back in time.' This is an unempowered clinician, not a confident clinician. I can tell right away when I go into a facility or an institution, if it's a medical model or a nursing model.

CJS How is that?

Lolly Uhm . . . by the demeanor, even the demeanor of who runs the meeting? Who's outspoken? Who makes the decisions? Who can even voice their opinions? Who is empowered to make changes for patients for improvement?

CJS Interesting . . .

Lolly And who gets the resources to do that? Because it all boils down to the buck eventually. But my philosophy is that . . . it boils down to the buck, but it has to be quality in there too. I mean we should be looking at efficiency in patient care. What's the most efficient . . . and by that I mean also cost efficiency. Outcome, best outcome and the most cost efficient way. I like that, the company I work for believes in that, patient is the center of the care, of the circle, absolutely. So I, they tolerate me, they even like me (laughing, both of us). They empower me to do more! (volume of voice rising) I'm enjoying it, I'm enjoying it! I love impacting . . . I'm mentoring clinicians in a different way . . . in a different way, in helping them get the tools they need to have to be confident, to be empowered, to fight the good fight for doing right by patients. Not just the one patient, but a multitude of patients. And some nurses, not all nurses have that, not all nurses have that. Even in their heart of hearts if they know the right thing to do, they step back from the challenge. And part of that I think is because so many of us are females.

CJS Ahhh . . . something there. . .

Lolly Male nurses just don't do that, so what I think is still missing in the nursing curriculum? To this day and age, is some kind of business. Healthcare is a business.

CJS It is.

Lolly Just like any other business. When we boil it down and nurses don't get educated around business! (Her volume rising through the past sentence, until she is nearly shouting 'business') You have to teach yourself.

CJS You just mentioned the gender issue, do you think that has an impact at all?

Lolly Absolutely, absolutely, absolutely. It's a little less now, but it's not where it should be for 2015. It really isn't. And I don't know what the fix is for that. I think we just have to get more men into nursing and that is happening. I don't know what the ratio is right now. Men to women in the field. But typically the men who do go into nursing, go into leadership, management roles.

CJS They're always visible aren't they . . .

Lolly They are visible. They not doing the bedside, day to day, and they're generally not mentoring one on one new nurses, they're in leadership decision making roles, most often, most often. Or they're in a high impact OR or ED situation. You don't generally see them up on a med-surg unit. So, uhm, and till that changes, I don't see that gender thing going away.

CJS Mmm . . . mmm . . .

Lolly Our younger nurses are cool in that they don't deal . . . you can't give them a piece of paper and say do this anymore. You gotta have it online, text them, whatever, they're very tech savvy. They want instant gratification, they want the information right away, cut to the chase. Give me what I need to know and what I need to do. Uhm, and we weren't like that . . . Were we? (volume of voice rising again)

CJS Times have changed.

Lolly Not necessarily bad or good, they just changed.

CJS You spoke about some of your attributes. What would you say are your top, in terms of competencies? What you bring to industry . . .

Lolly As far as . . . public speaking comes easy to me. So that was something that I took . . . when I got my Bachelors in Nursing I did take a speech, it was elective, it wasn't required, but I did take public speaking. And that was the first time I did that, I was not married at the time, I was dating my husband to be, that was my first real exposure and in that classroom, I was the only nurse there. Nursing didn't even come into the realm. So, how you could deliver your message. So I learned that and when, I was often, even in the very beginning of my career as an informal leader, because I spoke up. I was verbal and sometimes I had to learn to be careful about, I put an additional filter because I was always go for the right thing. Sometimes that was not always the politically correct thing to do. I learned that as a young nurse, you get your hands slapped a little bit. Or what I found out was that I didn't accomplish

anything by burning a bridge. And that's, I couldn't live with that. So, I modified and so I think that's an attribute. I'm confident, I love a challenge. Can't really scare me (laughing).

CJS Fearless (Laughing with LL) . . .

Lolly You know, a big group of surgeons, you walk in the room and they start right away just trying to tear you apart . . . woow . . .

CJS Do you think that in your role now, that's the way that you see yourself, and you see yourself as a leader . . . how do you perceive that others, others meaning those outside of your nursing group who have transitioned to industry, how do you feel, you kind of hinted at it earlier, but how do others, other nurses who aren't in industry, other nurses who are still in the hospital, or whatever care setting they might be in, tell me how you feel they perceive you.

Lolly I'll give you an exemplar. I have high visibility regionally and in my local state group. I've always been active with them. I got into, when I took a state job I never could go because I was unionized and couldn't get the time off, couldn't negotiate that. So, kind of for 15 months I was not around. And then, I took industry, I got back involved with that group. I may travel a lot so I'm not always there, when I worked at the hospital I negotiated time to go to conference, that was part of my contract. Because I went online and learned that's what I had to do, or I wasn't going to get that. I had to negotiate to get that. So the art of negotiation, I had to self teach. But, so I'm involved with them,

again, I've joined the leadership again, doing membership . . . isn't that insane, for the Region, because it's all a mess and they needed someone. O.K., I'll give you 2 years max, that's all I'm giving you. But recently, at a local state group meeting and that has a membership of about 45-50 certified wound clinicians, some type of certification, usually about anywhere from 12-20 meet on a monthly basis. And I had a meeting, the last meeting, we'd been talking about bringing in industry speakers, during those 2 hours, usually industry comes in, does a presentation on product, new information, whatever we also discuss cases and may present a case. There's minutes, there was minutes, they're not doing minutes right now, it was kind of formal, the chair changed so now we have a different kind of philosophy, of that group and she's been wanting to do a journal club. So a couple of months ago, she put out an email, does anyone have an article they want to discuss, so I'll be able to come to this meeting so I'm going to bring an article. It started that way and so at the last meeting, we were discussing literature and evidence again and she said, I'd like to get a template and so basically they asked me, and in this whole group I'm the only vendor nurse sitting there around the table, they're all either in home care or acute care, couple in long term care or rehab. And the Chair asked me, would I do this, would I get some templates, get some information and I said I would be happy to do it, I'd love to do it but I was so stunned at them asking me to do this because I'm in industry. And I said, I need to remind you of a disclosure, you do remember that I work for industry. I just want to put that out there. Everybody's O.K. with that if I do this? I'm going to be as objective as I possibly can about this. And part of it, the nurses, what's the age of the average certified wound care nurse?

CJS We're getting up there . . .

Lolly We're getting up there. And what, they're not tech savvy, and they didn't learn . . . an integrated conference room, beautiful conference room at this hospital that we're allowed to use on a

monthly basis, with coffee and everything. They couldn't figure how to get the screen down. And, so I said, O.K., I'm sure there's something in this room, there's a panel here, I'll get this. OMG, the screen comes down . . . I said, you know what, we're going to go over all this stuff. Because what I would love you guys to start doing, taking your photos, bringing in your case studies, putting them up. Bring them in on a USB Drive and put them up, so a picture paints a thousand words. Pictorials are the universal language, everybody can see. We know that one-dimensional photos aren't the best education tool, but they do play a role. And God knows, we're tested in our certification on that. So, there, I'm going to do that in May. I'm scheduled to bring my template. I've already done some research, I'm going to bring an article, we're going to look at the NPUAP/EPUAP/PPPIA 2014 Guidelines and we're going to look at skin assessment and risk assessment, those sections. And try to digest that. So, and that, that's where I think I make a huge impact because that group of nurses, many of them didn't even know that publication is out. I've been into big academic centers where they did not know. And so I brought that up to the state group. And some realized that there was a condensed version, but they didn't ever know that there is a full version with all the references and all the explanations for the recommendations of which 91-92% of them are expert opinion. So, and that was alarming to me, that was alarming to me . . . And we had a frank discussion about that and said, well how does a clinician find out about that? Find out and does she get an alert from NPUAP? Does she get an alert from WOCN? An email to say that there's a new publication? Hey, you? That doesn't happen. So, I think industry nurses play a huge role in the communication of those resources, because we aren't doing direct patient care. We are up here at the bird's eye view of things and we're not at that level, so we have the luxury of being exposed to all this, and what I believe, I'm obligated to do as an industry nurse is to share that and make sure that my customers, even not my customers, that I interface with, get that information, because I'm privileged, being exposed to that and I want you to have it too. Because if you have it and you are going to impact direct patient care at the grassroots level. So I think I play

that role. And that's a huge job satisfier for me at this point in my career. So I'm happy doing what I'm doing. I mean it gets frustrating like any . . .

CJS Oh sure, frustrations regardless . . .

Lolly No matter what you do, that's the satisfier.

CJS Now, you obviously as you just stated, there are many aspects of what you do, your role, that are very satisfying to you and you have a very positive outlook and perspective on your role and what you are able to accomplish. Is it your perception that others out there, share that with you?

Lolly Some. That is not universal, I don't know if it's even 50%. I don't know what percentage it is. It's a smaller group, industry nurses. I think that some industry nurses even hide the fact that they have a nursing background. That is a sad state of affairs in my opinion. I don't know how to really answer that or comment on that, because maybe I haven't been in industry long enough? We don't have, in industry, we don't have the avenue, because of competition, because of competition, we don't have the avenue or the environment to create those relationships. I mean I have relationships, strong years long relationships, with some nurses in industry, I have to be, I'm very aware of, we can't have a conversation about some of this stuff. That's unique to industry nursing, you have to be mindful of that . . . what I told this company too is that 'don't try to micromanage me, you will never get the product from hiring me if you want to micromanage me.' I am self-directed, I'm going to

assess things . . . guide me, absolutely, guidance. I have a wonderful boss at this point in my career, that thinks I walk on water. I don't, but it's O.K. that he thinks I do (laughing) . . . I'm not going to change that!

CJS Don't change that image (laughing with Liz) . . .

Lolly Not going to change that! And he does guide me, he doesn't micromanage me. He knows I'm going to do the right thing. I have integrity. I am going to, in fact I've told him, I am not risking my professional career integrity for any employer. I never have, never will.

CJS Don't expect you to start now. . .

Lolly Not going to. If I feel that I'm at risk, that my reputation, as a company, as an industry, you can take advantage of my credibility and my ethical standing in the community, like I can't let you jeopardize that, I won't. So, I think . . . and that's an O.K. relationship and it's O.K. to be frank about that. I don't think nurses are confident in that and therein lies the problem.

CJS So there may be a bit of a gap in perception between nurses in industry and those who aren't?

Lolly What is the platform for nurses in industry to inform each other?

CJS What is it . . .

Lolly There isn't, it doesn't exist. Because of we live in a capital society. I think maybe in Europe that would be very different, very different in another country, especially where there's socialized medicine. In a capital society with competition, frankly there's competition in my own company! But there's always competition. But there is competition. If my team in the geographical area is . . . so therefore there is not sharing and that philosophy needs to be let go of. The company's overall philosophy is to let go of that, let go of it. But uhm, if you're on a team that's not doing well, it's hard to let go of that, based as what was set up as parameters and rewards. Reward is money. How do you make money, competition.

CJS It's kind of a cycle.

Lolly It is. And nurses don't get educated about that in their curriculum (volume of voice rising with excitement), do they? If you took a business course, you get exposed to that. We, nurses don't get exposed to that. I don't believe even to this day and age, they don't understand how contracts in the front office affect patient care up on the 9th floor. Those dots are very obscure, that connect all of that. So, and some nurse management doesn't understand that. If you're a nurse manager, you manage your budget here on this unit, but do you understand that there's one pocketbook here? (laughing again) You may have to change purse or where the dollar bills go or maybe a checkbook, I'm not sure what you have, but it's the facility. I think that's changing as our third party payment system changes

as reimbursement. We've set up . . . the Affordable Care Act has made a huge change there. And so nurses have had an opportunity to have a stronger voice.

CJS A stronger voice . . .

Lolly A stronger voice . . . and they need to step up to the plate (strong voice) with that voice and be heard.

CJS And nursing overall . . .

Lolly And if they're not, they're not following the Code of Nursing by ANA.

CJS And that applies to this particular group . . . that we're talking about.

Lolly Yes, I think, we're charged with a Code of Ethics from ANA on nursing, to advocate for patients and all of that and we have to be mindful of that. I think, no matter what environment you're working in. Does that help?

CJS It's part of that platform.

Lolly It is that platform, but it's a different platform for us in industry, I believe. We have to be mindful of many things. I mean, this level, at all layers. At all levels, it's just different, it's just different. And maybe I'll learn more, feel differently a year from now. Cause I learn everyday.

CJS Sure . . . if we're lucky.

Lolly If we're lucky (laughing) . . . I can't help but learn everyday. What I do makes me learn everyday, so . . . and I hope that never changes. I know . . . (looking at the time)

CJS We've got a few minutes left. What I wanted to ask you was, if you could change one thing about your current role that you are in right now, what might that be?

Lolly One current thing in this role (thinking aloud) . . . Less hours. Industry nurses, there's not barriers and as nurses we're always, nurses generally as a personality need to be needed. And so setting up barriers, self-preservation sort of thing. We want to do the right thing. I get entangled in that. If Children's Hospital calls me and there's some . . . if uhhh . . . setting up that work life balance. In fact when I interviewed for this job and they asked me a similar question, I said, it's work life balance, work life balance. I keep getting hung up on that and I think as nurses and as specialty nurses, when you feel like everybody else doesn't have the knowledge you have and you want to share that and somebody needs that, it's hard not to deliver that. And you can be available 24/7 and so learning those skills. I think those need to be fine tuned better because you know, you're working on a team

and you get pulled by management in industry in a lot of different directions. And not just nursing staff.

CJS Is there anything that you can think of that, I know we had a whole hour, but it's just flown by . . . Is there anything at all that you'd like to share that we haven't touched on. I know that there is much that we could go on and on about, but is there anything that you came in here wanting to tell me that we haven't touched on?

Lolly The only thing that I, you know, I'm being selfish about this too, in that sense, this has all happened since coming into industry and I really want to publish an article, whether it's just in the region newsletter or in a journal or whatever . . . about this phenomenon of nurses that go into industry and being thought less of or jaded in some way because, I really, it really disturbs me in the research, that nurses need to be empowered know how to look at evidence really well and there's a lot of scanky evidence out there and there is some bad evidence that is even in refereed journals. To be able to look at that with a critical eye. I really want, I want to get that message out there because it disturbs me that I've been a nurse for a long time, 35 years or more and I've been a Certified Wound Ostomy Continence Nurse for 20 years and I've worked hard to establish credibility and I had that absolutely and I don't like that being jeopardized just because I switched my job venue, my career venue. And where would we be today without industry, who has the money to finance research because are hospitals, is every hospital able to do this? Is every nurse able to do this? Do a poster or whatever it is. Even low level quality improvement projects. So why is my state group looking to me

as an industry nurse to . . . I just want to be able to shed light on that and make nurses think about that and not think that just because I work for industry . . . I talk with a forked tongue.

CJS Exactly.

Lolly I'm still legitimate. I still am who I am, I'm still a professional and all those things in that Code of Ethics from nursing still applies to me.

CJS It sounds like you want to get the word out.

Lolly Yes! Yes! I'm on a mission to do that. That is on my heart to do that, only for that reason, selfish, it's a selfish reason, I want . . .

CJS But selfish for the greater group . . .

Lolly For the greater group, but I don't like having any sort of tarnish just because of the venue that I've chosen for this point in my career. That seems unfair to me.

CJS Lolly, we could go on and on (both of us laughing) and for the challenge that this has presented and going with the flow, so thank you very much!

Lolly My pleasure, my pleasure.

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