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**MEDICAL WORK/NURSING WORK: NEGOTIATING THE NURSE
PRACTITIONER IN PRIMARY CARE**

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**A DISSERTATION
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OF PRINCETON UNIVERSITY
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OF DOCTOR OF PHILOSOPHY**

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Abstract

The United States is struggling to provide health care in the face of ever increasing demand. As medical students continue their decades long march toward specialization, questions of how to provide generalist care become quickly intertwined with that of who will provide this care. One answer to this question is increased reliance on nurse practitioners. If a patient were to visit a primary care clinic, she may increasingly have her chief complaint addressed by a nurse practitioner rather than a physician. If we want to understand both the present and future of health care, we need to look more closely at these new clinicians, their practices, and the ways in which they may be creating spaces of difference for the delivery of medical care.

This dissertation addresses this need through a multi-sited ethnography of the nurse practitioner. To understand how nurse practitioners understand themselves as a profession, I used 12 months of ethnographic and narrative data from a nursing school, analyzing routine, formal talk about patient care. An essential finding was that talk about nursing practices emphasized skills of difference from physician practice. This was achieved through different constructions of patient problems and case complexity. In these accounts, patients were often socially, rather than medically complicated. I found that medical knowledge was assumed to be technically attainable, but that true nurse practitioner expertise required special knowledge of each patient.

In order to understand how nurse practitioners negotiated the meaning of their work in practice, I used data from 16 months of fieldwork at a community practice that used an interdisciplinary team model. In an organization with multiple layers of providers, the nurse practitioner became the manager of not only medical concerns, but was also called to troubleshoot both social and organizational concerns involving patients. Nursing's duty to care

required the skillful clinician to become conversant with the organization's view of the patient. This specific translation of nursing care allowed for the construction of an organizationally recognized area of expertise.

Through a performance of difference, nurse practitioners are doing more than constructing professional expertise or a personal sense of worth, they are changing expectations about what kinds of problems get solved during primary care encounters. As nurse practitioners colonize the exam room with a different kind of clinical performance, they are potentially redefining what it means to care for the sick.

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At Princeton, I first have to thank the members of my committee. My many, many thanks go to my Chair, Elizabeth M. Armstrong. While I worried constantly that no one would want to read a dissertation about nurse practitioners, she had enough confidence in my work for the both of us. I am grateful that she was the kind of advisor who didn’t tell me what to do, but

who listened carefully to what I wanted, and then did everything in her power to help me achieve it. Betsy, thank you for not just reading drafts and listening to ideas, but for moving several small mountains on my behalf. You were always in my corner. I could not have asked for a better advocate or mentor.

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that came with it, was sometimes all that stood between me and giving up. To the PACE members I knew, both living and dead, I dedicate this dissertation.

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Chapter 1 - Introductionⁱ

“I firmly believe that primary care will be owned by nurse practitioners in the next four to five years, and the physicians who are general practitioners will be going into the specialties.”

—Colleen Conway-Welch, Dean of Vanderbilt University School of Nursing
The Chronicle of Higher Education (Mangan 2013)

“Lifting the barriers on [nurse practitioners’] scope of practice will solve the health care dilemma.”

—Linda Pellico, Associate Professor, Yale School of Nursing
Slate Magazine (Reisman 2013)

As the nation continues trying to come to consensus about health care, there are many troubling areas that are at the forefront of the conversation. How can we better control costs? How can we increase the number of primary care providers as medical students continue to overwhelmingly flock towards specialty practice? How can we increase access to health care and address health disparities? While there is no single answer to these complex questions, there is one occupational group that is staking a large portion of its professional claims on being part of the answer: the nurse practitioner.

The nurse practitioner (NP) is a registered nurse who has an additional graduate degree that enables her to examine patients, make diagnoses, and make treatment decisions in a variety of health care settings. State by state, clinic by clinic, nurse practitioners are becoming increasingly prominent in the health care encounter. Although NPs can be found in many of the same settings in which physicians practice, they are disproportionately more likely than

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physicians to both specialize and work in those areas that physicians are abandoning: primary care (AANP 2012). In health care systems with increasing complexity and specialization, primary care providers are generalists that serve as the patient's first point of contact. Primary care physicians train in the disciplines of internal medicine, pediatrics, family medicine, or geriatrics. Rather than focusing on single systems, these primary care physicians are trained to understand the body and its concerns broadly.

Although complexity and specialization characterize modern health care, the need for primary care has never been greater. Most patients continue to seek out a primary care provider for usual care (Safran 2003). In efforts to control costs, many insurance plans require a primary care provider to serve as gatekeeper and manager of more expensive, specialist services. The supply of primary care physicians has not kept pace with this robust demand. Between 1985 and 2011, the proportion of US medical students who matched into primary care residencies declined 24%. Moreover, between 1999 and 2003, the proportion of internal medicine residents who went on to work in primary care dropped from 54% to 20% (Schwartz 2012). As the proportion of physicians in primary care shrinks, the proportion of nurse practitioners trained in primary care remains high. In 2010, an estimated 80% of NPs reported a primary care area as their "main specialty" (Goolsby 2011). This propensity has made the nurse practitioner a lightning rod for debates about how we provide, organize, and pay for health care.

The first nurse practitioner training program opened its doors in 1965. As these first few NPs began to practice, they immediately sparked both scholarly and professional interest. In the intervening years, questions and debates about the NP have only intensified. In the popular press, the NP has never been a more popular subject. Despite this unprecedented level of visibility as a profession, the work that NPs actually do is characterized by invisibility. In

quantitative terms, it is still difficult to even measure nurse practitioner work. National surveys of health care providers typically rely on sampling frames that do not capture individual nurse practitioners. Data collection on health care encounters uses billing data where NP work is not separately counted because it is typically billed “incident to” the physician with or for whom an NP works (Morgan et al. 2007).

When NPs were not hidden within the shadow of physician work, they are lost in the much larger population of nurses. In 2012, there were over 3 million registered nurses in the US. Nurse practitioners represent less than 6% of this overall group. However, until recently, national employment data did not collect the data needed to separate nurse practitioners from the larger group of nurses. Both the Bureau of Labor Statistics and the US Census Bureau did not separately estimate nurse practitioner counts until 2010. (U.S. Bureau of Labor Statistics 2010; US Census Bureau 2013).

Even though there have been recent shifts in data collection strategies, our estimates of the number of practicing (versus licensed) nurse practitioners and their impact in overall health care encounters remains plagued by these concerns. These problems characterizing NP work are not only in regards to data, but are deeply related to the assumptions that drive that data. Studies investigating nurse practitioner effectiveness continue to use physician practice as the standard of comparison. The guiding conceptual framework becomes one of physician-NP interchangeability: how good of a physician is the NP? As a result, researchers often find themselves estimating numbers to represent what fraction of a physician or physician work the NP represents. Within this framework, any notion of distinct NP expertise, values, or practices is rendered not only invisible, but unimaginable.

Sociologists who study clinical practice seem to share this grounding assumption. Since the birth of medical sociology in the 1960s, physicians have remained the actors of core concern. Sociological accounts do acknowledge that health care has changed since the height of physician dominance. Both sociological and historical accounts have documented the weakening of physician dominance assaults such as the rise of third party payers and the growing influence of corporate and consumer interests. However, sociologists have not yet come to grips with the growing diversity of providers. Physicians and bedside nurses have been joined by ever more specialized groups like physical therapists and machine technicians. Despite this variety, the sociological imagination continues to cast physician practice as total and hegemonic. It is, after all, still the physician's order that sets the wheel in motion, even if many hands keep it moving.

In sociological narratives, physician authority—although admittedly bruised—remains the singular authority over the set of cultural and material practices understood as medicine. But for an increasing number of women (and a small but growing number of men), being a nurse practitioner represents at least the possibility of not simply following doctors' orders, but of doing one's own work. It is that possibility that is the chief concern of this dissertation.

In exam rooms across the country, nurse practitioners are solving patient problems with increasing levels of independence and autonomy. Given this reality, it is no longer wise to assume that the goal of a nurse practitioner is to practice "just like" a physician. Trained in separate nursing schools, using separate nursing textbooks, and founded upon a century of separate nursing theories of practice, we might expect nurse practitioners to differ from their physician colleagues. Moreover, these differences should not automatically be understood as deficiencies, but as something, perhaps, of value. Assuming physician practice as the gold standard ignores the strains of dissatisfaction and mistrust that exist within physician encounters

(Betz and O'Connell 1983; McQuaide 2005; Safran 2003). We need to look more closely at nurse practitioners not just to obtain more accurate descriptions of their work, but because they are, for better or worse, creating spaces of difference in the delivery of health care.

The possibility, however, that NPs are doing their own work raises a set of intriguing questions. What should we understand this work to be? When a nurse completes a physical exam, makes a diagnosis, or writes a prescription, should we still consider this work the sole province of physicians? And if she does this work, but does it differently, how should we assign value or reimburse for this care? These questions concern more than semantics. How a society constructs its division of labor and how it understands the value of that labor, has a significant structural and cultural impact. How we construct categories of work, who we allow to do it, and how we expect workers to go about doing it—the answers to these questions powerfully shape the world, not just for individual workers, but also for the organizations that hire them, the clients that rely on them, and a society's categorizations of worth. And for those who work with people or on their bodies, the meanings they craft about their occupation shapes our very conceptions of our bodies, its problems, and the appropriate solutions to those problems. My dissertation investigates how shifts in the organization of medical work may change our practical understandings of what it means to care for the sick.

Why Study Nurse Practitioners Now?

There has never been a more pressing time to know more about nurse practitioners. The newly implemented Affordable Health Care for America Act will insure an additional 32 million individuals (The White House 2011). While these millions of newly insured will undoubtedly present in Emergency Departments with urgent complaints, the burden of their care will fall most

heavily on primary care providers. As medical students continue the trend toward specialization, questions of who will provide this care are weighing on the minds of state governments.

Our health care system has more irrationalities than any one profession can address, but nurse practitioners have staked their professional existence on providing primary care, particularly for the poor and those living in rural communities (IOM 2010; Savage et al. 2006; Van Zandt, Sloand, and Wilkins 2008). And policy makers, on occasion, have listened. The health care law names nurse practitioners and supports their training, not as assistants to physicians, but as autonomous providers, providing primary care services in community based practices which target the medically underserved (The White House 2011). Nurse practitioners will continue to be a part of any set of solutions to our current health care crises.

Another compelling reason to study nurse practitioners is, quite simply, because they are here. In 2011, the Kaiser foundation estimated that there were 180,000 Nurse Practitioners (Kaiser Family Foundation 2011). Compared to the over 800,000 physicians currently in practice, NPs appear to be a small fraction of the overall workforce. However, less than half of these physicians are in primary care specialties, whereas some have estimated that 88% of NPs are prepared in primary care specialties (AANP 2012). While good data on the number of NP health care encounters does not exist, the available estimates suggest that nurse practitioners are a significant presence in primary care encounters. As policy makers make decisions about both the value and scope of primary care, a better understanding of a growing share of its providers is warranted.

Nurse practitioners have also proven themselves to be effective providers. While nurse practitioners are often invisible as themselves, there is 50 years of research trying to understand “how good a physician” they are. This research suggests that NPs are at least as good as

physicians (Laurant et al. 2005; Lenz et al. 2004; Mundinger et al. 2000; Ramsay, McKenzie, and Fish 1982; Schiff, Donald W, Fraser, Charles H, and Walters, Heather L 1969). A recent literature review comparing NP and physician equivalence in primary care concluded that there was no difference in patient health status, treatment practices, or prescribing behavior (Naylor and Kurtzman 2010). Although these studies used a paradigm of NP-physician interchangeability, they also provided evidence of difference. While finding NPs to be at least as effective as physicians, they also find that NPs perform better in measures of patient satisfaction and in the provision of screening, assessment, and counseling (Naylor and Kurtzman 2010). Based on this evidence, patients are experiencing something different within NP encounters yet we do not have a clear understanding of what constitutes that difference. As NPs continue to expand into primary care, we may want to understand the contours of that difference.

Conceptual Approach

How should sociologists understand what the nurse practitioner is a case of? One place to begin is in the literature on the professions. The nurse practitioner could be added to a long line of case studies concerned with detailing and evaluating an occupational group's successful or unsuccessful professionalization project. However, the conceptual view of the NP as a rising professional, while useful, seems at odds with some empirical facts. This approach to the nurse practitioner case understands intra-professional competition largely in terms of inclusion and exclusion. Its analytical narrative leads us to look for the actions of self-conscious professional actors and their active strategies of expansion and enclosure. Certainly, growing NP practice autonomy cannot be explained without reference to the successful state-by-state lobbying of professional nursing organizations against professional physician organizations. However, to cast nurse practitioners and physicians as occupational competitors is too simplistic.

Nurse practitioners are still nurses; nurses and physicians have a century old tradition of working together on hospital floors and outpatient clinics. Early nurse practitioners relied on physicians as both political supporters and clinical mentors, even when many of their fellow nurses held them in suspicion. Today, newly minted nurse practitioners continue to rely on physician collaborators to learn the ropes of clinical work. Although their professional organizations may battle, individual nurse practitioners and physicians are less likely to find themselves at war in the clinic and more likely to find themselves in complicated relationships of negotiation and collaboration (Fairman 2009). As a practical matter, individual physicians working with NPs generally seek, not to outwit a competitor, but to work in relationship with a set of practices as delivered through the nurse practitioner. In this context, it does not make sense to talk in terms of simple inclusion and exclusion when nurses have always been as much a part of health care institutions as physicians, albeit with significantly less power. The more relevant goal is to understand the changing terms and contours of that inclusion and how it affects not only clinicians, but also health care encounters.

Similarly, health care organizations are no longer trying to decide if they can legitimately use nurse practitioners, but are actively engaged in figuring out how to use them. I conceptualized the nurse practitioner less as a rising profession and more as a new cultural object, a new technology in health care delivery. Health care organizations' variability in NP use is not only a reflection of unfinished skirmishes between professions, but reflects the conundrum of end-users who find themselves with a new technology. This dissertation will describe the everyday processes through which clinical and organizational actors come to a situated understanding of what a nurse practitioner is and what an NP does. I treat the nurse practitioner as both a boundary object and a set of practices worth understanding in its own right. While we

should not ignore the professionalization aims of nursing and its contests with medicine for autonomy, in actual work contexts, the relevance of these macro-political fights wanes. My dissertation focuses downward, at the micro-level, to investigate the everyday, meaning-making activities of social actors as they go about the business of doing their work.

Methodological Approach

The invisibility of nurse practitioner practices presents a challenge. Obscured in national encounter data, and hidden within the much larger population of bedside nurses in employment data, the nurse practitioner is difficult even to count, let alone examine. There is also the problem of generalizability. In the formative period of my research, I talked to a wide variety of people about the NP: nurses, nursing researchers, NP students, medical residents, clinic administrators, and friends and acquaintances who had seen NPs as patients. The practical problem that began to take shape was the sheer variety of ways in which nurse practitioners were being used. In some practices, NPs and physicians worked completely separately, each having their own panels of patients. In other practices, they would see the same patients, with the physician doing the initial, diagnostic visit and the NP doing the follow-up care; the organizational logic was that physicians excel at difficult diagnoses and nurse practitioners are good at medical maintenance.

In these stories, however, I also heard variance in organizational logics. In some primary care sites, the nurse practitioner did all the preventive care/well-visits, but in others, they handled all the same-day appointments, which are usually urgent-care/sick-visits that require diagnosis. Practicing NPs would tell me that organizations' trust in a particular NP, rather than institutional norms, determined their responsibilities—as NPs came and went, the organization shifted around them. If I took these accounts seriously, I would have to conclude that how NPs practiced and

which patients they saw depends less on credentialing and more on how both an organization and its clinicians understood and used NP expertise.

Although nurse practitioners have been providing health care since the 1960s, the reality on the ground suggests a profession very much in flux. How does should one study a quantitatively elusive, intensely variable, and fluctuating target? One answer is to focus less on the target, and more on how it moves. In order to better understand the nurse practitioner, I focused my attention on the everyday social processes involved in its formation. I used a multi-sited, ethnographic approach in order to understand both how nurse practitioners come to understand the grounds of their expertise, as well as how that expertise is understood and negotiated by others.

Site #1: The Nursing School

I began my work by examining the clinical stories nurse-practitioners-in-training shared with one another within a nursing school. From January to December of 2009, I attended courses with a cohort of family nurse practitioner students who were completing a master's level program.ⁱⁱ Family practice was one of several NP specialties administered by a nursing school within a Northeastern city. I attended all classes, took field notes, recorded selected lectures, and interviewed students. I did not read assigned material or do written assignments. However, my aim was not to do a content analysis of NP education, but to understand how NP faculty and students talked to one another about NP expertise.

In the context of the program, I began attending lectures at the beginning of their second and final 12 months of coursework. The first 12 months had been spent entirely in the classroom,

ⁱⁱIn October of 2004, the American Nurses Association recommended a clinical doctorate (DNP) as the minimum level of training for NPs. As of 2009, master's level training still represented the majority of programs, although many programs are in the process of phasing out their master's program and adopting doctorate programs. At the program where I did observation, there was no clinical doctorate program offered.

with courses focusing on science-based content like “Pathophysiology for Advance Practice Nursing,” nursing theory content like “Theories for Advanced Practice Nursing of Families & Individuals,” and courses on research methods.ⁱⁱⁱ The second year marked the students’ transition from training exclusively by classroom instruction to a focus on an aspect of practice previously reserved for physicians: clinical decision-making. During this second year, the program was roughly divided into two parts: coursework and clinical placements. Students spent 2 eight-hour days at their assigned clinical sites and an additional day attending two courses, back-to-back, at the nursing school. The coursework was designed to augment their clinical placements both in terms of content (e.g., a course on the health of older adults taken at the same time as clinical time with adult patients), as well as to support the skill of clinical decision making through in-depth case presentations and discussions of case studies.

The total time spent in class varied depending on the semester; for example, a day in the spring term consisted of six hours while one in the summer terms consisted of four hours. This cohort of FNP students consisted of 15 people at the start of my observations, with three students either leaving the family program, or postponing the necessary courses before the final semester. The students varied widely in age, from 24 to 43. Some older students had prior experience as a bedside nurse; others had pursued other careers before entering the program. The gender division in this cohort was in line with NP programs nationally; there were 14 females and one male.

As a study of NP socialization, my data are incomplete; I focused my observations on time spent in the nursing school. I did not observe how these NPs-in-training negotiated their preceptors, patients, or colleagues at their ever-changing clinical sites. However, the clinical

ⁱⁱⁱ These course names are not the actual titles of the courses of the program where I made observations but were taken from a similar FNP curriculum for the purposes of illustration.

stories that circulated in classroom instruction provide insight into how the profession thinks of itself, nursing objects, and NP practice. I noted the structure, content, and routine of nurse practitioner education; however, I paid particular attention to professional storytelling. Stories about clinical problems are not merely rhetorical strategies; they powerfully shape action through defining what a problem is understood to be and its possible solution. Through attention to the stories NPs told to and with each other, I was able to understand how nurse practitioners differently narrate their own objects of expertise, distinct from the physicians alongside whom they work.

Site #2: The Center

While professional storytelling is key to understanding the construction of NP expertise, how might these stories of expertise be enacted (or not), on the ground, in real-time, in negotiation with patients, employers, and other health care providers? I made an *a priori* decision to select a site from among nurse-managed health care organizations. Organizations apply the label “nurse-managed” subjectively rather than objectively; a nurse-managed organization self-consciously declares itself to be so. The National Nurse-Managed Clinic Consortium (NNCC) is a national membership and advocacy organization that maintains a roster of like-minded health care organizations. There are entrepreneurial nurses who operate their own health care organizations who are not members of the NNCC. NNCC members share an explicit recognition of nurses as the primary provider, a commitment to a nursing model of health care, and a mission to serve those with the least access to quality health care.

Although nurse-managed clinics comprise a small portion of health care organizations in the United States, I chose such a practice as a strategic site. Within these organizations I expected to see, in sharper relief than in other settings, how nurse practitioners would live out

their notions of their expertise. In addition, I expected to see more direct negotiation in a setting where the nurse potentially had more power with which to negotiate. Third, I also expected that through attention to an aberrant case, assumptions about what is, and is not, medical work would be illuminated and brought to the fore rather than buried in the background of assumption.

In January of 2009, using the publically available NNCC membership list, I made contact with each of the seven nurse-managed, primary care organizations located in the same, northeastern city. As with most field work, a mix of access and serendipity determined my sites. While actively pursuing multiple sites, I visited the last of the seven. Here and at most other sites, the designation “nurse managed” did not refer to individual but organizational management. A university based school of nursing provided both fiscal and administrative support for the practice.

However, this site was unique in that it was not simply a medical clinic, it was a member of the PACE program. PACE is the acronym for the Program of All-Inclusive Care for the Elderly. All PACE sites offer primary health care and other comprehensive long-term care services to adults aged 55 and over who are eligible for Medicare and who have a physical, cognitive, or medical limitation that qualifies them for nursing home placement. The goal of the program is to provide enough support to enable medically frail older adults to remain in the community. To do this, PACE supplies not only medical services but provides—and manages—home health care aide services, social work services, and supportive services such as adult day care and center-based recreation and wellness programs.

Financially, PACE is an incentivized capitation program; PACE sites receive enhanced payments from Medicare for each enrolled patient. Once enrolled, PACE becomes both the direct provider of core services as well as the payer for other services. In order to incentivize

cost savings, PACE operates as on a “till death do us part” model; because each site will have to pay for expensive hospital visits and possibly long-term care, they have an incentive to use their enhanced capitation payments on services that might delay or avoid these outcomes. Because of the long horizon of their relationships with patients, they call their enrollees “members” rather than patients. While the primary care clinic lay at the heart of the program, the clinic itself was embedded, both physically and administratively, within a larger organization: the Center.

The center was both a building and a network of services. The building was made of red brick and was four stories high. It housed the medical clinic, a physical and occupational therapy department, a social work department, and multipurpose rooms for member activities and dining. As a network, the Center managed not only life inside the building, but much of member’s lives outside the building. The center provided transportation of members not only to its building, but to specialist appointments and to and from the hospital; it also contracted for and managed home health care aides and skilled nursing services, facilitated members moving into subsidized senior housing and other assisted living facilities, and managed the regular home delivery of medications and incontinence products. PACE’s goal is to provide this network of services in an integrated, coordinated fashion. Consequently, it requires every PACE program to use the interdisciplinary team model. Every member’s care had regular, mandated input from their primary care provider, a primary care nurse (RN), a physical therapist, an occupational therapist, a recreational therapist, and a social worker.

When I first determined to make contact with the Center, I set-up a meeting with the Dean of Community Practice; she was the administrative link between the practice and the nursing school. When she heard about my interest in nurse practitioners and primary care she said, her voice shifting as if to deliver a warning, “Well, we’re much more than a medical

clinic.” And I carefully considered her warning. As a member of the PACE program, what I would see here would be different from most medical practices. However, I also heard an opportunity. What nurse practitioners do cannot be understood without attention to what others in the same arenas of work are also doing. We cannot forget that nurse practitioners are bringing their expertise into domains of work that already have occupants.

Occupations inhabit fields of action that are dense with inter-professional collaboration, negotiation, and conflict. While state level fights over the legal scope of NP practice might seem to fully determine NP work, equally important negotiations over the legitimate boundaries of NP work occur in intra-professional interactions within workplaces. The center’s reliance on a comprehensive, multidisciplinary team approach to care made it an analytically useful site for observing negotiations around work and decisions about patients. Through attention to interactions on multi-professional teams, this dissertation provides an analytical window into workplace negotiations as the site of fights for professional legitimacy as well as the grounds for changes in ideas of what constitutes the work itself.

This dissertation also considers the organizational context of nurse practitioner practice. If the iconic physician is an autonomous, self-employed consultant, the institutional history of nursing has helped to shape the nurse practitioner as employee. Nurse practitioners provide increasingly autonomous care, not in solo practices, but within bureaucratic health care organizations. This context also influences the character of nurse practitioner expertise. Clinicians may negotiate, but they do so within a set of organizational constraints and expectations. When nurse practitioners do different kind of work than physicians, they may also become different kind of organizational actors, simultaneously shifting and reacting to changing expectations of what kinds of problems nurse practitioners should solve in the exam room.

In October of 2009, I began volunteering at the Center, spending my time with members in recreational activities. While my observations as a volunteer informs this work, fieldwork I completed from October of 2010 through February of 2012 supplies the data. During these 17 months, I collected observations focused on the clinical work of three interdisciplinary teams. Four teams managed the Center's population; however, I largely excluded a fourth team from my observations because it drew its patient panel from "atypical" members: those who received only home-based care because of an inability (or sometimes unwillingness) to attend the Center, and those who spent their in-center time in the secured Alzheimer's wing.

As mentioned above, each team had representatives from a variety of disciplines. During moments of group decision-making, I paid attention to all team members. These moments occurred in two different settings. First, each team had a weekly meeting where they discussed member cases. I attended these meetings. Second, I paid attention to other arenas of information sharing and team decision-making such as "public" conversations that happened over each team's email list, and through conversations that happened in hallways and through open doorways. I paid special attention to moments of role ambiguity, work negotiation, and conflict.

In all cases, I relied on written field notes. Although unable to capture the detail of everyday conversations, I captured repeated patterns of both physical and verbal behavior through the repeated taking of field notes. While I paid attention to how each team worked together, I focused my attention on some disciplines more than others. Because I primarily sought to study clinical negotiation, I focused on the nurse practitioners, the primary care nurses, the physicians, and the social workers. For each team, I shadowed each in turn, in order to document the structure and routine of their work. I also interviewed the members of each interdisciplinary team. In addition to those clinicians who were the analytical focus of my work,

I interviewed occupational therapists, physical therapists, appointment schedulers, and center administrators. In total, I conducted 44 interviews with 32 unique staff members.

Dissertation Overview

This dissertation addresses four specific questions through data collected at two different kinds of sites. First, what cultural tools and practical strategies do nurse practitioners use to craft arenas of expertise? In primary care, NPs are entering a field of work that already has a legitimate occupant: the physician. Yet, as medical students continue to gravitate toward specialty practice, the primary care physician is often absent. However, because they remain the ideal of medical practice, the ghost of the physician must always be reconciled. In a terrain still considered physicians' rightful domain, how do NPs create a professional space of their own?

Second, in the space they may uneasily occupy, what kinds of problems do nurse practitioners differently name? Sociologists of medicine and work have long investigated the intersection of physician work and the construction of patient problems. Patients turn to professionals not just to solve our problems, but also to name them. We give professionals the authority to make our problems visible; the contours of that visibility give our problems meaning, value, and legitimacy. If nurse practitioners do this differently from physicians, then how might the objects of their expertise be differently constructed? As nurse practitioners increase their presence in the exam room, our investigations may have to account for different renderings of clinical problems.

Third, what specific practices do nurse practitioners use to solve patients' problems? A personal understanding of one's expertise is one thing. But NPs face employers and patients who expect real fixes to their patient complaints. What specific kinds of practices do nurse

practitioners use to solve problems? What kind of practical strategy does the nurse practitioner become?

Finally, how do nurse practitioners' employers, colleagues, and patients understand their role? When a health care organization decides to hire a nurse practitioner instead of some other kind of provider, what expectations drive that choice? This question takes on particular relevance in primary care, where nurse practitioners' roles overlap the most with physicians'. As NPs work with/under/alongside physicians, how do both professions come to a practical understanding of the difference in their roles? And how are these understandings negotiated amidst the practical demands and internal logics of their employing organization? While state law broadly specifies the legal scope of NP work, the impact of "shop-floor" negotiations has particular importance because we are living through the historical moment when these boundaries are actively shifting.

In Chapter 2, I address the set of cultural tools that nursing has used to ground its claims of expertise through an historical understanding of the logic of "separate spheres" and its relationship to gendered notions of work. This chapter provides an overview of the historical and cultural foundations of the division between physician and nursing practices, as well as the current troubling of that division. I then empirically pursue my questions of interest using three different approaches: narrative, ethnography, and biography. Narrative has particular analytical weight in the study of health care practices. Despite medical advances, the body continues to speak its complaints in a language that is difficult to cipher. In the face of this inarticulateness, medicine remains an interpretive activity (Montgomery Hunter 1993).

One of the primary skills that physicians-in-training learn is to rework the stories told by bodies, patients, and laboratory tests into one, definitive medical account, using the conventions

of specific medical genres (Anspach 1988). Sociologists and anthropologists have used the narratives of physicians-in-training as sites of analysis to understand the active rhetorical processes that reconstitute individuals as patients and bodies as sites of clinical problems (Fox 1957; Good 1994). What are the kinds of professional stories that nurse practitioners tell? What kinds of problems does NP storytelling call into existence? In Chapter 3, I analyzed the clinical stories that NPs-in-training heard and told in order to understand the narrative strategies nurse practitioners use to construct both clinical objects and professional expertise.

This dissertation also uses biography. Actual people, not ideal types, populate occupations. Members of an occupation, as well as the skills we require of them, shape the social character of an occupation. As late as the 1970's, medicine was almost entirely male and nursing nearly all female. While more men than women currently practice medicine, in 2012, women represented 46.4% of all US medical school matriculants (AAMC 2012). However, there is a growing gender divide among subspecialties, with women overwhelmingly going into primary care specialties. Nursing, however, remains overwhelmingly female; 90% of registered nurses and 86%% of NPs were women in 2012 (Bureau of Labor Statistics 2013).

Chapter 4 analyzes particular biographies of nurse practitioners in order to understand NPs in a broader system of occupational and social stratification. Using the career biographies of nurse practitioners, I explored the ways in which nursing technologies of care are not only gendered, but tried to understand how their specific biographies intersect with specific gendered and classed careers. How does the structure of nursing education and labor markets make being a nurse practitioner seem more possible for some people than being a primary care physician?

In Chapter 5, I augment the preceding chapters' analysis of narrative with analysis of the materiality of NP work. Nurse practitioners may tell stories about their expertise, but how do

they enact that expertise, in real-time, in negotiation with employers, patients, and colleagues? My fieldwork at PACE explored the social process through which new claimants come to "make sense" in an already occupied domain of work. I use this data in Chapter 5 to address how these negotiations around work both shaped and were shaped by the expectations of two very important clients: patients and the employing organization. Clinicians may negotiate, but they do so within a set of organizational and client constraints.

This chapter provides evidence that nurse practitioners are not just telling stories of difference, but are practicing differently in their performance of medical work. Through this performance of difference, they changed client expectations about the kinds of problems addressed during primary care encounters. This chapter demonstrates that when new occupational groups enter a particular jurisdiction, they not only potentially transforming notions of who can do what kind of tasks; by fighting to erect new boundaries, they can transform the meaning of the work itself. If NPs are sometimes doing something different than physicians, both as professional and organizational actors, then this may challenge exactly what it means to provide "primary care." Because whether we call it medical work or nursing work, primary care is the policy battleground for new forms of organizing, providing, and paying for health care.

In Chapter 6, I look at a site of professional negotiation that previous work on nurses has ignored: competition with other female-dominated professions. In order to claim a unique expertise within a field previously occupied by physicians, nurse practitioners use a set of legitimating tools claimed by a host of other caring occupations, the most established of which is social work. Using fieldwork from the Center, I examine how these nurse practitioners successfully convince their colleagues, their employing organization, and their patients that they, rather than the social workers, can best provide solutions to problems that fall outside narrow

definitions of medical problems. This chapter explores the NPs' boundaries of responsibility with claimants besides physicians as well as the practical, everyday strategies they use to negotiate.

Chapter 7, the concluding chapter, has three elements. First, it will provide a reflective summary of the dissertation. Second, it will make a substantive argument about what this all means for the NP professionalization project and, possibly, for the primary care physician's de-professionalization project. Finally, it will provide some reflective thoughts on what this can mean for patient care.

Through an examination of professional narratives, intra-professional negotiation, and organizational logics, this dissertation will illuminate the distinct processes through which notions of what constitutes medical work, medical expertise, and patient care can be altered, not only at the level of national fights over credentialing and regulation, but through shop floor negotiations. My work suggests that at some times, and in some places, nurse practitioners are incorporating different practices in their performance of medical work. Through this performance of difference, nurse practitioners are doing more than creating professional expertise or a personal sense of worth, they are changing expectations about what kinds of problems get solved "in the clinic," during primary care encounters.

This dissertation is fundamentally a story of the ways in which understanding of certain kinds of medical practice is shifting because of nurse practitioners' performance. As nursing colonizes the exam room with a different kind of clinical performance, they are potentially redefining what it means to care for patients. Attention to NP work matters, not only because of what it can tell us about this rising profession, but because of what it can tell us about changing

health care practices and how they may shape our very ideas about what it means to care for the sick.

Chapter 2 – The Gendered Division of Labor in Health Care

Prior to the 1960s, there was no such thing as a nurse practitioner. When the first few NPs began practicing, consensus about them was not immediately achieved. Throughout the 1970s and early 1980s, nursing and physician organizations continued to argue—with each other and among themselves—about how to understand this entity. Is the nurse practitioner a more skilled “super” nurse? A less skilled, junior doctor? Some kind of differently skilled hybrid? The first practitioners were somewhat ambivalent about whether they should align themselves with pediatricians or nurses. In their day to day work, these first practitioners worked alongside physicians who served as both mentors and supporters while the main nursing organization, whose leadership was at the hospital bedside and away from the clinic, initially criticized them as abdicating their role as nurses and “wanting to become doctor” (Fairman 2009).

Today, nursing unequivocally claims ownership of the work that nurse practitioners do. Their training happens within nursing schools; their practice is prescribed by state nursing acts and governed by nursing boards; and it is professional nursing organizations that lobby and organize for their interests. However, the NP work that nursing claims can appear to be very similar to the work that physicians claim. Primary care organizations explicitly hire nurse practitioners to solve the kinds of patient problems that might also be solved by physicians. When NPs diagnose and authorize medical interventions, they are crossing an historical boundary between nursing and medicine.

However, boundary crossing is not without consequences. Symbolic boundaries serve as the conceptual rationale for the institutionalization of social differences and systems of social stratification. Social actors wield not only material but symbolic resources as they engage in contests over the production, diffusion, and transformation of boundaries (Lamont and Molnár

2002). In this sense, nurse practitioners are a kind of boundary object, a collection of practices that traverses and serves as a point of negotiation between nursing and medicine. Boundary objects, however, are not static bridges; they have a generative capacity to reconfigure established boundaries and make new distinctions. This boundary-work is designed to achieve an apparent differentiation in goals, skills, and substantive expertise between one group and all others (Gieryn 1983). The question of differentiation presents a practical problem for nursing. In order to claim NP practices for its own, nursing cannot depict NPs as junior doctors—who use or borrow medicine’s expertise—rather, nursing must realign the boundaries of its own profession in order to distinguish what NPs do from what physicians do. However, if nursing remains successful in claiming NP practices for its own, individual physicians and medicine as a whole are pressured to reconsider the current boundaries, and perhaps, to construct different ones. Who and what these new boundaries include will impact both nurses and physicians, as well as how we organize and deploy these workers.

One of the goals of this dissertation is to understand the on-the-ground boundary work that occurs between nursing and medicine through their negotiation of the nurse practitioner’s domain. I argue that this interactional work is part of a larger shift not only in how we categorize medical labor, but also the meanings we assign that work. In order to understand the boundary work that is happening today, we must begin with an historically grounded understanding of how our current professional and work boundaries came to be. This chapter will review the historical construction of medicine and nursing as separate professions, discuss the symbolic resources that remain at the core of this separation, and the contemporary structural shifts that are troubling the established lines of this separation.

The Birth of Curative Medicine

Our current understandings of medical practice and medical work have themselves been shaped by a particular set of cultural, institutional, and political arrangements. Although western medicine traces its professional lineage to Hippocrates and Galen in ancient Greece, we should not see the medical profession as an unbroken collection of practices that simply incorporated new facts along way. In Birth of the Clinic, Foucault describes the transformation of medicine through a history of the transformation of knowledge (Foucault 1994). He argues that the birth of medicine in the 19th century as a clinical science was more than just the incorporation of new information, but a radical transformation in perception—a new way of perceiving the body of the sick, and of seeing the disease in the body.

Foucault begins with a description of how physicians in 17th century France understood illness prior to this shift. These physicians saw the bodies of the sick through a “qualitative gaze”; they understood illness as something that was produced by a socially embedded body. Rather than counting or charting symptoms, these physicians tried to discover why a particular body was producing illness through attention to biography, social situation, and temperament. However, this view began to change in the middle of the 19th century. The French Clinical School in Paris began to argue for a new view of disease as a set of specific entities that existed apart from individual bodies; these new entities were to be understood as having their own, predictable courses and related clusters of symptoms.

This transformation in perception also signaled the intertwining of medical practice with the rising power of science. Until that time, medicine was practiced as a philosophical art that was separate from work in the natural sciences. Foucault noted, for example, that anatomists had been performing autopsies to understand how the body worked for decades without anyone, physicians included, making the connection between this “science of life” and the treatment of

illness. However, in the 19th century, autopsies began to be performed with “new eyes” in order to understand the seeds of illness. Medical practitioners began to develop an eye for isomorphism, matching the experience of illness to what could be seen in the body. Other techniques such as taking of the pulse, percussion, and the use of the stethoscope also contributed to the ability of practitioners to make apparent what was previously unseen. Although physicians were initially distrustful of the melding of science with medicine, these technologies and tools of science eventually came to be considered their domain. This shift in perception spread, slowly but decidedly, from the French School to England and eventually, to the United States.

The Rise of Medical Power

However central the role of new forms of knowledge was to the rising dominance of the medical profession, we cannot understand the rise of medical power through knowledge alone. In The Social Transformation of American Medicine, Paul Starr asserts that the “development of medical care, like other institutions, takes place within larger fields of power and social structure” (Starr 1984, pg 8). In this work, Starr describes both the cultural and political strategies through which physicians transformed themselves from a powerless collection of low-status individuals, into a powerful, high status professional group that possessed cultural authority over an increasing proportion of social life. While improvements in the efficacy of medical treatments certainly raised the prestige of western physicians in the early part of the 20th century, the story of their rise to professional dominance began decades prior, with a set of political moves.

Physicians in the 19th century did not have a corner on the market for the treatment of illness. The landscape was littered with other practitioners, including midwives, homeopaths,

and Eclectics. The term “physician” itself did not necessarily refer to a singular profession with one approach. In order to consolidate their power, medicine put aside their sectarian divisions, and successfully worked to restrict the term “physician” through limited admissions to professionally regulated medical schools and restricting entry to the profession through regulated licensing. Medicine’s ability to close the boundaries so sharply and securely around its practices has made it both a model of successful professionalization strategies, as well as an almost singular case whose success has rarely, if ever, been replicated.

In explaining medicine’s success, Starr, as well as historians like Howell and Rosenberg have also highlighted a shift in the physical location of medical practice (Howell 1991; Rosenberg 1995). Throughout most of the 19th century, the iconic physician was located at the bedside, within the patient’s home. However, in the 20th, the hospital came to be the normal site of medical practice. This new terrain was part of the set of forces that led to the rise of modern medical practice. In the 19th century, hospitals were largely a continuation of the tradition of almshouses for the poor. These unclean and inhospitable institutions were largely places for the treatment of transient seamen and the “sick-poor”; anyone with even the most modest of means received care in their own homes. At the turn of the 20th century, hospitals increasingly became places where middle class patients paid to receive care. The aforementioned connection between science and medical care happened in part because of the concentration of medical technologies inside the physical hospital; these new technologies brought doctors and their patients away from the domestic sick bed and into the hospital. Physician practice and physician training began to be increasingly located at this new site of medical technology: the teaching hospital (Howell 1991).

The consolidation of medical authority and the transformation of physician status cannot be understood without attention to gender. Physicians were able to change their 19th century status from slightly above household servant— beholden to domestic rhythms and worldviews— to respected expert, in part through distancing medicine from domestic-centered lay practices through scientific explanations of disease. Similarly, they distanced their work from the contexts in which biologically defined diseases existed: in the bodies and through the lives of their patients. Moving patients from home to hospital, and learning to see generalizable disease in specific bodies was part of the cultural work involved in constructing a medical expert. Medicine was not only demographically male; the profession effectively masculinized its work.

The way that medicine came to differently see the geography of illness has to be understood as an historical phenomenon. The narrowing of physician concern to the diagnosis and curing of diseases was not an a-historical inevitability, but an historical development. Similarly, the changing organizational geography of physician practice was critical to forging the link between medicine and technology. The rise of hospital care and the rise of physician authority were significantly intertwined.

Nursing as a Caring Occupation

At the same time that physicians were leaving the caring hearth for the hospital, nurses were learning to bring care into the hospital. Historian Reverby charts the beginnings and history of professional nursing (Reverby 1987). In colonial America, wives, sisters, daughters were all called to nurse as an expression of love and responsibility for others. But this “expression of love” was also clearly an obligation a woman owed her family. Reverby notes that no other duties protected women from the demand to nurse relatives. “Nursing was to be,

therefore, a woman's duty, not her job. Obligation and love, not the need to work, were to bind the nurse to her patient."

The growth of the urban middle class made it possible for families to hire nursing labor. As long as the woman of the house made sure nursing care was done, even through paid labor, her obligations were still fulfilled. The employed nurse was either a domestic servant, sporadically pressed into this new service, or "the professed nurse," an older woman who could attest to having nursed her own relatives, but who could not manage the physical requirements of other kinds of work. Nurses who worked in the few hospitals were typically working class women whose work replicated the labors of servants, cooks, and washerwomen. Nursing was an activity rather than skilled work, an activity that could only respectably be done out of affection. However, the influence of Florence Nightingale in 19th century England began to shift the conception of nursing.

Florence Nightingale is credited with transforming nursing work from an unskilled labor of love to a paid occupation in which respectable women could engage. Although founding the first nursing schools was her crowning achievement, her narrative framing was at least as important in the birth of professional nursing. In the preface of her seminal Notes on Nursing, Nightingale writes, "Every woman, or at least almost every woman, in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid—in other words, every woman is a nurse," (Nightingale 1860). Nursing, Nightingale tells us, is part of a woman's domestic duties that relies not on special knowledge, but everyday knowledge. This "everyday knowledge" she writes, "...is recognized as the knowledge which every one ought to have—distinct from medical knowledge, which only a profession can have." Despite this pronouncement, Nightingale does not spend the next 130 pages expounding on womanly

virtues or feminine knowledge. Rather, she describes, in exquisite detail, everything that is uncommon about this common knowledge, excoriating middle class women (and the “respectable” women who provided paid nursing services within middle class families) for their ignorance of all she describes. She ends her volume with this pronouncement: given these gross deficiencies of English women, nursing skills could not be learned within the family circle, but could only be taught through formal training.

In one slim volume, Nightingale managed to do three things. First, like other female social reformers of the late 19th and early 20th century, she made use of a gendered language to create a legitimate place for middle class women within the paid labor force. Nightingale joined these reformers in appealing to the natural virtues and knowledge of womanhood to newly imagine women (that is middle-class, white women) into a landscape in which they hitherto could not exist (Ginzberg 1992; Kunzel 1995; Welter 1966). Second, and more importantly for the profession of nursing, Nightingale marshaled an argument that nursing work was not simply a woman’s obligation but could be a woman’s professional calling. Carrying out this calling however required not just womanly affection, but institutionalized training. Through changing nursing from mere work to a skilled calling, Reverby argues that Nightingale was explicitly trying to feminize nursing through disassociating it from its current working class occupants and connecting it with middle class values.

Third, Nightingale’s rhetoric of nursing care established the first clear boundary between nursing and medicine. Nursing knowledge was everyday knowledge “distinct from medical knowledge, which only a profession can have.” However, this was not entirely a statement of feminine or professional humility. Nightingale strongly believed that “medical therapeutics and ‘curing’ were of lesser importance to patient outcomes, and she willingly left this realm to the

physician” (Reverby, 7). At a time when physicians were turning toward science and away from direct patient care, Nightingale was creating a skilled army of nurses whose explicit role was to observe patients, respond to their physical needs, and be attentive to their mental and social needs. For Nightingale, physicians cured, and nurses cared—but skillfully and in a way that materially mattered for patients. This initial gendered division of labor in the hospital came to ground the gendering of each profession’s practices. It wasn’t simply medicine that worked to separate itself from other occupations; nursing used its own set of symbolic resources and material practices to set itself apart, both from servants and from physicians.

The Work of the Dichotomy

However, a reliance on care as an organizing principle should not be understood as an unmediated choice. Although Reverby claims that Nightingale decided that nursing should “willingly leave” the medical realm to physicians, it is also true that nurses were entering the hospital—the very site of the consolidation of physician power. Scholars like Anne Witz alert us to the idea that the professional projects do not have access to a universal set of strategies. She argues that we need to pay attention to the gendered dimensions of professional projects and their relationships to gendered understandings of dominance and subordination. Later scholars of the professions have highlighted the role of stratification by calling our attention to the interplay between strategic action and access to resources. Marginalized groups like female-dominated occupations choose some strategies over others because they lack open access to institutional resources such as colleges and universities (Witz 1990).

The assertion that nurses are professionally called to care should be historically understood as one of the few strategies available to create a new respectable occupation for women outside the home. Unlike physician work, nursing as an occupational activity had few

precedents outside of servant labor. Similarly, although the female separate sphere was subordinate, it did have its own sources of power. Creating an identity based on sisterhood provided a political base for nursing (Reverby 1987). An appeal to separate spheres was one of the most convincing discourses at nursing's disposal to gain entry to the hospital without threatening doctors and as well as providing a basis for a separate, nursing expertise.

Care and caring continue to be explicitly used as a way for nursing to differentiate itself from other medical professions. While nursing organizations mostly accepted a subordinate role to medicine in the curative domain, nursing has continued to cling fiercely to the language of separate spheres. The internal politics of nursing are filled with examples of one group of nurses charging the other with forgetting nursing's focus on care. When the first nurse practitioners began to practice, nursing groups formally rejected these first NPs for "wanting to be doctors" and forgetting their duty as nurses.

Blurring the Lines

Throughout most of the 20th century, the separate spheres of nurses and doctors remained intact. However, the boundary between them has become increasingly blurred, in part because of key changes in the organization of health care. In the mid 20th century, new spaces for medical care began to serve as breeding grounds for the sharing of practices between physician and nurse. Nursing historian Julie Fairman argues that the development of critical care units in the 1950s was one such location (Fairman and Lynaugh 2000). These units were rooms with small numbers of critically ill patients who required 24 hour, acute care. In these spaces, the practical need for knowledgeable caretakers motivated some physicians to show nurses how to assess and communicate a patients' condition. In other intimate spaces in the hospital,

physicians began to delegate, not just technical tasks but key elements in clinical decision making, such as how to take a health history and perform a physical exam.

At the same time that nurses were taking on more complex work in the hospital, opportunities were also opening in outpatient settings. The problem of physician shortage is not only a current problem, but is one that has been with us since the 1950s. The post WWII baby boom increased demand for primary care physicians for maternal and child care. Many rural and suburban practices had growing demand for their services, but did not have the revenue to hire more physicians. Moreover, rural communities often lacked the kind of local amenities that would make their communities attractive to young physicians. But patient demography was not the only problem; increasing physician specialization was decreasing the proportion of primary care providers.

The problem of the missing physician opened the door for new policy experiments in the provision of primary care. One of the most successful of these experiments was the nurse practitioner. The nurse practitioner was the brainchild of nurse Loretta Ford and pediatrician Henry Silver. Anecdotally, some physician-owned practices in rural communities were already independently “making do” with nurses to stretch their ability to provide services. Sparked by these collaborations, Ford and Silver formalized this local, on-the-ground sharing into a formal training program for nurses who wanted to practice clinical decision-making, or curative medicine.

When Ford and Silver started the first NP training program in 1965, their chief concern was not the professional aspirations of nurses, but the intertwined problems of access to care and increasing physician specialization (Fairman 2009). Both were concerned by the lack of primary care physicians to provide maternal and child healthcare. They believed that nurses could be

trained to deliver much of the routine, primary care for women and children. This increased need for primary care providers was not only felt at the local level, but also at the national level, sparking a federal response. The passage of the Rural Health Clinics Act in 1977 allowed NPs to receive direct Medicare reimbursements for their services if they practiced in areas with physician shortages. It was the NPs in these primary care clinics, autonomously serving the economically vulnerable and the geographically isolated, who set the stage for future blurring of the line between nursing care and medical cure. These clinics were ground zero for negotiations between physicians and nurses about their growing shared work with patients.

Medicine in Search of Care

At the same time that nurses were beginning to venture into the realm of curative medicine, medicine found itself in need of more care-centric technologies. Physicians honed curative medicine when its patients suffered primarily from acute conditions. However the primacy of this kind of medicine has been challenged by three shifts: the rise of chronic over acute illness, the growth and diversity of ambulatory care settings, and the growing need for primary care providers to practice disease management rather than cure illness. During the last half of the 20th century, the United States completed its final stage in the transition from being troubled by infectious disease to being troubled by chronic disease. The role of “one-time” cures began to fade as the population began to suffer from conditions like heart disease, diabetes, and hypertension.

Similarly, as the population ages, there is an increase in the number of older adults who require supportive health care both at home and in long-term care facilities. The “care” that patients required was at once supportive, but also highly technical and dependent on complex clinical decision-making. Nurses who were to work in these settings, NPs as well as those

without advanced degrees, began to increase their level of science training to prepare for these new demands. Although there is evidence the nurses are increasingly performing curative activities, the analogous transformation has not happened for physician practice. One might argue that while nursing has expanded its domain of work and finding new spaces for its increasing set of skills, medicine has chosen to specialize and increasingly narrow its arena of concern, even as it expands its repertoire of interventions. Nurse practitioners are an important site of sociological analysis, not simply because they are understudied, but because their creation occurred concurrently with these other important changes in health care.

The question of NP-physician interchangeability is often explicitly or implicitly at the heart of discussions or research on the nurse practitioner. However the NP is not a new category that stands on its own, but one that exists within the larger occupation of nursing. Even as it acceded authority to medicine in the curative realm, it claimed its own authority in the caring realm. The boundary between medicine and nursing is not simply about establishing hierarchical lines of authority, it is also the grounds for the separation of expertise. One of the tasks of this dissertation is to demonstrate how nurse practitioners craft expertise through strategies of difference rather than those of interchangeability with physicians. As nurses, NPs have access to the same symbolic and material boundaries that constitute nursing's caring, separate sphere. Just as Nightingale's logic of nursing being a woman's skill was professionally useful in the 19th century, the logic of nurse practitioners practicing a fundamentally caring skill also has its uses.

The door to nursing's expansion was opened with arguments of need. Physician absence in primary care created a vacuum for other entrants. Need, however, is not enough to explain the cautious professional gains of the nurse practitioner. Professional autonomy, independence, and legitimacy isn't simply about collecting new skills, it's about claims to cultural authority.

Nursing could ably fill a technical space without fulfilling a cultural one. Physician discomfort with nurse practitioners isn't because of what they do—physicians have always looked toward nurses as skilled and able assistants—but because they are increasingly doing it without medicine's symbolic and legal ownership. A vacancy may have opened the door, but the shape of that doorway made use of a rhetorical strategy that was able to accede authority to medicine at the same time that it annexes parts of medical work under caring work.

The nurse practitioner then becomes a peculiar kind of boundary object. One of the ways in which such objects work is by allowing interaction and communication between boundaries; the object allows exchange and work to get done while keeping the boundaries intact. At the level of meaning, the NP adequately fulfills this role; she is a nurse who continues to care for the whole-person needs of patients, just with different tools and in a different setting. As a nurse, she is not the physician's competitor; she is part of the physician's team. Nurse practitioners are just another example of nursing assisting medicine to attend to the needs of patients—a role they have always played. Nurse practitioners at once gained entrance to a new domain at the same time that they appeared not to have moved at all. Nursing does not seem to question medicine's expertise; the rhetorical boundaries between nursing and medicine remain intact.

The boundaries may be intact, but the terrain underneath them is shifting. When nurse practitioners first entered the exam room, they entered at the fringes of medical care—among the poor, the geographically isolated, and more generally in outpatient primary care. Nurses continue to acquire new responsibilities in the hospital; however, the hospital remained at the center of physician authority and activity. But these outpatient outposts became new spaces of action; physician absence created a space not just for NPs to perform new work, but to do this work as nurses. Nurses are not authorized to practice medicine, but they have always been

allowed to provide health care. The activities that happen in outpatient clinics have become health care, and those who provide it have become health care providers.

This quiet transformation in what kind of worker patients might find in the exam room has not gone uncontested. However, while physician organizations like the American Medical Association make headlines with their position statements against the nurse practitioner, little attention has been paid to the cultural work that nursing must do to contain the NP. If nurse practitioners are to provide primary care as nurses, then how do they use nursing's symbolic framing of care to understand their work as distinct from other occupations? And what is the relationship between the symbolic framing and their material work?

The gendered logic of care and caring labor that nursing used to first gain entry into the workforce remains both internally and externally salient. Since its first moves to reframe sick care done in the family circle as the province of trained nurses in home or hospital, nursing has sought to elevate care as both a skill and a unique area of expertise. Even though the actual work that nurses perform has become ever more specialized and technical, the profession still understands its work as unique in *how it cares* for patients. However as nursing stretches up the professional ladder, there are ongoing tensions between its desire to be seen as a respected profession while retaining its identity as a fundamentally and uniquely caring one. While this tension has been evidenced throughout nursing's history (Bourgeault 2006; Reverby 1987), it has arisen anew in the case of the nurse practitioner. As nurses who seem to be called both to cure and care for patients, how do they reconcile this seeming contradiction? More to the point, in what ways are they able to reconcile this contradiction in ways that are both convincing and that make practical sense to evaluating others?

Finally, the historical boundary between nursing and medicine is not just along the lines of authority, material work, or even gender stratification, but also along the lines of knowledge. Expertise is grounded in claims to knowledge. For nursing, claiming a distinct form of knowledge has been a difficult argument to make. For much of their professional history, it is an argument that nurses themselves were not always sure they wanted to make. While the slogan “Doctors Cure, Nurses Care,” may appear to be nothing more than a cliché, for nursing, it remains at the heart of its professional identity. However, care is not usually understood as knowledge, but as affect embodied in action. Nightingale left science with its abstract knowledge in the hands of medicine, keeping a practical, everyday knowledge for nurses. The historical conundrum for nursing has always been to professionalize altruism. Most scholarship concludes that this conundrum is a fatal flaw. Nursing, the literature says, is a failed profession.

I would argue, however, that there is perhaps a more complicated answer to this question. One of the central observations that motivated this dissertation was the very real success of nursing. Nursing, while continuing to embrace a gendered, professional logic of care, has secured middle class wages and solid gains in prestige for its denizens. When compared to professions like medicine and law, nursing may always fall short. However, if we consider them on their own terms, we have to not only accept but also explain nursing’s achievements. The case of the nurse practitioner is even more astounding in that their rise has come with real gains in independence and practice autonomy. And they have won these rights despite making no obvious claims to a separate field of knowledge. Although nurses have increased their training in the sciences, and nursing continues to try to move its credentialing regimes away from the vocational track and into the university, their vocational legacy continues to shape the profession. Medical students traditionally spend years taking coursework before they ever

encounter a patient. Bedside nurses continue to be trained in vocational and community college settings where exposure to patient care happens almost immediately. Medical work is grounded in knowledge; nursing work is grounded in practice. One of the tasks of this dissertation is to demonstrate how nurse practitioners craft expertise through strategies of difference rather than those of interchangeability with physicians. If not through claims to abstract knowledge, how is nursing able to craft convincing narratives of expertise for nurse practitioners?

Chapter 3 - Narrative Constructions of Difference in Nurse Practitioner Training⁴

Stories of what went wrong, of close saves and near misses, are common in medical settings. Shared from senior practitioner to junior practitioner, from attending to resident, such stories serve both to humble the listener with the inherent uncertainty of medical practice, as well as to emphasize moments where not just knowledge, but expertise is required. In both the sociological and health literature, the iconic teller of such stories is the physician. While nurses, medical assistants, and a host of other medical technicians are needed to keep the complicated array of health care services afloat, the true protagonist in any medical drama is the physician.

However, in real life, the physician's position as lone protagonist has been challenged on many fronts. Sociologists and historians have written numerous accounts documenting the introduction of other interests into health care: payers (Stevens, Rosenberg, and Burns 2006), lawyers (Rothman 1992), empowered patients and patient advocacy groups (Epstein 1998), as well as the federal government (Starr 1984; Stevens et al. 2006). These interests, to use the terminology of Rothman, are "strangers at the bedside;" they are non-clinicians who have literally or figuratively come to be present at the clinical encounter. Although NPs are a relatively new occupational category, it would be difficult to think of NPs as "strangers" at the bedside. Unlike lawyers, ethicists, or even alternative health providers who draw from their own bodies of knowledge, nurses have always been on the inside of medical practice, if often unacknowledged.

Nurse practitioners are part of the over 100-year history of professional nursing in the United States. But since the first NP training program started in 1965, nurse practitioners have

⁴ Early ideas from this chapter were presented at the 2009 Carework Conference in San Francisco, CA. An initial version of this chapter was presented at the 2012 Annual Meeting of the American Sociological Association in Denver, CO.

slowly been transporting nursing from the bedside to the exam room. Those first few practitioners have now swelled to over 180,000 and find themselves in a position to contribute to their own sense of what constitutes clinical practice. Nurse practitioners may be found in a variety of clinical and administrative locations; however, their presence in ambulatory and primary care settings is where their uniqueness within nursing is the most visible, and where role redundancy with physician practice is the most probable. The growth rate of NPs in primary care has been rising rapidly while that of physicians has slowed to a crawl. Between 1995 and 2005, the number of primary care physicians increased an average of 1% per year while the number of NPs working in primary care rose by 9% per year between 1994 and 2007 (GAO 2008). Physicians are increasingly becoming, as nursing historian Julie Fairman notes, “one of many” providers of health care, particularly within primary care (Fairman 2009). While most NPs continue to practice in collaboration with physicians rather than in independent practices, their autonomy within the clinical encounter defies any understanding of their work as simply carrying out doctors’ orders.

These demographic facts should raise questions for sociologists as well as those concerned with health policy. While all eyes focus on nationally prominent changes in health care policy, there has been a quiet shift in local policies in who can legitimately provide health care. How might these new providers incorporate themselves into the cultural and theoretical terrain of work that we call medical practice? What tools and strategies might they use to create a unique space for themselves within a landscape considered the legitimate domain of physicians? How do they construct notions of their expertise? This chapter explores answers to these questions through ethnographic fieldwork at an educational graduate program that trains nurse practitioners specializing in family practice. The data come from the stories, both formal

cases and informal stories about patients that faculty, lecturers, and students shared with one another about the clinical encounter during their in-class curriculum. I focused my analysis on the totality of these narratives but chose to pay close attention to the moments when uncertainty appeared within them. More than the memorization of clinical facts and textbook cases, the ability to encounter and resolve the uncertainties of clinical practice is what transforms a skilled technician into a professional who wields clinical judgment. I posit that narrative moments when uncertainty appears and is resolved are useful data for developing an understanding of how an NP program expresses the ideal performance of competence and professional expertise to nurse practitioners in training.

Training for Uncertainty

This work draws from two core projects within medical sociology: a concern with uncertainty and professional socialization. Uncertainty is a chief dilemma of social life; in medical sociology, the concept of uncertainty has carried specific, analytical weight. The concept was first formalized by Talcott Parsons (Parsons 1951) as one of the primary dilemmas of medical practice. Parsons wrote descriptively about the uncertainty inherent in the role of the physician: in the moment of the therapeutic encounter, uncertainty arises when the limits of medical knowledge meet the limitless expectations that patients and society at large have of the physician's role and abilities. Although many of Parsons' descriptive insights have since been critiqued, extended, or revised, sociologists and memoirists alike remain engaged with medical uncertainty as a kind of existential condition that is particular to the physician's role within the clinical encounter.

Although Parsons first noted uncertainty as a central dilemma of medical practice, it was Renee Fox's classic essay *Training for Uncertainty* that provided the first full elucidation of how

uncertainty shaped physician training and ultimately physician practice (Fox 1957). Through empirical observation and interviews of physicians-in-training, Fox described how students learn to see and acknowledge the uncertainties of medicine and how to cope with them. Fox describes three types of uncertainty that confront the student: uncertainty that comes from the limits of medical knowledge, uncertainty that comes from the ignorance of the physician, and the uncertainty of distinguishing between the two. In this account, as in that of Parsons', medical uncertainty is primarily a function of the indeterminacy of medical knowledge. Through the intern and resident years, the aspiring physician confronts the limits of what medicine knows as well as the realization that it is impossible for any one individual to master the vast and ever increasing body of medical facts.

This encounter with uncertainty becomes a central professional dilemma for the physician-in-training. Who am I? Who is the physician if not an expert who has attained mastery over his subject? Fox describes how training for uncertainty involves learning to effectively manage this uncertainty; the performance of confidence is an essential part of learning to doctor. The idea of managing uncertainty or "training for control" was taken up critically and more fully by later scholars (Atkinson 1984; Light 1979). Light argued that the emphasis of medical education was as much about learning to control uncertainty as it was about acknowledging it. He argued that there was a real danger of physicians learning to over-control uncertainty through a narrow focus on medical technique and treatment philosophies rather than attending to the needs that the patient would define as salient. Similarly, Atkinson argues that medical students learn to be dogmatic in the performance of certainty rather than learning to acknowledge the uncertain limits of their knowledge. Although Light and Atkinson question the chief role that Fox gives to uncertainty in medical training and raise the specter of

patient/provider conflict, their criticisms are better understood as extensions and correctives to Fox's understanding of medical uncertainty rather than refutations. The point of contention in these critiques is how the institutions of medicine and medical education deal with uncertainty, not with its characterization. However, what these works uniquely highlight is that the strategies used to "seal the breach" of uncertainty are an integral part of the medical profession's performance of skill.

Others have investigated how new practice realities may have changed how medical uncertainty is experienced. Timmermans and Angell investigated how the role of standardized protocols and the use of evidence-based practice guidelines may have affected how pediatric residents experience and deal with medical uncertainty (Timmermans and Angell 2001). Protocols and other standardized practice guidelines have the potential to minimize uncertainty by leading the clinician through a diagnostic algorithm and by offering a standardized treatment protocol after a diagnosis has been made. However, what they found was that these guidelines became another source of uncertainty, which Timmermans and Angell call research-based uncertainty. The practice of performing literature reviews and evaluating studies became a new set of skills to master for residents and was the cause of the creation of new strategies for managing uncertainty like arranging journal clubs for reading published guidelines and "how-to's" on how to synthesize and summarize the medical literature. In their conclusions, evidence-based medicine served less to minimize the experience of uncertainty and became simply another source of uncertainty. Ever multiplying practice guidelines and evidence-based research was simply added to the vast sea of medical knowledge that no individual physician could hope to master. The conclusion from their account is that while the detail or "local color" of medical uncertainty has changed, its basic character has not.

However, what is missing from most of these engagements with medical uncertainty is a concern with how a particular understanding of medical uncertainty comes to be shared by clinicians-in-training. While Parsons and the scholars that followed write with descriptive specificity about how uncertainty is experienced and managed by certain physicians in specific contexts, the fact of medical uncertainty itself is often described as a dilemma of a generalized physician (or physician in training) and their encounter with clinical medicine; the character of that uncertainty seems to arise, seemingly fully formed, when expectations for diagnostic certainty clash with the uncertainty of medical knowledge both within the field and within the individual physician. However, it is not entirely clear that this characterization of medical uncertainty is inherent to the training encounter. There are many areas of uncertainty that physicians-in-training master in clinical practice. In the hub-bub of the hospital floor, one might imagine that residents might also find salient their encounters with the uncertainty of institutional regimes, of relationships with the myriad assortment of staff, or of patients' lives. Although other scholars have suggested these and other sources of uncertainty in physician practice (Fox 1957; Light 1979), there is largely silence surrounding how medical uncertainty, the uncertainty that is considered to be at the core of the physicians' sense of skill, comes to be perceived in a particular way; few scholars concerned with medical uncertainty raise the question of its construction. This taken-for-granted characterization of medical uncertainty may also have kept students of the health professions from asking, to what uses might a particular construction of uncertainty be put? Why might clinical uncertainty be constructed in one way and not another? Are the features of this encounter (such as the clinician's perception of patient expectations, what constitutes their professional knowledge, and the character of the "clash" or conflict between them), the same for any independent medical clinician?

This chapter will analyze the tools and strategies that nurse practitioners use to define and understand their own professional experience by revisiting the concept of medical uncertainty. This work seeks to understand the new phenomenon of autonomous NP practice as well as to refine our understanding of how the clinical encounter is shaped. Attention to how medical uncertainty appears within the stories and training of other providers trained for independent practice, such as nurse practitioners, will provide a shift in perspective and perhaps modify how sociologists see and apply medical uncertainty to the texture of clinical practice.

Attention to medical uncertainty is also a useful analytical lens through which we can see how skill and expertise are defined. The rise of NP independent practice within the larger field of medical care has not gone uncontested. The most vocal opponents of autonomous NP practice have been physicians, most notably through public resolutions approved by the physician organizations like the American Medical Association and the American Pediatric Association (American Academy of Pediatrics 2006; American Medical Association 2005; Committee on Pediatric Workforce 2003). Less public but no less consequential has been reticence on the part of private health insurance companies to acknowledge NPs as independent providers of care for the purposes of billing, effectively barring them from independent practice regardless of their state's regulatory environment (Hansen-Turton, Ritter, and Torgan 2008). These political and structural barriers to autonomous NP practice have been the chief concerns of nursing advocates. Two good introductions to these issues can be found within an historical consideration of nurse practitioners (Fairman 2009) and an edited volume on nurse-managed wellness centers (Hansen-Turton et al. 2009). However, equally important strategies for acquiring professional legitimacy are rhetorical and practical claims to a unique area of knowledge and practice.

Everett Hughes discussed this aspect of professional legitimacy in an essay on the occupations. Hughes observes that the legitimate mandate of any profession rests on two related claims: that it has mastered a unique body of knowledge and that it alone can perform (or, I would add, supervise) the complex set of tasks and techniques that arise from that knowledge (Hughes 1984). In making claims as independent health care providers, nurse practitioners have a practical quandary. Although nursing claims its own theoretical orientation (for example, a holistic consideration of the ill person), nursing practice also relies on medical knowledge. This overlap in knowledge is replicated at the organizational level; unlike alternative providers like chiropractors or acupuncturists, NPs based their early inroads into mainstream healthcare on claims to role interchangeability: According to most quantitative evidence, NPs can and do provide some aspects of care, such as primary care, “as well as” physicians (Lenz et al. 2004; Mundinger et al. 2000). The quandary becomes, given the pragmatic strategy of arguing for role interchangeability and their learning from the same well of knowledge as physicians, what then are the tools that NPs use to construct their own notions of unique professional expertise?

One way of discovering how a profession defines its area of expertise is to focus on how it constructs the objects of that expertise, in this case, clinical objects. There is a large and interdisciplinary literature on how medical objects come into existence. In Birth of the Clinic, Foucault charts the history of modern medical epistemology and practice, referring often to the birth of the “clinical gaze,” a gaze that breaks with the previous view of the body as belonging to an individual whose symptoms were related to their unique temperament, biography, and social location to one which recast the body as merely the site of disease processes which themselves, if seen correctly, are standardized and predictable (Foucault 1994). This remaking of the body is the process of creating the clinical object. Some scholars have focused on the monopoly of

power that allows physicians to remake the physical body in their profession's image (Freidson 1970; Starr 1984) while others have written about the various social processes through which clinical objects and clinical problems are multiplied or transformed (Conrad 2007; Zola 1972).

This paper is concerned with how individual providers learn to see clinical objects.

Anthropologist Byron Good argues that this "seeing" is not simply a result of science training (Good 1994). Good observes that time spent in the anatomy and pathophysiology labs does not just teach biological facts, but a particular hierarchy of the physical: in the exam, you may hear about symptoms from the patient or see signs on the body, but a budding physician comes to understand that they are linked to ever finer, internal, physical structures, down to the biochemical or genetic levels, which is "what's really wrong" with the patient. In the same vein, presentations about clinical cases are not just recitation of details but can be thought of as a learned genre of storytelling through which persons are constituted as patients and as sites of clinical problems. In writing about forms of medical speech as genres of storytelling, Good argues that these stories are not "merely" discursive practices, but are "speech acts," powerful ways of acting that call for further action in the form of medical intervention. In this sense, clinical narratives serve two purposes: to define the borders of appropriate clinical objects as well as the requisite behavior that should follow - the performance of professional expertise.

Professional Socialization Through Storytelling

Work on the construction of medical knowledge more generally is a broad and interdisciplinary affair. However, the literature most applicable to the knowledge related to physician practice is the work on medical discourse and its relationship to professional socialization. Although there is broader work on physician education and its role in socialization, the work on medical discourse demonstrates the importance of "professional talk"

and storytelling in understanding how professional behavior is shaped and professional norms are transmitted.

A great deal of work using conversation and discourse analysis has focused on how physicians speak during clinical encounters. This work has provided evidence that the medical encounter is a socially structured, asymmetrical system of exchange through which the dominance of medical knowledge over lay knowledge is performed (Beckman and Frankel 1984; Cicourel 1981; Mishler 1985), the internal logic of medical practice can be seen (Fisher and Stephen B. Groce 1985), and larger cultural assumptions about the moral worth of patients is displayed (Sudnow 1967). Scholarship on physicians-in-training has often focused on the informal or subcultural habits of talk that develop as a response to the practical dilemmas encountered in their role as students and by the work environments encountered in their role as residents (Becker et al. 1976; Mizrahi 1984). What is often noted from this work is how this informal talk differs from the formal, explicit norms of the profession. This informal talk is marked by “gallows humor” and often pejorative typologies of patients, which runs counter to the profession’s stated goals of a universal, rational, and beneficent orientation to patients. Analysis of informal talk is part of a significant trend in the sociology of medicine that departs from the prescriptive and normative perspectives of the 1950s, work which drew much of its evidence from what the profession said about itself or from an idealized role that the profession had in society. Later work focused our attention not on what the profession says about itself, but asked us to focus on the informal or hidden curriculum that is evidenced by what people do in particular settings. However, one of the most insightful works on the role of “doctor talk” in professional socialization is based on formal speech, the case presentation.

In her classic work, Renee Anspach analyzes case presentations delivered by interns and fellows in two neonatal intensive care units (Anspach 1988). She argues that routine and formal talk that is delivered about patients (rather than to patients) is an important vehicle of professional socialization through which “physicians learn and enact fundamental beliefs and values of the medical world,” (357). The beliefs and values that she finds are being communicated through the ritual of case presentation are depersonalization of the patient into a purely biological object, minimization of the physician’s role in decision making by viewing medical technology as the agent, and emphasizing the subjectivity and thus unreliability of patient accounts. These case presentations serve to socialize the young physician into believing that medical knowledge is objective, that different doctors should be able to observe the same thing if adequately trained, and that the patient cannot be trusted for objective knowledge of their situation. What Anspach’s work provides is a useful model and rationale for attention to the explicit and routine talk that happens during the training of health care providers. Her work demonstrates that through ritualized and formal characterization of cases, physicians-in-training learn to look at a patient and see a medical object; through attention to what those objects are constructed to be, we can see what medicine considers to be its realm of knowledge. Case presentations are an important genre of storytelling that occur along a continuum of formality depending on the setting and the audience.

Following in the footsteps of Anspach, case presentations have become a well-studied genre of medical storytelling. However, other scholars, like Good, have built on Anspach’s work and made a more general case for the role of storytelling in medical education. One of the most compelling arguments is made through Kathryn Montgomery Hunter’s ethnographic analysis of medical narratives as they appear in a teaching hospital--oral, written, formal, and informal

(Montgomery Hunter 1993). The crux of her argument is that medicine is an inherently interpretive activity in which narratives play a key role. Like Anspach, she notes that physicians-in-training all encounter the epistemological gap between the abstract, general knowledge of the sciences and the concrete, specific knowledge of the individual patient. Clinical judgment is the tool used to fill this gap, and clinical stories are the mechanism through which this skill is taught. However, Montgomery extends Anspach in noting that while many of these stories are formal and recognized as part of the curriculum (i.e., case presentations), informal stories, typically unrecognized as part of the curriculum, also serve important functions in clinical education. Montgomery notes that anecdotes form around clinical aberrations and are an important strategy in teaching clinical judgment. Anecdotes, rather than textbook cases, are more likely to explicitly communicate uncertainty through illustrating the limits of medical knowledge. These anecdotes also model clinical judgment in that they describe the moments of uncertainty where the physician has to struggle for a solution, and even in the absence of a solution, has to decide what should be done. Informal as well as formal clinical narratives play an important part in modeling professional expertise for clinicians-in-training, most visible in narrative moments of difficulty or uncertainty, and are a useful resource for developing an understanding of the contents of that expertise.

The wealth and depth of these literatures are based on empirical observations of physicians, medical students, residents, and fellows. What are the kinds of stories that circulate among nurse practitioners and NP students in a training environment? What can their stories tell us about how NPs construct medical uncertainty and the tools they use to construct professional expertise? And what might these stories tell us about the assumptions underlying our existing theories about the existential condition of medical practice?

Notes on Methodology

In January of 2009, I began attending courses with a cohort of Family Nurse Practitioner students who were completing a master's level program.⁵ The program was one of several NP specialty programs administered by a nursing school within a Northeastern city. This cohort of students consisted of 15 people at the time I began my observations. They varied widely in age, from 24 to 43. This wide range was in some cases a reflection of differences in prior experience as a bedside nurse but was in others a reflection of a career change. The cohort was mostly female; with one male student, the demographics are comparable to the gender makeup of NP programs nationally. Although there was some variation in how individual students navigated the program requirements, the spring semester of 2009 was the beginning of their second and final 12 months of study. The first 12 months had been spent entirely in the classroom, with courses focusing on science-based content like "Pathophysiology for Advance Practice Nursing," nursing theory content like "Theories for Advanced Practice Nursing of Families & Individuals," or courses on research methods.⁶

The semester I began observing marked their transition from strictly classroom instruction to a focus on that aspect of health care that was previously the domain of physicians: clinical decision making. Students spent two, eight-hour days at their clinical placements and an additional day attending two courses, back-to-back, at the nursing school. The total time spent in class varied depending on the semester; for example, a day in the spring term consisted of 6 hours while one in the summer terms consisted of 4 hours. The coursework was designed to

⁵ In October of 2004, the American Nurses Association recommended a clinical doctorate (DNP) as the minimum level of training for NPs. As of 2012, master's level training still represented the majority of programs, although many programs are in the process of phasing out their masters program and adopting doctorate programs. At the program where I did observation, there was no clinical doctorate program offered.

⁶ These course names are not the actual titles of the courses of the program where I made observations. To retain anonymity, titles were taken from similar FNP curriculums for the purposes of illustration.

augment their clinical placements both in terms of content (i.e., a course on the health of older adults at the same time as clinical time with adult patients), as well as to support the skill of clinical decision making through in-depth case presentations and discussions of case studies.

Mirroring descriptions of physician training, clinical stories made up the core of didactic expressions in the NP curriculum I observed. However, they appeared in different locations, both structurally, and in the educational trajectories of students. The structure of advanced practice nursing education differs significantly from medical education. Nurse practitioners programs are masters or doctorate level programs; all entrants have already achieved a bachelor's degree, passed the RN licensing exam, and have usually had some experience as a bedside nurse. The curriculum builds on that knowledge and experience. Although there are extensive differences in NP and MD education, too many to be explored here, one key difference is that NPs are trained for their particular specialty. Therefore, students training for primary care do most of their clinical placements in outpatient, ambulatory settings rather than in emergency departments or hospital wards. Second, they do their clinical work as individuals rather than as a cohort of residents. Their primary experience as a group happens almost exclusively within the classroom. Patient cases are presented to fellow students and clinical faculty within the classroom setting rather than in the halls of the academic hospital.

The two courses taught each semester were divided in approach: the first course was primarily didactic, formal lectures given by the school's nursing faculty as well as guest lecturers, some of whom were from the university's medical school and a few of whom worked outside the university system. The second course contained student case presentations and collaborative discussions of these and other cases. During a six-hour day, a lot of information was exchanged, much of it technical and clinical in nature. I chose to focus less on the technical

content and more on the stories being told about patients or patient care. During didactic lectures, these stories took the form of either formal, illustrative cases or informal anecdotes. In the more collaborative and discussion oriented course, I paid close attention to the case studies students presented and discussed, anecdotes that faculty added to the discussion, and “spontaneous” patient stories that the students volunteered from their clinical sites. I recorded these stories with either hand-written or typed notes during each class. As I narrowed my analytical focus, I began taking selected audio recordings. The data for this paper excludes data from the summer semester due to significant differences in the format of instruction. In the account that follows, statements or words in quotation marks were captured verbatim either through my written notes or from audio recordings. Descriptions of discussions and other statements attributed to individuals that are not in quotes are summaries constructed from field notes. All first and last names of faculty and students are pseudonyms.

Most ethnographies that take place in professional educational settings are taken up with questions of professional socialization. To some degree, this paper is concerned with NP socialization. I focused on data that was deeply related to how NP students were to understand what their particular clinical and professional role should be upon graduation. While I did not follow students in actual clinical practice, what I did capture were the explicit, classroom moments, when professional narratives were shared between teacher and student: formal case studies, ethical cases or “quandaries”, and informal sharing of clinical stories. Using Good’s terminology, I was able to capture both the sharing and co-construction of “speech acts” during formal and informal educational narratives.

Uncertainty in Diagnosis

In some semesters, the didactic courses only contained my cohort of FNPs. In other semesters, the FNPs shared lectures with other NP specialties like Critical Care and Pediatrics. However, whether the class contained 16 or 60 students, the routine of these lectures remained similar. The lecturer would arrive, prepared to deliver a multitude of PowerPoint slides on a topic like Rheumatology, rapidly followed by a second and sometimes third lecturer presenting on their respective topics. On one such day, the first lecturer was Sarah Robinson, MPH, APN-BC (Advanced Practice Nurse-Board Certified).⁷ She came to talk to us about Acute Respiratory Infections (ARI). Sarah, like many of the lecturers, was a nurse practitioner who works in clinical practice but is also a full-time lecturer at the nursing school. In her lecture, she went through slides describing the full range of acute respiratory infections, from the common cold to community-acquired pneumonia. She began with the epidemiology of these conditions as well as their public health impact. Then she began to focus on typical presentation of each condition, which is to say, what are the symptoms that drive people in the office to see you? What might the differential diagnoses be based on their presentation and history? Which conditions might the physical exam help you to rule out? Sarah spent most of the lecture on what might be considered “the typicals”: how a typical patient presents with ARI, the typical treatment, and typical “herbal” or alternative remedies that patients might already be taking. She intersperses “the typicals” with generalized, illustrative stories. She tells the class that adult patients won’t usually come in complaining of fever or a stuffy head, but with symptoms that interfere with their daily functioning, like a non-productive cough or hoarseness. She warns students that when patients come into your office, sick, hoarse, coughing, and have been sitting in your office for an hour, they will often push for tangible treatment in the form of antibiotics. But what is one of the

⁷ Due to historical as well as continuing state differences in credentialing regimes, credential designations for nurse practitioners vary.

driving forces behind the high use of antibiotics, she asks? Patient demand. Sarah stresses that it's important to educate patients about when antibiotics are useful, and when they are not. As most ARI's are viral, she explains, antibiotics are not usually helpful.

In these illustrative stories, there is little uncertainty. Their pedagogical use seems to be to place medical or statistical information within a narrative context that is clinical, i.e., not just the list of symptoms associated with a disease process but how patients arrive in your office, what patients may expect, and pointers on how to address their expectations. However, there is more to clinical practice than typical or average presentations. *In practice*, Sarah warns, *you may not see the typical presentation*. For example, older adults might simply present with confusion. Even though they are taught classic cases straight from the textbook, she tells the class, "Remember that we're treating human beings." By this statement, she means that there is always individual variation. In community-acquired pneumonia, she continues, sometimes the films (from x-rays) will be clear (no sign of illness); a normal lung exam does not rule out pneumonia. On her final slide of the section, Sarah had printed, in large, bold font: "No single finding is very sensitive," underscoring the inherent uncertainty in medical diagnosis.

In my observations, I heard similar examples, examples of what might be considered "classic" medical uncertainty, when the textbook cases don't match what one sees in practice. On a different day, during a lecture on the presentation and treatment of Depression, the lecturer, Rachel Hansen, CRNP (Certified Registered Nurse Practitioner), offered a sobering example of uncertainty. *Whenever I give a lecture*, Rachel began, *I always talk to the docs at my practice to see what they have to say*. Dr. Young had recounted a situation that had happened to him 3 times in the past 11 years. *Someone comes in*, he told her, *presenting with depression*. *In a few short months, they're dead from cancer*. Depression, the story impresses, might not just be depression.

The uncertainty lies in the difficulty in knowing the difference. Although students are tasked with memorizing the classic signs and symptoms of various conditions, students were often impressed with stories of atypical presentations; stories where what they should expect to see will stand in stark contrast to what they've read. The moral of these stories is that they must never forget that human variation leads to uncertainty of diagnosis in clinical practice.

Uncertainty in Treatment

Stories of uncertainty regarding making a correct diagnosis would appear to have a similar function in nurse practitioner education as it does in physician education. However, diagnostic uncertainty was not the most prominent type of uncertainty I encountered. Rather, the most often discussed instances of uncertainty were in discussions of how to deliver appropriate treatment to patients. Stories where students and faculty struggled over what was the best course of action for a patient were most likely to occur during either formal case presentations given by students or during less formal case discussions. For the formal case presentations, the students took turns presenting an extended case through a PowerPoint presentation. The presentations were based on formal, written cases chosen by the faculty. The cases the students received were typically $\frac{3}{4}$ of a page, single-spaced. They had an hour to make their presentation, including questions and discussion. Unlike descriptions of residents learning how to do case presentations through peer learning and trial and error with attending physicians, these presentations were highly guided. There were a series of questions and topics that each presenter was required to discuss. Moreover, to ensure that the presenter prepared the correct material for the edification of her peers, each presenter had to verify that they had come up with the "correct diagnosis" with faculty prior to their presentation.

Students took turns making presentations. On one such day, it was Elaine's turn, her first presentation of the semester. Elaine's case was Chuck. "Chuck," reads Elaine, "is a 35 year old white male." Chuck, we learn, is currently using heroin, although he had previously been clean for 5 years. He's currently staying at a homeless shelter. Today, we are to imagine that he has come into Elaine's office complaining of weight loss and sweating. Elaine goes through the faculty provided questions that guide the case presentation. What is significant about Chuck's history? What else about his history do we want to know? Which bodily systems would we include as part of the exam? What's missing from the physical exam findings as written in the case? Elaine goes through Chuck's History of Present Illness. She goes through a list of differential diagnoses. Given his presentation, which differentials can we rule out?

These cases are not intended to publicly test the presenter's ability to get to the right answer; Elaine has already had her diagnosis approved by the faculty. However, the rest of the class, although less certain than Elaine, has few doubts about the probable diagnosis. The assigned textbook reading for this day was on acute upper respiratory infections. Even with limited clinical knowledge, I, the sociologist, suspected that Chuck had active TB, thanks to Sarah, the guest lecturer, who had finished her lecture on acute upper respiratory infections not 30 minutes prior. The class perfunctorily arrived at a diagnosis of active TB, agreeing on an order for a chest x-ray to confirm the diagnosis. Once the diagnosis of TB was agreed upon, the required medical action seemed clear. Elaine takes us through the evidence-based guidelines for TB treatment, step by step. She lists the sources she used for her treatment decisions. Although she warns us that the treatment for TB changes rapidly because of resistance, she also assures us that the published guidelines stipulate that providers should contact their local health department to make sure their prescribed treatment is up to date.

The case seems straightforward and Elaine prepares to finish up her presentation. But one of the faculty members, Julia Cross, interrupts her. “Excuse me, Elaine. Before you go on, I’m wondering if we can talk about what to do for Chuck right now.” Chuck, Julia explains, is not a simple case of TB. He’s currently using heroin and lives in a shelter. Given this situation, what would you do? Elaine tries to problem solve. *The health department*, offers Elaine? She explains that when she was preparing the case, she called the county health department to ask what their active TB protocol was. In that phone conversation, they informed her that in cases of active TB, they not only investigate, they also coordinate treatment, including paying for it if necessary. However, for Julia, the problem is not solved. She turns to the rest of the class and reiterates her concerns. *Chuck is actively using. How likely do you think it is that Chuck will come back, every day, for the directly observed therapy necessary? Chuck’s habit makes him not very reliable. He is also staying at a homeless shelter. Do you let him go back to a shelter with active TB?* Another student steps in to problem solve; *perhaps, you should send Chuck to the hospital?* Julia answers the question with a multitude of her own. *So, we have Chuck admitted for weeks while he takes the medication? Do you think someone who needs to use heroin is going to willingly stay in the hospital? How likely is it that he will even go? And do you think the hospital will admit him for that long with no insurance?* Julia works in a local emergency department. She speaks, we are to assume, from a wealth of relevant experience. Despite the litany of questions, neither Julia nor the other faculty present offered any answers. “This is not a cut and dried situation,” Julia concludes. No one is certain what to do about Chuck.

Not every case presentation raised such intractable problems. On a different day, it was Jan’s turn to present. Her case was Martin. Martin is a 54 year old, African-American male.

Given his presentation and history, she concludes that Martin has hypertension. To treat his hypertension, Jan would write him a prescription for a calcium blocker, considered the best first line treatment. The fictitious case elaborates that on follow-up, his blood pressure seems to be well controlled. But two years later, we are told, Martin arrives back in Jan's office. His blood pressure has gone up. From a conversation with Martin, Jan learns that he has lost his job, lost his company-sponsored health insurance, and has consequently stopped taking his medication due to the cost. What should we do? Jan suggests we switch his medication to something cheaper. She shows a slide picturing a flyer from the Wal-Mart \$4.00 formulary. (The Wal-Mart formulary made regular appearances in PowerPoint slides and in handouts.) Calcium blockers were not listed on the formulary, but generic diuretics, which are still commonly used for hypertension, are listed. There was some discussion of the ethics of prescribing a potentially less effective drug for Martin, i.e., making treatment decisions based on cost rather than clinical evidence. One student suggested trying to find a drug assistance program for which Martin might qualify. In this case, either choice was plausible. Like Chuck, Martin's case presented the students with uncertainty, but unlike Chuck, there were seemingly more options through which it could be resolved.

The cases of Chuck and Martin were clinically unique, but they raised similar issues that abounded in the case presentations I observed: patients who had lost their health insurance, who presented with comorbid substance abuse issues, or who were immigrants who may present with cultural or spiritual differences that present challenges to effective communication. What I found notable in such cases was the *lack* of a purely medical uncertainty. Just as in the cases of Chuck and Martin, the students would cite the specific published guidelines or online resources they used to guide their treatment; it was an explicit aspect of completing the assignment. In

Chuck's case, Elaine cited the Centers for Disease Control's guideline for TB. In Jan's case, she cited the JNC-7 guidelines. Many of these guides are downloadable to Blackberry's or iPhones. I occasionally saw students look up a guideline on their smartphones during class in order to resolve a treatment question that arose in class. The medical knowledge NPs are asked to know is indeed vast, but it is potentially knowable, or at least, accessible. The uncertainty of these cases was not about TB or hypertension. In these cases, we do see evidence of Foucault's standardized and predictable disease processes. But there were still sources of clinically relevant uncertainty; in many cases, the source of clinical difficulty was contained in the unpredictable, un-standardized, situations of patients.

In the literature on physician education and medical uncertainty, interns and residents are also described as encountering the uncertainty of "the social" of medical practice. In Fox's work *Training for Uncertainty*, she describes a case conference where there is an unresolved debate on how inclusive medical care should be. One student quoted in this work asked "is it or isn't it part of the doctor's job to be concerned with such things as where his patients buy their food?" (239). However, in later work, there is a growing consensus that part of what it means to learn to doctor is to learn to see patients as purely biological objects. Anspach finds this in her study of the language of case presentations, that the formal language used strives to "depersonalize" the patient. What is notable about the case presentations I observed among NP students is that the social context of patients is not so much "encountered" and processed; rather it is consciously included within highly stylized, pedagogically oriented cases.

Skill in the Face of Uncertainty

Neither stories of uncertainty in diagnosis nor stories of uncertainty in treatment are recounted purely for narrative enjoyment. These stories often contain morals and identify the

location of professional action. With enough time and study, anyone can memorize guidelines (or with enough dexterity, anyone can look them up in a pinch). But in the exam room, what ameliorates both types of uncertainty is clinical judgment. How is clinical judgment performed in the stories that faculty tell students?

Seeing the Whole Person

It was toward the end of class on a Wednesday evening. We had already sat through three lectures, one on Cholesterol, one on Women's Health and Menopause, another on Osteoporosis. Then we had sat through a student case presentation that had run long, a little over an hour. We had just had a short break and were reassembling to discuss the final case before the end of the day. Perhaps because the energy in the room was a little low, or perhaps the case reminded Rachel, the instructor, of something; but for whatever reason, instead of moving directly onto the case discussion, Rachel asked the class if they had anything they wanted to share from their clinical placements. None were forthcoming, so Rachel, as she often did, shared a story of her own.

Rachel began to describe a woman who came into her office, "for something small, like a cold or something." They started talking and the woman shared with Rachel that she had been experiencing angina, a recurrent pain in her chest. The woman had gone to a local hospital to see her parent's cardiologist, the one who had treated both her parents for MIs (heart attacks). Rachel emphasized "both parents for MIs" by raising her voice slightly and opening her eyes a little wider. The signal was unambiguous: this was important to Rachel, and should be important to us. But it seemingly wasn't important to the cardiologist. According to the patient, he ordered a stress test. Normal. *Based on that test, he told her she was crazy, it was all in her head. That she should "go home and get a life."* The woman, still experiencing angina, paid out of her own

pocket to get her heart scanned. All normal. The woman left her office. But a few days later, Rachel got a call from a crossing guard because this woman was having chest pains. Rachel told her to go to the Emergency Department. Rachel then called the ED and told them to “please, please cath her,” a diagnostic procedure that images the heart and blood vessels. Rachel explains that she had a good relationship with the physicians at the ED; they knew her and trusted her judgment. “We had a rapport,” she recounted. After catheterization, they found that one of the woman’s arteries was blocked by 90%. Rachel didn’t know why the stress test was normal, or even why the heart scan was normal, but she located the error within a narrowness of vision. The doctors, Rachel explained, were just looking at the tests and not the whole picture. They weren’t looking at the whole person and they weren’t listening to the patient. “With her family history?” Rachel asked incredulously? “Heart doctors look at the heart, lung doctors look at the lungs, but the job of the nurse practitioner is to look at the whole person.”

There are many ways in which this story could have been told. Rachel could have told this as another encounter with medical uncertainty; by all the first line tests used to diagnose heart disease, this patient’s condition was normal and yet, her condition defied the tests. This story could also be a story that highlighted Rachel’s clinical intuition; clinicians of all stripes share stories of the time they or a colleague “had a hunch” that there was a malignant tumor or an impending stroke. But what Rachel emphasized for the class was less her individual intuition or uncertainty in diagnosis and more about her professional approach as a nurse practitioner. She listened to the patient instead of telling her to “go home and get a life.” She paid attention to “the whole person” rather than basing her judgment exclusively on diagnostic tests. In many of the stories I heard, medical uncertainty in diagnosis can be overcome through ever more careful attention to the patient; to their individual and family history, to the patients’ own intuitions, and

to their life situation. Doctors may have their expertise--an expertise that I never witnessed NP faculty or students denigrate or discount--but these nurse practitioner students were learning that they had their own unique domain of skill. More importantly, this skill of paying attention to patients is not simply about providing comfort or a listening ear to patients, but in the case recounted above, this “paying attention” was a skill that was talked about as having real, clinical consequences.

The View from the Patient

In the previous case, listening to the patient’s concern was an intrinsic part of “seeing the whole person.” The literature on physician training tells us that while medicine considers the patient’s description of their symptoms to be irreplaceable in clinical diagnosis, the physician is not trying to understand the patients understanding of their illness, but is trying to divine the “true” disease. Nurse practitioners, using medical knowledge, are also charged with diagnosing a disease or condition. But I also observed a countervailing tendency to understand the “view from the patient.” Rose Jordan, MSN, CRNP, gave a lecture on hypertension. She began with the epidemiology. Hypertension, she told us, is a common condition in the US; despite effective treatment, there are a lot of barriers to good control. After screening, patient education is one of the most important barriers. *Sometimes, opined Rose, we think we’re doing a good job, but things just aren’t getting communicated.* Rose begins to describe a case, an example where things didn’t get communicated.

A patient comes in to see Rose for a visit. The patient is an 80-year-old woman. She comes into the visit with her daughter, who is 60. After taking a history and performing a physical exam, Rose made a diagnosis of hypertension. Rose described to the class how she carefully explained to the patient what hypertension means. She writes a prescription. She tells

her to take 1 pill a day, to get blood work done within a week, and then to come back and see her in a month. “I explained it to her. I wrote it *all* down.” Well, when the patient comes back in a month, her blood pressure hasn’t moved. Rose asks the patient if she’s been taking the medication she prescribed. *I took it for 3 days, and then I stopped. Isn’t that what you’re supposed to do?* Her daughter turns to Rose and asks, *isn’t this one of those pills you take for 5-7 days?* Rose tells the class that she thought she was being clear. She wrote everything down; there were 2 sets of ears. But neither the mother nor her daughter understood. Because they didn’t understand that hypertension was a chronic disease. “I didn’t stress the chronic nature of the disease.”

The uncertainty, the difficulty of this case was not the diagnosis or treatment of hypertension, it was contained in the patient. Patient education is part of the toolkit of all primary care providers, but the skill or lack of skill of Rose, the NP, was in her ability to foresee and adequately cope with the uncertainty presented by how a patient understood her words. This is a story not of success, but of failure. The implication was that Rose should have been able to understand the situation from the patient’s point of view. If Rose had began from her patient’s own view of illness as always acute, she might have been able to more effectively communicate her recommendations. *Patients*, Rose concludes, *won’t always hear what we think we’re saying. Patients don’t always understand what we think they know.* The skill of the NP is defined, in part, by her ability to manage this uncertainty through, in part, coming to some understanding of the patients’ point of view.

Relationship as Skill

In many of the clinical stories told by faculty or presented by students, patients are a never-ending source of uncertainty. However, one of the primary strategies used to manage this

uncertainty was *knowing your patient*. Family NPs like family practice physicians have an ideal of working within a consistent practice with the same panel of patients. This ideal of “relationship” figured prominently in the stories I observed. Returning to the lecture on acute respiratory infections, Sarah discussed treatment options for community-acquired pneumonia. One decision that needs to be made is whether to treat patients at home or in the hospital. “We’re moving away from pure ‘gut’ decision making” about where to treat. She explains that they’re trying to be more systematic in how they think through the parameters that might make a difference in patient outcomes. One way of making this decision is to use an online severity index calculator. The tool is designed to take the guesswork out of this particular treatment decision. Sarah opens a web browser and walks them through an example of the online tool.

However, she tells the class, you also need to evaluate the context of the patient, and she begins to tell a story. Sarah had a patient whom she had been seeing for years. The woman was 78 years old and she comes into Sarah’s office with pneumonia. According to the guidelines, the woman should be treated in the hospital by age alone. But, Sarah says, she knew the patient and the patient did not want to go to the hospital. The woman had a cat and didn’t want to leave the cat alone. So Sarah used her judgment and decided to treat her at home. They kept in daily phone contact so that Sarah could know how she was doing. Sarah also knew that the patient had a support network close by that could help her with adherence to her medication and who could keep tabs on her mental functioning. A student raises her hand to ask, “what if you don’t know her and she didn’t want to go to the hospital?” Sarah responds, “Well, nobody wants to go to the hospital. But if she had just walked into my office and I hadn’t seen her before? I would have sent her to the hospital.”

In stories like these, knowing the patient is one strategy that the practitioner can use to manage uncertainty. More importantly, knowing the patient is often a prerequisite for the performance of skill. In Sarah's story above, a computer algorithm gives the right treatment decision for a generic patient. If the woman had not been a known patient, Sarah and the algorithm would have been in agreement. In such cases, provider discretion is limited. But with a known patient, with a history and a relationship, Sarah was able to practice clinical judgment and perform expertise through the skill of knowing her patient.

In the following hypothetical case, students were asked specifically to think about the ethical dilemmas presented by a patient and to be prepared to discuss them. In the discussion that followed, the relationship with the patient became one of the pivotal points of decision-making. *Steve is a 28-year-old Caucasian male. He came into your office complaining of chronic back pain. He had been in a car accident 6 years ago, but the pain never went away. He came in asking for a prescription for Percocet, a combination of a narcotic and an over-the-counter pain reliever. He reports that he's allergic to both Tylenol and Ultram, two non-narcotic alternatives. He tells you that his last doctor refused to give him any Percocet but he needs it for the pain. What do you do?*

Is Steve a drug-seeking patient? Rose begins the discussion by saying "There are a lot of red flags in the case." Amy, a dark haired student in her late 30's, feels that this is a "sticky situation." Steve is undoubtedly in pain, so sending him away without doing anything for him may not be the best thing. Or, Amy adds, *he may be depressed*. Or perhaps he is addicted to Percocet. But drug addiction is a medical condition too. What's he supposed to do, detox at home over the weekend? For Laura, a no-nonsense ED nurse, there is nothing "sticky" about the situation. In her opinion, it's clearly not appropriate to give someone Percocet whom she's never

seen before. A third student, Jason, believes that because this is Steve's first visit, it's probably not the time to bring up drug addiction. He'd never come back. Jason would give Steve a script for 10 pills and make a follow-up appointment to see if they could come up with a plan for treating his pain differently. One of the other faculty members, asks, is Percocet indicated for this kind of pain? For back pain? There is agreement that no, according to the guidelines, Percocet is not indicated. *But, she adds, Jason is right. This is a "dilemma of the first visit."* "How do you go forward with someone where you don't have a relationship but would like to build one?"

In this case, the relationship between the provider and patient became the crucial point upon which the discussion hinged. Not knowing Steve presented a particular kind of dilemma. Steve presented a complex set of medical and social needs that were difficult to address in one visit. The appropriate action for the hypothetical provider is uncertain. Published guidelines provide guidance for the treatment of back pain; however, without a relationship, how to go forward in addressing Steve's needs remains unclear. The primary strategy for managing this uncertainty revolved around building on the possibility of future relationship. The skill of the hypothetical nurse practitioner would be gauged by her ability to get Steve to return for a follow-up visit.

Constructing Uncertainty, Constructing Skill

The patient may be essential in assisting the physician to decipher the problem through talk, but the object of the physician's expertise is contained within the body. Whether true or not in any particular case, this is the ideal of medical practice. Through my fieldwork, I find that while nurse practitioners share the same exam rooms and see the same patients as a physician might, an NP's patients were constructed to be different kind of clinical objects. For example, in

the case presentation about a patient who presents with the symptoms of active TB, the instructors and the class went through the differential diagnosis and treatment guidelines. However, a great deal of conversation occurred about the social situation of the patient who was homeless and currently living in a shelter. What do you, as a clinician, do with a patient who has active TB and who lives in a group living situation? The conversation was not simply an example of professors attempting to start a conversation of “professional ethics” but was a conversation grounded in questions of appropriate treatment that was replicated in other clinical narratives. How do you provide treatment to individuals living in difficult situations? How do you create a relationship with a patient so that they return for ongoing care? Nursing objects were not contained inside the individual body, but had a much larger geography. Through clinical stories, the FNP students were being taught to see qualitatively different kinds of bodies and different kinds of patient complaints.

These stories of uncertainty also provided an important space for the construction of skill. The larger tradition of nursing practice claims a holistic view of the patient. However, bedside nursing performs its role within a separate sphere from physicians. The intensive care nurse and the physicians that staff the ICU do not normally share roles; regardless of what each may or may not know about the others’ practices, they are organizationally dissimilar. The practical quandary for nurse practitioners as a profession is that, at times, they and physicians *do* share roles. What might having a holistic orientation mean for practitioners who share the same time constraints for the patient visit as physicians, who are asked to use their own clinical judgment to make diagnoses, and who often dictate treatment autonomously, typically alongside physicians? This paper raises questions about what such a clinical orientation might mean for actual practice. There is one ethnographic study that suggests that NPs may practice differently (Fisher 1995),

and quantitative work that suggests, based on differences in patient satisfaction, that NPs may have different relationships with their patients (Roblin et al. 2004). However, what this paper adds is an empirical rendering of what a holistic orientation might look like in the professional stories that NPs tell about their practice. In the nurse practitioner's telling, such an orientation includes attention to the life context of the patient. When complexity and uncertainty occur, it is due to the complexity and uncertainty of the patient's situation. Within these stories, when the NP encounters the patient in the exam room, their existential dilemma is less about the possibility of falling short as an expert of medical knowledge and more about falling short as an expert of the patient's life.

A major finding of this chapter is that this view of what constituted NP clinical objects had significant impacts on what NP expertise and skill consisted. In the ideal of NP practice found in these professional clinical narratives, there is certainly medical knowledge to be mastered. It was experienced as voluminous and never-ending, much like the experience of medical students as described by Becker and colleagues. However, I found a "smoothing over" of a purely medical uncertainty. In many faculty lectures or student presented cases, "the literature" and "the evidence" figured prominently. The diagnostic and treatment protocols of conditions encountered in primary care were presented as largely known within the literature and hence, knowable by the individual practitioner. I found that the most common source of uncertainty was not the limitations of medical knowledge or of what an individual student can learn, but the limit on what one could know about the patient. The clinical quandaries were about managing treatment regimes in difficult situations: What do you do with a TB patient who is homeless? What do you do for a patient who has lost their health insurance and can't afford the medication you originally prescribed? Solving those problems required the enactment of

skills such as knowing the patient and understanding the situation from the patient's point of view. Through attention to uncertainty, I found that the objects of NP practice and the conception of NP skill differ in significant ways from what we know about physicians. For NPs-in-training, it was not the biological body that was cryptic and difficult to decipher, it was the patient's social life.

Conclusion

This paper has a core concern with developing an understanding of how nurse practitioners may be constructing a professional identity, not as assistants or skilled "stand-ins" for physician practices, but as autonomous clinicians with their own practices. This work has demonstrated that claims to legitimacy are not only addressed *outward* to evaluating audiences, but must also focus *inward* to evaluating selves. As a new occupational category, nurse practitioners are not simply tasked with fighting political battles to be able to practice in ever more autonomous ways, they must also create an internal understanding of how they understand their professional role. Their stories were engaged in crafting skills of difference; NP skill lay not in her ability to see patients as a physician might, but in her ability to see them quite differently. The communication of that difference was made visible through different constructions of uncertainty.

The implication of these findings go beyond the particular professional concerns of the nurse practitioner; these findings help us to more clearly see the assumptions embedded in our current notions of clinical uncertainty. It was Anselm Strauss who eloquently argued that our tendency to see professional homogeneity among physicians blinded us to the tremendous amount of variation between specialties. He observed that even within a specific specialty like radiology, the practice demands of different settings meant that even the view of two radiologists

might differ quite radically (Strauss 1975). Yet, medical sociology continues to invoke and empirically research a singular idea of “medical practice.” The tendency of the literature on medical professionalization to focus on residents--when practice is the most homogenous--has further blinded us to variation in the conditions that shape the existential realities of different medical practitioners. In moving outside medicine altogether and looking at a different autonomous clinician of mainstream Western medicine, we can more clearly see the ways in which narrative tools of practice are shaped by particular practice realities as well as by claims to a unique and convincing area of expertise.

Nurse practitioners have been advocated as one solution to the growing need for primary care providers. However this policy solution is based on the assumption that NPs are simply stand-ins for physicians. While it is true that nursing has used the argument of interchangeability to great political effect, it is useful to interrogate that assumption. Sociologists might usefully interrogate this assumption to critically evaluate current clinical practices and to differently understand how the inclusion of nurse practitioners might alter patient care.

Chapter 4 - Nurse Practitioner Careers

In most of this dissertation, I present data that focuses intently on NPs actions rhetorically, narratively, and in their practices. However, NPs identities also influence the occupation. Most NPs are women. Although an increasing number of men are joining the ranks, data on nurse practitioner training suggests that it will remain a female dominated profession for the foreseeable future.

Understanding the significance of female domination of the NP profession is more than just a question of more women choosing some work over some other; the context in which some choices get made over others influences this significance. I am interested, not only in the ways in which nursing technologies of care come to be gendered, but by how NP biographies intersect with specific gendered and classed careers. What is it about the structure of nursing education and labor markets that make being a nurse practitioner seem more possible for some people than others? This chapter will use interviews from NPs-in-training, NPs, and bedside nurses in order to understand who NPs are in a broader system of occupational and social stratification.

Gender Segregation and Work

Scholars of gender and stratification have long grappled with the persistence of sex segregation at work. In human societies, gender is one of the most fundamental and enduring bases for division of labor. In preindustrial Europe, although both men and women did the work of harvesting together, most of the labor was divided by gender, with women weeding and raising domestic animals and men doing the plowing and threshing (Padavic and Reskin 2002). A gendered division of labor persisted after the Industrial Revolution, with men performing paid labor in factories and women performing unpaid labor in the home. Although this division of

labor often remained out of reach for poor women, this prevailing gender ideology still affected working women through constraints on what kind of work they could do, as well as consistently low wages for the work they did do. The distinction between middle class women's exclusively unpaid work and poorer women's low-paid work further highlights the relationship of class to gender stratification.

Women not only did different kind of work, they did differently valued work. While non-industrial societies often accorded less social value to women's labor than men's, the rise of capitalism literally put a price on that difference. Marxist scholars have argued that industrialization heightened the value of men's work because they both produced goods and possessed the money to buy them. Under this new system of evaluation, women, working inside the home and decreasingly involved in domestic production, were newly understood as producing nothing of value (Padavic and Reskin, pg 28). Poor women, who had to work outside the home, primarily sold domestic work—which was unpaid when performed for one's family and poorly paid when completed for another.

In contemporary, industrialized societies, women from all social strata have joined men in the paid labor market. However, although men and women now work for pay in roughly equal numbers, gender segregation is alive and well; by and large men and women do not go to the same workplaces, nor do they do the same jobs. In the U.S, almost half of all female employees work in occupations that are more than 75% female. The 2012 Current Population Survey shows that women make up 91% of all nurses, 95% of all childcare workers, 75% of all K-12 teachers, and 79% of all data entry keyboard operators.

Gender segregation in employment has consequences. Female dominated occupations pay less than male dominated ones. However, even when the job itself is taken into account,

women make less than men, suggesting that pay inequity is not just a reflection of the value of the work, but reflects the fundamental devaluing of women's work. Historical case studies reflect the same devaluation; when women came to predominate as veterinarians, clerical workers, and teachers, the pay and status afforded these positions shifted downward. Sociologists of the professions have noted that feminization often accompanies deprofessionalization. Female dominated occupations pay less in part because, quite simply, women do them (Kimmel, Michael 2013).

However, this gendered attribution of value is not simply accorded to actual men and women, but to our ideas about the work itself. A burgeoning literature on carework—work carried out through sustained personal interaction and motivated by another's welfare (Nancy Folbre 1995)—tries to understand why society continues to devalue caring labor, although such labor is fundamental to its functioning. Examples of careworkers include primary school teachers, health care aides, nurses, and social workers—the same occupations in which women make up the predominate population.

Definitions notwithstanding, our cultural understanding of what constitutes carework encompasses its association with female domains, both because unpaid female family members have traditionally performed carework and because it uses skills and perspectives aligned with women in the popular imagination (Paula England 2005). Gendered features of interpersonal interaction, relationship, and particular forms of emotional labor characterize carework apart from the gender of those who perform it. And these workers pay a price. In their work estimating the pay penalty of care workers, England, Budig, and Folbre found that in almost every case, workers involved in nurturant care work receive lower wages, all other characteristics of the job and the worker held constant (2002).

Gender scholars have charged us to recognize that societies produce gender, not only through ideas of normative behavior, but through their institutions. The educational institutions that create workers and the organizations that hire them are intricately involved in reproducing the normative grounds for everyday stratification through sorting and evaluating. Workplaces are social institutions that function like factories, producing and reproducing gender. These institutions create gendered normative standards, express a gendered institutional logic, and reproduce gender inequality in a way that has broad repercussions for society (Risman 2004).

Nursing generally and nurse practitioners specifically exist within the context of the larger reality of a gendered division of paid labor. Nursing has not remained predominately female simply because individual women prefer this kind of work more than individual men. Cynthia Fuchs Epstein would call this a “deceptive distinction.” The deception is when observed gender differences in behavior or outcome are assumed to be caused by sex-linked differences (Epstein 1990). Scholars like Epstein challenge us to understand these choices as shaped by a set of structural forces involved in larger systems of stratification. Women choose nursing for individual reasons, to be sure, but they make choices within a set of social constraints.

Understanding these social constraints is important. Policy makers thinking through the scarcity of primary care providers typically use a model of individual choice to understand the problem. They reason that physicians must be rationally choosing specialization because of the balance of incentives and incentives. They cite data noting that primary care physicians are paid less, are less respected by their physician peers, and unlike specialists, have to accept being on call. Others argue that these external incentives have shaped an internal culture. Medical schools have a culture that pressures students to be “more ambitious” than to settle for primary care specialties. Policy makers and advocates call for higher pay for primary care to change

incentives, but as long as specialists require more training than primary care providers, they will probably be better compensated. However, economic incentives alone do not determine individual job choice or larger systems of job sorting.

These discussions fail to consider the ways in which class and gender locations determine which individuals who find themselves in jobs dedicated to the daily routine of caring for people. Nurse practitioners and physicians have very different careers. They are not simply different products at the end of distinct training regimes; they faced different choices and different constraints prior to their training, during their training, and in their longer career paths.

So who are nurse practitioners? Why do they choose to become nurse practitioners? What path did their choices create? And what did these choices look like? This chapter uses interviews from NPs-in-training at my nursing school site as well as interviews from nurse practitioners at the PACE center. At the nursing school, I collected ten interviews of nurse-practitioner students. At the Center, I interviewed five NPs. Three of these I observed in the clinic as well, one was a part-time NP, and one exclusively did home visits for homebound patients. I also interviewed three other NPs who did not serve in a primary care capacity. This chapter captures the career trajectories of 18 NPs and NP students. They represent a wide spectrum in age, pathways, and ambitions. This chapter synthesizes the different ways in which common experiences bind these individual stories together.

NP Careers/Nursing Careers: Many Roads

How does one become a nurse practitioner? As explained in Chapter 3, every nurse practitioner begins as a nurse. With a bachelor's degree and registered nursing license, a prospective nurse practitioner typically spends two years earning a master's degree before she sits for an NP licensing exam. This linear-sounding chain of events masks the fact that

becoming a nurse practitioner was the culmination of a long and varied history for most of my respondents.

Maura, for example, said that becoming a nurse practitioner was something “I stumbled into. I really did.” Maura began her career in health care in 1972. With only a high school diploma, she took a job as a hospital unit clerk at Franklin Roosevelt Hospital in a suburban, east coast community. She took courses at a community college close to home and earned an associate’s degree in nursing—the most common educational route for nurses in the 1970s. Two years later she had her RN license and stayed on at Franklin Hospital as a nurse. The profession was pushing towards requiring a bachelor’s degree for entry to practice. Like many of her colleagues, Maura pursued a bachelor’s degree to become a different nurse, not a better one. After two years as a bedside nurse, “I knew that the last thing I wanted to do was stay working on the floor.”

Maura continued to work full time, while she went to school. Earning a few credits at a time, she finished her bachelor’s degree in nursing in 1982 at the age of 31. At this point, Maura “started applying for everything that came down the pike, management wise.” She eventually landed a position in staff development at Kennedy Hospital, coordinating the Hospital’s internal nursing training and continuing education programs. As she intended, her bachelor’s degree took her off the floor. Maura enjoyed her new position; she also credits it with introducing her to nursing education, something she would continue. Still, she wanted to “keep her hand in clinically,” so, in addition to her full-time position, she joined the nursing pool at Kennedy, working a few shifts a month. She was satisfied with this position for about four years, but then she started to think about pursuing a master’s degree in order to do something different. Still working, she began to take classes, part time to become a clinical specialist.

Clinical specialists provide disease management to a hospital's population of patients. Maura wanted to focus on diabetes management in the hospital. "I was at [the university taking classes] probably six months. I was in class and somebody said, you must be one of those nurse practitioner students. And I said, 'a what?'" Maura didn't even know such a thing existed. "I had not even been exposed. We had [no nurse practitioners] in our hospital. I'd basically grown up there....as a unit clerk, got my associate's, became a staff nurse, got my bachelor's, came to staff development. I was there for a total of 13 years. So that was all I knew." Maura researched the nurse practitioner profession and decided to change course.

I thought, well, this will make me more marketable in the long run. ...While [all nurses with master's degrees] are called advanced practice nurses, clinical specialists cannot prescribe. I thought well, becoming an NP, I'll have another license. I can teach because [being an NP] doesn't preclude you from teaching. But I could also hang out my shingle and be independent. I could work with a doctor. I could work in a variety of settings.

And so it was dumb luck. Best dumb luck I ever had.

Doing what she had always done, Maura completed her master's degree while working full-time in staff development and taking a monthly shift in the nursing pool. It took her 3.5 years, but she graduated in 1990.

Maura took her first nursing job in 1974. Sixteen years later, she took her first job as a nurse practitioner. Maura's slow accrual of educational credentials reflected changes in nursing as much as Maura's personal circumstances. Nursing has changed along with Maura. Although a movement toward bachelor's degrees began for nurses in the 1970s, a clear majority of practicing nurses did not have a four-year university degree. Similarly, although nurse practitioners existed in the 1970s, they were far from commonplace.

Maura's narrative didn't include "forced" credentialing. Although the American Nurses Association continues to make pronouncements about desired credentials, nursing shortages and hospital need reduce the impact of these pronouncements. In 2012, only half of all practicing nurses were bachelor's degree prepared. Some have had no college experience at all; for decades, hospitals trained cohorts of "diploma nurses" through a vocational rather than a university orientation. In all likelihood, even if Maura had stopped at her associate's degree, she would still be employable as a bedside nurse, even today.

For Maura, education wasn't something she needed to do in order to make nursing possible, nursing was something that made education possible. For Maura and many others like her, nursing provided an accessible path for the higher education necessary for a stable, middle class career. Nursing was as much a means as the goal. Maura's nursing career, encompassed a series of incremental aspirations. She got her bachelor's degree to move off the floor and into administration; she became a nurse practitioner to be "more marketable" and get "another license" to work in an expanded variety of settings. For other respondents, becoming a nurse practitioner was the culmination of a dream—not the dream of being a nurse, but the dream of higher education.

Hana always aspired to higher education. "Ever since I was a little girl, I dreamed of going to a top ten, Ivy League School. So it's sort of a dream come true, because I come from an underprivileged background." Hana began with big dreams, but, as she tells it, she had to alter her plan, because she had her daughter. As a single mother, working was a higher priority than schooling. Like Maura, Hana's first step on the educational ladder was community college, where she received training as a licensed practical nurse (LPN). Licensed practical nurses provide basic nursing care, but cannot dispense medication and are supervised by registered

nurses. With a credential that allowed her to work, Hana slowly moved her way up the rungs, first obtaining her RN license, and then her BSN—working full time each step of the way. The road from LPN to BSN was 11 years. During that period, Hana married and had a second child. While managing a family, Hana maintained a stable, ten-year career in critical care nursing. Then, at the age of 41, she decided to revisit those earlier dreams and began applying to graduate school. Twenty-one years after her first certification as an LPN, Hana was almost finished with her first graduate degree. “I call myself a kind of Cinderella story. I come up from community college all the way up to the Ivy League.”

Nursing provided opportunities otherwise unavailable for many women on the lower end of the economic stratum. Historically, nursing was an aspirational occupation for women needing respectable work at a time when being middle class meant not working. For many nurses practicing today, nursing was an occupation they could reach because the training was affordable and accessible. Florence Nightingale’s first nursing programs were hospital based training programs. This vocational model of nursing education remained the most salient until well into the 1970s. In my group of 18, the oldest, Sarah, began her nursing career as a diploma nurse. She graduated from high school in 1957. She recalls that her family never talked about college. “We weren’t poor, but we didn’t have money for things like that.” Her mother cashed in a life insurance policy for \$100; this was all Sarah needed to begin training for the \ career that would allow her to firmly reside in the middle class for decades to come. Nursing has transformed from a vocational career to a professional one during Sarah’s career, and she now has a master’s degree.

Although nursing has been caught up in the credentials-arms-race like many other modern occupations, a vocational ethic continues to inform the profession’s structure. Although

not everyone espouses this belief, it is still a salient belief that any nurse can be trained to do any nursing activity. However empowering this belief may be for some, it is a belief that mitigates the power of seniority. Income data on nurses show length of time in the profession provides little difference in income. Nursing may be anomalous in making it easier for women to enter and exit the labor force. However, the devaluation of seniority creates an odd form of egalitarianism: nurses are not penalized for exiting the labor force primarily because there are few wage gains to staying.

Professional and Institutional Supports

The educational and career trajectories of women like Maura, Hana, and Sarah are stories of individual triumph, will, and determination; but they are also stories of how particular institutional and organizational arrangements can support personal aspirations. First, the structure of nursing education made it possible to pursue a succession of degrees in cohesive fragments. The road from an associate's degree to a bachelor's degree is not always smooth. Organizational fiefdoms in higher education can make credit transfer difficult. But Maura and Hana were not scrappy pioneers; they were following a well-worn path that nursing makes structurally feasible. In order to transform a workforce dominated by diplomas and associate degrees, many colleges and universities—particularly those affiliated with hospitals—offer structured “bridge” programs for practicing nurses who want to pursue a bachelor's of science in nursing. These bridge programs did not die out, but continue to thrive. The state where Maura practices had 42 accredited RN-to-BSN bridge programs. Nursing remains a viable option, not only for stable work, but as a structured path to higher education for thousands of people, particularly women.

Second, Maura and Hana were able to remain employed while pursuing not only their bachelor's degrees, but also their master's degrees. All but the most privileged graduate students work while going to school, but the synergistic effect between nurses' work and their educational aspirations differs from many student experiences. It is common for NP graduate programs to assume that their modal student is a working student. These programs have to pragmatically account for the fact that aspiring NPs are often already working nurses. In important ways, not just a few, but the vast majority of their students are career changers for whom getting an additional degree needs to be possible within the context of working. At my nursing school site, all 15 students worked at least part-time as a floor nurse through the first year of the master's degree. Of the 12 who stayed through the second year, all but two continued to work part-time or full-time on the floor. The structure of classroom instruction made this possible. During the year of my observation, all in-class instruction happened all in one day. In the spring, class occurred on Wednesdays from 1 pm - 7:30 pm; during the summer semester, on Tuesdays from noon- 4:30 on Tuesday; and in the fall, on Wednesdays from 10 am- 4:30 pm.

This schedule was not arranged to accommodate just any working student, but a student working as a hospital floor nurse. A person working 9-5 in an office would not be able to take an entire day off during the week. At my PACE site, I asked some of the primary care nurses (RNs) why they didn't take courses at the school of nursing with which the PACE center was affiliated. They told me that the schedule of classes made it impossible. As clinic rather than hospital nurses, they could not take an entire day to attend. For floor nurses, who work 12-hour shifts, having classes all on one day was not only possible, but desirable. This kind of schedule allows hospital nurses to work full-time and attend school. Other nursing schools arranged their schedules to appeal to different populations of working students: evening classes, night classes,

and weekend classes. However, what is constant is that it is not just some schools, but most schools of nursing who assume that their students work.

Maura earned her master's degree in the late 1980s by taking classes part-time. Among the NP students I observed in 2009, there were three, including Hana, who were managing the program in the same way. All were married and had dependent children; in their early 40s they were only a few years older than Maura had been when she pursued her master's degree. However, three of the students I observed were balancing full-time school with full-time work. One such student was Francis.

By the second year of the program, Francis was 27 years old. When I asked her how she balanced coursework, clinical rotations, and work, she replied: "I work double shifts. On Fridays, I work basically from 7 am until midnight. I'll come home and crash for five hours, and then I'll wake up around 5:50 and go back to work and do another double." Francis takes 4 hours of vacation time each week in order to keep her number of hours at full-time. Other students, like Deborah, packed full-time hours into three days a week. I spoke with her in October, less than two months before she was scheduled to graduate from the program, and just one month before she was scheduled to give birth to her first child.

Until last summer, I worked 40 hours a week. I dropped down to three, 12-hour shifts in the summer. So now I work Friday-Saturday-Sunday, or Saturday-Sunday-Monday. And now, being pregnant, I don't drink coffee. I only drink 20 ounces of Diet Coke. I don't have much of a social life. Which is a problem. My family feels neglected that on holidays when I might have time off, I choose to stay and sleep in and catch up on my entire year of no sleep. But you make it work.

Deborah and Francis were unusual in their ability to manage full-time work and school, even among their peers. Perhaps they excelled in efficiency and organization. However, all the efficiency in the world would not have mattered without one organizational fact: Deborah and Francis could not have managed these schedules without the nursing school's routine of class one day a week.

Neither Maura nor Hana highlighted the third point of synergy in their stories, but other respondents referred to the importance of tuition benefits. Hospitals that need to attract and keep scarce workers commonly offer tuition benefits. The terms of these benefits vary from more to less generous; in 2008, this university-affiliated hospital would reimburse tuition at the nursing school for two courses a semester for nurses who worked full-time and one class a semester for nurses who were permanent part-time. The workers then owed the hospital a certain amount of service per courses reimbursed; in practice, by continuing to work while they studied, students would owe one year of service after graduation. Because the nursing school was affiliated with a private university, the tuition benefit was a significant incentive. As one student put it, "It's like a \$60,000 education. I don't know how many people would've taken that on if there'd been no tuition benefit." Eight of the ten NP students I interviewed received a tuition benefit for at least part of their master's education. Of the eight NPs I interviewed, seven reported using their employing hospital's tuition benefit program for their master's degrees. Nurse practitioner students worked, not only to generate income while going to school, but also because keeping their jobs significantly subsidized their tuition.

Nursing Careers and Family Careers

For the nurses that I spoke with, the structure of nursing training made higher education accessible. While I spoke with 18 out of a population of thousands of NPs, the narratives of their

nursing careers highlight not the stories of how 18 individuals became nurse practitioners, but the particular institutional arrangements and structural supports that made nursing education possible. However, these arrangements did not just make higher education financially accessible; it allowed the development of professional goals to coalesce alongside family and reproductive decisions. Older cohorts of women like Maura may not have chosen nursing explicitly for this reason. However nursing was one of the few careers in which they would face little penalty for taking time out of the workforce. Maura began having children while she was working and taking courses toward her bachelor's degree. Like many women, she left the labor force for a little over a year after the birth of each of her two children. One reason for women's lower earnings relative to men's is that many women exit the labor force to rear children; these exits affect cumulative income growth as well as the speed of climbing up an occupational ladder. As a nurse, Maura's time away from the workforce likely has no impact on her current wages.

The persistent demand for nurses also means that even without institutionalized extended parental leave, nurses can be fairly confident of finding a job when they choose to re-enter the labor force. None of the nurses I spoke with, whose careers spanned the 1960s to 2010, had *any* periods of unwanted unemployment. They uniformly told stories of easy access to jobs. Many told stories of receiving job offers as students, before they even graduated. Several of the NP-students I spoke with had received informal job offers at their clinical rotation sites. Early in her NP career, Maura's primary care physician offered her a job—while taking her history, he found out she was a nurse practitioner and offered her a position on the spot. Also, because hospital nursing is structured around shift work, working parents can work three days rather than five. One nurse practitioner described the “hand-off” she and her husband managed—when their first

child was born, she was home with her during the week while her husband was home on the weekends. While this schedule is taxing, it can make child care arrangements easier to manage. Several nurses mentioned how much they valued being home for the afternoon school bus.

Younger respondents spoke of choosing nursing because they believed it could be more easily managed with children and family life than other options. Stephanie, a nurse practitioner student, had wanted to be a doctor as early as junior high school. Born in 1977, nearly 20 years after Maura, Stephanie had more professional options as a woman. She never thought she'd become a nurse. "Why would I want to be nurse? I didn't want to be anybody's flunky." She graduated at the top of her high school class and was accepted to a private, Ivy League University. She majored in biology and completed a pre-med curriculum. Stephanie recounted developing doubts about traditional medical practice. "The doctor doesn't always take into account how a person lives, what their resources are." However, she imagined that she might practice medicine differently: bringing in alternative medicine, or practicing as part of a holistic, multidisciplinary team. She dreamed of opening her own practice so she could treat patients in the manner she saw fit.

When she graduated from college, Stephanie chose not to apply directly to medical school, but took a series of positions in bench and clinical research. One of these positions was at an oncology clinical research center. As she watched the physicians in action, her doubts about medicine increased. "I was noticing that a lot of doctors were in debt. To me, [they seemed] poorer. Not in a sense that their salary has decreased, but that there's a lot more cost involved in being a doctor. Malpractice insurance. And primary care is where I wanted to be. And you really don't make money being a doctor unless you're a specialist." She wondered if medical school debt made sense.

But Stephanie had other concerns besides debt. “I was noticing how the doctors were spending so much time at work. And I was like, ‘oh my God, I’m a woman!’ I want to have children. I don’t want to put them in day care. I want a job that is more flexible.... As a female, I didn’t want to be spending ten hours at work every day and not have time to spend with my children.” For an intertwined set of reasons, part personal, part practical, and part professional, Stephanie began to reconsider her decision to pursue medicine and to seriously consider a career in nursing. However, Stephanie did not envision a career as a bedside nurse. At the research center, physicians weren’t the only clinicians she saw in action. It was also the first time that she knowingly came in contact with a nurse practitioner. “I was noticing at the time how knowledgeable nurse practitioners were and how much control they had over their patients. They had a lot of control.”

Instead of applying to medical school, Stephanie decided to apply to nursing school. Because she already had a bachelor’s degree, she applied to the nursing school’s accelerated, “second-degree” BSN program. Just as Maura could tap into a structured curriculum that bridged her associate’s degree to a BSN, Stephanie tapped into a structured curriculum that allowed individuals who already had a bachelor’s degree to obtain a second bachelor’s in nursing in 18 months. Because Stephanie knew that she wanted to be a nurse practitioner, she had simultaneously applied to both the BSN and MSN program—an option the school allows. After graduating with her BSN in 2006, Stephanie took eight months off to gain clinical experience working as a nurse, and then matriculated directly into the masters program.

I interviewed Stephanie nine months before she expected to graduate. I asked her what kind of practice she expected to be working at in five years, she replied:

In five years? I'll probably be retired. I told you I wanted to stay home and take care of my kids. I don't want to be punching no clock. I want to be able to have a flexible timeline. And a flexible career. Which nursing is—flexible. That's good. If I'm not retired, I might be working a part-time job. I won't be full-time. Or, I might be. ... I may be teaching. I do want to teach nursing students. So that's a possibility in five years. Or less. Retired—at home, taking care of my kids.

At the time of our interview, Stephanie had neither children nor spouse. In her telling, nursing wasn't an in-the-moment pragmatic decision, but the more possible choice in her imagined future. When Stephanie saw her future self with children, nursing seemed to align better with her goals than medicine. She expected nursing to give her choices that medicine would not. She didn't think she'd want to work full time, but, she hedged, "I might be." In Stephanie's estimation, being a nurse practitioner was not just a more practical choice than medicine; it was a good choice—perhaps even a better choice for someone interested in primary care.

One of Stephanie's classmates told a similar story. Mary-Anne grew up in Maine. She had always planned to be a physician. Her entire family went to the same general practice physician in their small, rural community. That was the kind of provider she wanted to be—a small town physician who was part of the community. Her family physician also served as a mentor. "He would always say, 'oh, Mary-Anne, she's going to med school.' When the interns were there, he'd have them come talk to me." But as she made her way through college, she began re-think this decision. "I was like, oh, this doesn't feel right. Just kind of the lifestyle, the length of time—this isn't exactly what I want." She elaborated: "I knew I wanted a family. And I wanted to be able to spend time with them. Like, my mom took 13 years off as an ICU nurse to

raise her children. And that was really important to her, and I know it was really important to us.”

Mary-Anne, like Stephanie, grew up in a different era than women like Maura. The range of normative occupational choices for women is much broader. A few of the older women that I interviewed spontaneously addressed the question of why they hadn’t become physicians. Jan, a 49 year old nurse practitioner and doctorate-trained clinical researcher, recalled “I was one of those kids that always wanted to be a nurse. I got a lot of pressure to go into medicine instead. And I really didn’t want to do that. I’m not really sure if it was a confidence issue on my part, or if I really just wanted to go into nursing.” Gina, who was 54 at the time of our interview said, less ambivalently: “There was nobody encouraging me—my parents in retrospect now say, they should’ve said, go to med school. But at that time, there was nobody saying, ‘you know there is another option for all this, and that’s medical school.’ But I’m not sure if I would’ve enjoyed medical school. I enjoy nursing.”

Younger women—and their families—encouraged them towards an expanded set of career opportunities, including medicine. Some of the NPs-in-training I interviewed also had educational opportunities that made those different possibilities achievable. Stephanie graduated from an ivy-league institution and Mary-Anne from a competitive, small liberal arts college. Both majored in sciences and were strong students. Women like Stephanie and Mary-Anne, beneficiaries of institutional and family investments, were not necessarily expected to put family-life first. Mary-Anne may have found her mother’s decision to leave the workforce inspiring, but she faced the condemnation of her choice as anachronistic.

She recounted a recent telephone conversation with her aunt and godmother. “She’s an occupational nurse. And she knows what I’ve been doing. I’ve been telling her. And she said to

me, ‘When are you going to stop this and go back to medical school?’ And I’m like, I don’t like where this conversation is going. Because this really hurts.” Mary-Anne’s small liberal arts college had no nursing program and, as is typical of such institutions, no structured guidance for students who wanted to pursue careers seen as more vocational than academic. She relied, in part, on an “open-minded” college academic advisor, who was the first person to suggest she consider becoming a nurse practitioner. Not everyone was so open-minded. When she told her family physician and mentor that she was considering nursing she recalled, “He sort of looked at me strangely. And this is a guy that has two nurse practitioners in his office. And they were wonderful.”

Nursing Makes Other Things Possible

For younger women like Stephanie and Mary-Anne, being a nurse practitioner was their first career choice. They never planned on other careers in nursing. Their ambitions were never in nursing generally, but in specifically becoming nurse practitioners. Mary-Anne grew up with a mother and two aunts who were nurses, yet she had never considered the option. Stephanie didn’t have this kind of exposure, but she knew enough to assert, “Why would I want to be a nurse? I didn’t want to be anybody’s flunky.” For older cohorts of women like Maura and Hana, becoming a nurse practitioner was a second career. Maura had spent all but two of her 40 years in the labor market as a nurse; she became a nurse practitioner after almost 20 years of working as a bachelor’s prepared nurse. Although we could understand the difference between these groups of women as primarily a cohort effect, the nurse practitioner as ‘the more possible second career’ is still relevant for women and men today.

Sam occupied a middle ground among my respondents. He was 30 years old when I met him. He had worked as a nurse for eight years before he went back to graduate school. If Maura

stumbled into becoming a nurse practitioner, Sam stumbled his way into nursing. I asked him how he decided to become a nurse. “People ask me that question, and I never have a really good response. I went to a state school. I remember filling out the paperwork and you had to choose a major. I don’t know why I chose it. But once you get into it, a year or two into it, [I thought,] why stop now?” After graduating, he worked in general nursing for four years until he decided to go back to school. “I love bedside nursing, taking care of patients, day in and day out. The hours are good. The money is good. You have job security. But, I think I just couldn’t imagine myself doing that for the next 30 years of my life.” He went on to say:

I’ve never been somebody who thought I worked under a physician or just followed orders. I never practiced like that. And I still don’t practice like that. But I just wanted to make more decisions for myself. And I think it’s a great profession to do that.

Because there are so many things you can do. You can do research and have a clinical practice, and you can teach. You can do a lot of stuff. You can specialize if you wanted to take care of pregnant women and be a midwife, get involved in anesthesia. Nursing has infiltrated all those areas.

When I asked Sam where he expected to be in five years, he replied “I think I would love to have a doctorate someday.... In fact, my advisor is a clinician educator, so she spends part of her time, like a very limited amount of time, like four hours a week, seeing patients. But she spends the rest of her time in research. So I think incorporating [both clinical work and research] somehow—I see myself doing that.”

Hana and Maura gave retrospective accounts of using nursing as a means for higher education and career advancement. Younger respondents prospectively believe that nursing will continue to make such moves possible. Even as Sam finishes a master’s degree, he has a clear

view that nursing will make another graduate degree possible and another career in research and teaching. Stephanie also thought that if she is in the paid labor force in five years, she might be teaching. Respondents believed nursing would make not only their current ambitions, but future ambitions possible.

Sharon had a bachelor's degree in biology and had been working in a biophysics research group for ten years. But "research money was getting harder and harder. We had the war in Iraq and research funding got cut in half." Being in a soft-money funded position made Sharon feel vulnerable. "I had to find another way of surviving and hoping the research could still survive." So, as Sharon described it, she "walked to the next building over" to the nursing school. Just like Stephanie, she did an accelerated BSN and MSN. "There was no other career that I could see that gave me the diversity to go in any direction that I wanted and was financially stable."

Sharon had worked her way through each step of her education; financial security was always in the forefront of her mind. In service to this, Sharon had taken her nursing degree in a variety of directions. She continues to do research and publish her work on peripheral arterial disease; she teaches community nursing to undergraduate nurses; and she works part-time as a nurse practitioner. But Sharon also plans to open a practice—an all-inclusive geriatric practice like the one where she works as an NP—in a rural community like the one in which she grew up.

Conclusion

When the AMA argues that nurse practitioners and physicians are not interchangeable, they are correct in many ways. Despite the rise in non-traditional medical students, the pathway to becoming a physician remains both linear and narrow. The modal pathway to becoming a physician is to go directly to college after high school. With perhaps one year in between, one then matriculates into medical school, followed immediately by residency. This narrow pathway

selects for a very specific student profile. According the AAMC, in 2012, the median age of medical school matriculation was 23 for both men and women; the mean was 23 for women and 24 for men (AAMC, 2012).

Prospective physicians sign on for an almost monastic existence. These young people are expected to devote themselves entirely to their training; they sleep little and have diminishing room for other commitments like family or employment. Although incoming cohorts in medicine are nearing gender parity (the 2012 medical school cohort was 48% female), the structure of training calls for socially male students. Women who pursue medical education, childbearing, and childrearing at the same time face very real obstacles (Jagsi, Tarbell, and Weinstein 2007; Willett, Lisa L. et al. 2010).

Regardless of the sex of their occupants, both medicine and nursing are gendered careers. Medical schools design their education for an individual who either has no family commitments, or who has a partner or spouse at home who primarily manages those concerns. Even as the demography of new physicians has changed, a certain set of gendered assumptions governs physicians-in-training. Women who join medical school's ranks find themselves beholden to a male structural rhythm to which they must adapt. Conversely, nurse practitioner education is far from a monastic enterprise; most programs assume that their students have multiple engagements. For those I interviewed, the roles of wife, mother, and breadwinner could not be separated from their role as students.

Medicine and nursing are also classed careers. Nurse practitioners in training are multiply engaged, not just with family, but with making a living. For students concerned with how to pay for school, nursing provides a series of structural possibilities that medicine lacks. Similarly, a structured credentials ladder allows students to have an educational trajectory with a

long time horizon. For women who take time out of the labor force for childrearing, this allows them to pursue their professional goals throughout their lifespan. Marriage and children may alter one's professional trajectory, but it does not stop it.

In key ways, nurse practitioners are not physicians. All along the way, structural processes select for different kinds of students. We should, perhaps, expect these different kinds of students to become different kinds of clinicians. Most of the literature on physician abandonment of primary care focuses on the rational disincentives. However, a better understanding of why and how individuals are becoming nurse practitioners allows us to better understand why NPs are choosing primary care.

Chapter 5 - Professional Actors, Organizational Actors⁸

During my time at the nursing school, I focused on nurse practitioner narrative practices. Faculty and students told stories to one another about a distinct nurse practitioner expertise. And this distinct nurse practitioner expertise was not narratively practiced on interchangeable diseased bodies, but on specific, socially located bodies: the poor, the uninsured, those with addictions—people caught in a complicated web of social and interpersonal difficulties. I summarized these findings to a physician I knew who was completing a post-residency fellowship in pediatric anesthesiology. He nodded, considering my observations, but then said, *Well, med students also form ideas about how they think they will practice, but then reality sets in.* What happens when these students leave school and are faced with the reality of the clinic?

The data we have about nurse practitioners suggests that they are not, primarily, opening their own practices but are overwhelmingly employees of hospital and physician-owned group practices (Goolsby 2011). The responsibilities held by and procedures used by NPs are important organizational matters, as well as internal, professional and inter-professional matters. How should we understand stories of a different kind of NP expertise within the context of mainstream health care? And what happens when a nurse practitioner's notion of her expertise meets the boundaries of other occupations? I went beyond the professional claims of nurse practitioners to explore how they went about negotiating their domain of work within an actual practice. I left the nursing school. But I didn't go far.

Partly by design and partly through serendipity, I found myself within a community practice operated by the nursing school. I had been looking for a clinic in a specific kind of

⁸ Some ideas and content from this chapter were presented at the 2011 Carework Conference in Las Vegas, NV and the 2011 Eastern Sociological Society's Annual Meeting in Philadelphia, PA. An earlier version of this chapter was presented at the 2012 Annual Meeting of the Society for the Study of Social Problems in Denver, CO.

location. Nurse practitioners have always been located professions—the creators of the first NP program graduated a cohort of practitioners who they envisioned would work to serve women and children located in medically underserved rural and urban communities (Fairman 2009). The health care needs of certain kinds of patients in certain kinds of communities had generated these first NPs. Federal regulation later solidified this connection: NPs first gained practice independence in areas designated as medically underserved by the U.S. government (Fairman 1999). In these settings, NPs were legally able to provide primary care without direct physician supervision. At these margins of medical care, NPs began to explore, in practice, personal reflections, and organizational discussions, what nursing practice might be in this new role.

Today, individual NPs work in health care settings that serve the full economic, geographic, and race/ethnic spectrum of U.S. society. However, in many ways, NPs continue to be located, both rhetorically and institutionally, in the midst of vulnerable communities. In position statements about proposed federal legislation to improve access to primary health care, the two most influential NP professional organizations cite NP practice as an important way of providing primary care to vulnerable populations. Specific language in bills introduced into the house and senate in 2007 and 2009, which nursing leaders helped to shape, called for federal support of nurse-managed health centers because of their role as providers of the underserved and uninsured (S. 2112 in 2007; S 1104 and HR 2754 in 2009; NNCC Newsletter 2009). Even general claims as to the cost-effectiveness of NPs as primary care providers are not singularly aimed at payers, but echo a special concern for people of limited means.

Institutionally, the National Nursing Centers Consortium, a national advocacy organization for community-based health centers managed by nurses, equates organizational nursing leadership with an explicit mission “to provide access to quality health care for

vulnerable populations and eliminate health disparities” (www.nncc.us, 2010). A significant majority of these centers rely on academic nursing centers for leadership, staffing, and financial support, further locating nursing research and leadership within underserved communities.

While I could have found NPs anywhere, I decided to look for them at a site where I could expect NPs to work within the full legal scope of their practice, and where I might see the kind of expertise that their professional narratives reflected: skill in managing the socially complicated and medically vulnerable. I chose to look for nurse practitioners within a nurse-managed health care center, choosing among organizational members of the National Nursing Centers Consortium. I visited all seven of the nurse-managed, primary care sites within one northeastern city. I visited the Center where I did my research last.

Through a Dean at the Nursing School, I had arranged to a tour with the Center’s director of staff education, Katherine. Katherine invited me into her office and explained the Center’s model of care. As a PACE site, they provide all-inclusive care for older adults. All of their patients, who they refer to as members, are eligible for nursing home care, but PACE seeks to support them as they live in the community. Their center had about 400 members, spread out among four clinical teams. She described a full time nurse practitioner as leading each team, but the team also included a part-time NP, a social worker, a physical therapist, an occupational therapist, and a physician. When I asked about the physicians’ role, Katherine leaned in and said with a slightly lowered voice, *The NPs are capable of doing most of the care. The physicians are mostly consultants.*

This idea of physician as consultant was one I hear over and over again at the nurse-managed clinics I visited. At most of these sites, calling a physician “a consultant” had a very specific meaning: the physicians were not on site. At one practice, the director said, *We have a*

collaborating physician, but he has a practice someplace else. At another site, their collaborating physicians came to the clinic bimonthly, not to see patients, but to provide general advice and staff education. However, the Center was clearly different. The physicians were physically present and saw patients. PACE mandated its centers use an interdisciplinary team model. At this site, NPs and physicians would have to work—one way or another—as a team.

This nurse-managed center operated under the regulatory and fiscal constraints of the real world. Many nurse-managed centers, supported by nursing schools, were *working towards* financial sustainability rather than having achieved it. As a site under the federal PACE program, the Center had to figure out the intricacies of proper bill coding, and they lived under consistent organizational pressure to keep member enrollment high enough to stay solvent under capitation.

Federal program money brought federal program regulation: the Center not only had physicians on-site, they had a physician as medical director—perhaps for many reasons, but chiefly because regulation required it. Even using nurse practitioners as the primary care provider of record required the Center to apply for a waiver from PACE. The center may have been nurse-managed, but the Center’s nurses had to manage in the world they found, not a nursing-centered world they made. One month after my first visit, I began volunteering with the Center’s recreation department. Eleven months later, I began my fieldwork in the clinic.

The Clinic

A brown, brick building with four floors houses the Center. Typical members spend their time on the first and second floors. They arrive between 9:30 and 10:00 a.m., moving past reception and into the first floor multipurpose/dining room for a light breakfast of cereal, fruit, and coffee. Between 10:30 and 11:00 a.m., staff shepherds about 150 members onto one of the

building's two elevators to the second floor. The second floor houses another multipurpose/dining room, physical therapy, the chapel, and smaller rooms where informal groups meet to crochet or play dominos. Despite all of this social activity, the presence of the clinic strongly asserts itself into center life. When a member steps off the elevator in the morning, a caregiver consults a list: "Mr. Samuels!" she might say. "You're needed in the clinic!"

The clinic takes up the entire east wing of the second floor. Entering the clinic, you pass by a small waiting room on your left and the medical assistant's office on the right. As you begin a linear ascent down the hallway, about every five feet, small cutaways or "pods" accommodate each primary care team. Three teams serve the general population: the blue team, the black team, and the red team. Team members were spread throughout the building, but inside the clinic, a full-time nurse practitioner and primary care nurse anchored each team. I spent most of my time at the Center stationed inside one of these pods. I followed each nurse practitioner and primary care nurse in turn, up and down the hallway, inside their offices, and hovering both in and outside exam rooms. When not directly shadowing an individual, I took up residence in the hallway that stretched the length of the clinic, noting the flow of members and following the action.

The clinic, however, was not the only site of clinical work. Each team had a weekly meeting that started at 9:30 a.m.: black team on Wednesdays, blue team on Fridays, and red team on Thursdays. The wider team regularly gathered in these meetings—the physical therapist, the occupational therapist, the social worker, the recreation director, the nurse practitioner, the primary nurse, and sometimes, the physician. I regularly attended these meetings in order to

understand how the team understood member problems, and the role each team member played in solving them.

Through attention to these sites of clinical work, I expected to address three questions. First, how do some nurse practitioners go about doing what they do, and when they provide patient care? Do they find ways of exercising the “doing of difference” that the nursing students and faculty at the school expected? Second, I wanted to understand how actual NPs negotiated a unique area of expertise alongside other kinds of clinicians within a primary care setting. Third, I wanted to understand how these negotiations around work both shaped and were shaped by the expectations of patients as well as the employing organization. Clinicians may negotiate, but they do so within a set of organizational and client constraints. In this chapter, I explore the distinct processes through which notions of what constitutes medical work, medical expertise, and patient care can be altered, not only at the level of national fights over credentialing and regulation, but through shop floor negotiations.

Negotiating the Nurse Practitioner

Much of the research on work and occupational change has taken a macrosociological view. Abbott’s transformative work argued against viewing each occupational group as a lone actor trying to attain a singular professional status; rather, he focused our attention on the interrelations between groups and the battles they waged *with each other* for jurisdiction within shared fields (Abbott 1988). Although Abbott’s work profitably shifted our attention to relationships rather than single actors, it also defined the relevant stage of action as the field and the relevant actors as occupational groups. Following this course of study, a number of accounts of both medical and non-medical work have focused on field-level activities, such as contests

over regulation, certification, and credentialing (Bourgeault 2006; Kunzel 1988; Linker 2005; Witz 1990).

Indeed, professional medical and nursing organizations have been engaged in very open contests over the nurse practitioner and her scope of practice. It would be difficult to understand nurse practitioner's gains in autonomy without understanding these professional battles. However, a focus on professional organizations obscures the role of individuals in occupational change. While ethnographers routinely make calls in favor of fieldwork's role, this call takes on particular importance in the study of occupational change. In systems of occupations, actors do not simply jockey for position within fields; occupants of particular jobs do so *within* organizations and *with* occupants of related jobs. How do new claimants come to "make sense" in an already occupied domain of work? When a health care organization decides to hire a nurse practitioner instead of a physician, how do they come to an embedded understanding of what it is she does? And as she works with/under/alongside physicians, how do they both come to a practical understanding of the distinctions between physician work and nurse practitioner work?

Although several interactional turns have changed the study of work and occupations, most of this scholarship still defines the actors as distinctly professional actors. From this perspective, individuals and their practices may affect what happens in workplaces, but their identity and motivations as professional actors determines this effect. In only paying attention to professional actors, we lose sight of one very important aspect of occupational change: the work itself. When new occupational groups enter a particular jurisdiction, they not only transform notions of who can do what kind of tasks; in fighting to shift accepted boundaries, they engaged implicitly in acts to change the meaning of the work itself. When a nurse provides primary care, is it still medical work?

In order to address these gaps in the contemporary literature on occupations and work, this dissertation has reached back into history to take up the call of a prominent sociologist of both work and medicine, Everett C. Hughes. Hughes argued that we should study the occupations not only to understand what workers do, but also to learn about the social worlds they inhabit. In this framing, individuals are not simply people but “peoples,” representatives of different worlds who possess different logics, values, and understandings of the world that guide their actions.

In the workplace, these different understandings undergird the construction of competing worlds of work. Given these differences, work gets done through conflict, struggle, and negotiation. Methodologically speaking, analytical attention to these moments of contestation makes competing logics of “the work” visible; through attention to the process and outcome of negotiation we can see how they alter, dismantle, or newly create worlds of work. This dissertation uses clinic-level negotiations about the performance of medical work to understand what different kinds of medical practices the inclusion of nurse practitioners in primary care can create.

Hughes also introduced a line of inquiry that has become central to the sociology of medicine—the naming function of professionals. Reflecting on the case of physicians, Hughes notes that the authority to name problems for clients is, in part, what it means to be a professional. He notes, “it is in the course of interaction with one another and with the professionals that the problems of people are given definition” (152, *Sociological Quarterly*). For professionals who work with people or on their bodies, negotiations surrounding the doing of work are not only a meaning-making activity for workers, but for their clients. Attention to medical work matters not only because of what it tells us about those who performs the work, but

because of what it tells us about how patients are cared for, and ultimately, what kinds of clients they may find themselves becoming.

This paper begins with Hughes in asking, what patient needs do nurse practitioners name in the doing of their work? What kinds of problems do NPs make visible by addressing them in medical encounters? This dissertation addresses these questions through ethnographic methods. Rather than relying simply on evidence of what nurse practitioners say they do or even on what they, solely, do, it relies on interactional data within an interdisciplinary team that includes physicians, social workers, occupational therapists, physical therapists, and bedside nurses. Through attention to interdisciplinary negotiation, I sought to understand how actual NPs negotiated a unique area of expertise alongside other kinds of clinicians within a primary care setting. Finally, this dissertation sought to understand how these negotiations around work both shaped and were shaped by the expectations of patients as well as the employing organization. Clinicians negotiate in conversation with client expectations. This paper takes an ethnographic look at the distinct processes through which notions of what constitutes medical work, medical expertise, and patient care can be altered, not only at the level of national fights over regulation and credentialing, but through shop floor negotiations.

Troubling Clinicians

When we turn our view to the national stage, there is one party in these workplace negotiations who is deeply troubled by the nurse practitioner: the American Medical Association (AMA). The AMA is the most prominent professional organization that represents the interests of physicians. In 2009, the AMA launched a “Truth in Advertising Campaign” to deal, head-on, with the imagined epidemic of rogue bands of nurse practitioners masquerading as physicians. This campaign has led to the passing of legislation in several states requiring health care

providers to plainly identify their credentials to patients. Such legislation does not threaten nurse practitioners; NPs clearly have a professional stake in being visible, not mistaken for physicians. However, the symbolic legislation and ad campaign target NP legitimacy; without calling NPs and other non-physician providers liars, these efforts rhetorically construed them as a kind of living-lie against the truth of “real” physician practice. This campaign is only the latest and most visible manifestation of longstanding AMA resistance to autonomous nurse practitioner practice.

The reasons for this resistance bear further reflection. Although real tensions sometimes occur on hospital floors (Stein, Leonard I, Watts, David T., and Howell, Timothy 1990; Stein 1968), broadly speaking, professional nurses and physicians have worked alongside one another in U.S. hospitals for well over 100 years. This relationship is not simply one of tolerance, but of symbiosis. The receptivity of nursing for more complex work has increased its domain of legitimate practice at the same time that it has freed physicians to pursue work ever further removed from the immediacy of patient bodies, needs, and demands. Today, bedside nurses employ many of the techniques and tools that once belonged exclusively to physicians. And for nursing, this expanded role has increased their job satisfaction (Sandelowski 2000).

The history of the nurse practitioner encompasses this kind of professional symbiosis between medicine and nursing. Although some physicians were cautious about this new provider, professional physician organizations were the first to embrace the nurse practitioner. Nursing organizations shunned early nurse practitioners as “wanting to play doctor,” while the American Pediatrics Association welcomed them to their professional meetings (Fairman 2009). Some physicians viewed the nurse practitioner, like the increasingly skilled bedside nurse, as “freeing” them from doing the more routine work of immunizations and preventive care visits. Viewed as a skilled assistant, the NP was seen as helping the medical profession.

The AMA's current ire against the nurse practitioner as signals an important shift. The AMA clearly sees the contemporary nurse practitioner as more threat than assistant. However, market competition cannot explain the threat: demand for physicians is higher than ever, both in primary care and in the specialties. Indeed, it is precisely physician scarcity makes the use of the nurse practitioner so practically compelling for health care organizations. Still, the AMA rightly perceives the nurse practitioner as a threat to physicians because she calls into question the exclusiveness of medical authority.

Medical Authority

Despite the rising complexity of nursing work, the bright red line that has continued to divide nursing from medicine is the performance of clinical decision-making. A bedside nurse may have the training to assess, describe, and monitor a patient's physical condition—she may even learn ever more sophisticated techniques and technologies through which to do so; however, only a physician can *legitimately name* through diagnosis what is wrong with a patient, and it is only a physician who can then *decide* the course of treatment. The cultural and institutional authority of physicians to control and direct all medical action, both actual and symbolic, lies at the heart of medical authority. A nurse practitioner student relayed the following example to me.

A patient with asthma shows up to the Emergency Department with shortness of breath. The first line provider is usually a nurse, who can decide to administer a bronchodilator to open the patient's airway. Two things must be understood about this encounter. Although the nurse made a decision about treatment, she did so under a physician's standing order—legally, she acted on behalf of the physician rather than autonomously, even though the physician had yet to set eyes on the patient. But more tellingly, the technical description of the nurse's action is

“supporting the patient’s breathing,” not “treating an acute exacerbation of asthma.” Although both phrases could describe the same action, the cultural, clinical, and legal meaning is altogether different. Only a physician has the authority to affix a diagnosis to a patient, and only a physician can decide how to treat that diagnosis through medical intervention.

Except, that is, if the nurse is a nurse practitioner. In 24 states, nurse practitioners can legally diagnose and make treatment decisions without a collaborating physician (Kaiser Family Foundation 2011). In all but two states, NPs can write prescriptions for the range of medications appropriate to their specialties and practice settings (AANP 2012). Even in those states that require NPs to have agreements with collaborating physicians, these agreements provide, not “standing orders” about specific interventions, but a broad framework about the nurse practitioner’s scope of *independent* practice. These agreements usually stipulate the nature of physician presence, which runs the gamut from full-time on-site physician availability to availability only by phone. The broad nature of these agreements indicates that even in the most supervised of settings, NPs use their own authority to make decisions in their moment of encounter, up to and including when and if they require physician input. This breaching of the lines of medical authority makes the nurse practitioner a newly problematic provider—not, perhaps, for individual physicians, but for the profession as whole.

The AMA is troubled by the nurse practitioner because they understand, perhaps clearer than most, that what the public understands the NP to be is inextricably linked to our notions of what constitutes medical practice and the very nature of medical authority. The AMA would prefer a version of the NP as “physician extender,” the skilled assistant who extends the physician’s eyes, hands, and expertise. But NPs increasingly work autonomously, and increasingly understanding themselves as independent clinicians. In this vision, the nurse

practitioner certainly has practice limitations, but, like her physician colleague, she judges her own limitations.

As an autonomous clinician, what do we consider the NP to be doing? If we believe she is doing medical work, then we may have to rethink what we mean when we talk about, organize, and pay for this care. Given both the present and potential future role of nurse practitioners in primary health care, descriptions of medical work should take their practices into account. My research seriously considers the introduction of the nurse practitioner into the medical encounter through sustained ethnographic attention to negotiations within an organization providing primary care to the medically and socially vulnerable. I found that organizational breadth and patient-centered depth both marked NPs' care of patients.

Although the NPs' performance of medical authority alongside physicians varied, I observed a distinct vision of NP expertise that made her the local expert, and sometimes authority, over each patient. Negotiated through *a professional openness* to patient and organizational expectations, the nurse practitioner performed an expertise that was both unique and legitimate, but that was also local and gendered. By differing from physicians, nurse practitioner practices could change organizationally embedded understandings of what counts as medical work, shifting what it means to medically care for the sick inside primary care health care organizations.

I used pseudonyms for all names that follow and altered personal information of members. Quotation marks indicate language taken verbatim from a recorded interview directly captured in a written record in the moment. Italics indicate language reconstructed from field notes.

Norah and the Team Blue

How do nurse practitioners provide care for chronically ill, medically frail, older adults with limited or stretched personal resources, within the context of an organization that manages prescriptions, transportation, home-care services, specialist appointments, and social work services? To find out, I embedded myself in team blue with Norah. Norah has been a nurse practitioner with PACE for 5 years. Norah provides and manages medical care for an average of 110 patients. She has been providing geriatric primary care for 11 years and describes herself as “good at what I do.”

Norah’s colleagues at the Center seemed to share this assessment. I heard from aides, team blue staff, clerical staff, and members of administration that Norah being was “one of the best” NPs. I share this information not as a quantitative finding. When I asked Norah how the Center’s administration evaluated her job performance, she did not describe chart audits or panel studies of her patient outcomes. Much like the professional culture for physicians, administration evaluated Norah primarily by whether she got the work done, not how.

When I began following Norah, I did not come without expectation. Based on both popular depictions and personal experience, I expected to see the familiar and iconic medical encounter: closed exam room doors, behind which an efficient taming of chaotic signs and symptoms produces a singular chief complaint, diagnosis, and appropriate medical intervention. What I did not expect was how much of the clinic encounters in Norah’s day happened to an arrhythmic beat, shaped by constant interruption, through telephone, email, and physical visitation by staff.

Clinic Encounters

On a Tuesday morning, I sit with Norah while she looks over her list of patients for the day. And then, her phone rings. Operating on automatic, she answers after the first ring. “Oh hi, Carol.” Carol is the daughter of one of her patients. She is calling Norah because there is a problem. Her mother is currently in a rehabilitation facility recovering from a hip fracture. PACE had arranged to transport her mother from rehab to a follow-up appointment with the orthopedic surgeon. However, PACE failed to notify the facility, and her mother was not ready for transport when the driver arrived. Her mother missed her appointment.

Sitting in Norah’s office, I listened as she made apologies to smooth over Carol’s frustration, detailing what she will do to “make it right.” “I’ll have the [appointment clerk] reschedule the appointment. And we’ll make sure the nursing home knows this time.” Norah writes down this new task on the notepad she routinely keeps by her phone. Because when Norah says she’ll contact the appointment clerk, she means that she will walk across the hall and ask Marsha, her appointment clerk, to reschedule, verbally emphasizing how important it is to notify the nursing home “this time.”

Before Norah could get through the pleasantries of ending the call with Carol, she notices the clinic receptionist standing inside her doorway. The results of her monthly check of vital signs of every member detected elevated blood pressure in Ms. Robins. PACE’s clinical guidelines mandates these checks. Does Norah want to see Ms. Robins? Elevated blood pressure is not always cause for concern; some members had poorly controlled blood pressure while others maintained a consistent blood pressure that was higher than normal. Whether Norah chose to see Ms. Robins was not solely dependent on it being elevated, but partially depended on her particular clinical history. Talking partly to herself and partly to us, Norah

announces that Ms. Robins pressure “is never elevated,” and that yes, she would like to see her. Trying to be helpful, I volunteer to go get Ms. Robins and bring her back. I find her sitting quietly in the waiting room. When I called her name, she gets up to join me and, without benefit of walker or cane, walked slowly but easily beside me. Her physical independence sets her apart from much of the Center’s frail population. As we walk back to Norah’s office, we carry on a casual conversation about the Center activities she likes. During our conversation, I formed the impression that Ms. Robins was cognitively capable, although Norah informed me later, that Ms. Robin’s appearance and demeanor presented a false picture of independence. Like many members, Ms. Robins’ dementia made her an unreliable historian of her own routine. Consequently, Norah didn’t begin the encounter by eliciting a history from Ms. Robins, but by saying “we’re going to see if we can get your daughter on the phone.”

Norah looks up the number in the electronic medical record and then dials. Putting the call on speaker Ms. Robins’ benefit, she narrates her concern to the daughter. *Has anything changed about her diet or her routine?* The daughter proposes a simpler explanation for the elevated reading: her mother ran out of blood pressure medication days ago. And no, she didn’t know why the refill hadn’t arrived. Still on the phone, Norah goes on a sleuthing expedition. Turning to her desktop computer, she looks online at the pharmacy records. Finding Ms. Robins’ records, she sees that the pharmacy did, indeed, fill the prescription. But for some unexplained reason, it hasn’t been delivered. After more online sleuthing, Norah assures the daughter that the medication will go home with her mother today. After ending the call, Norah hangs up and immediately dials the Center’s medication nurse on the third floor. Not content to trust the pharmacy’s online records, she wants to verify the order’s receipt and confirm that the pharmacy will deliver Ms. Robins’ medications. She ends the call with an additional request to

deal with a more immediate concern: *Can you come down and give [Ms. Robins] her regular dose of Lasix [blood pressure medication]? She missed it this morning.* The thread of the encounter began with an elevated blood pressure. Norah followed that thread, even as it wound its way through pharmacy records, delivery schedules, and the Center's medication room. Like she did with Carol, Norah took a number of steps to "make things right" for Ms. Robins.

Making Things Right

It didn't take me long to notice that "making things right" was a regular feature of Norah's day. The most obvious client for whom Norah made things right were the Center's members and their families. Her phone resounded with urgency, all day, with direct calls from members and their families. Calling to complain about transportation. Calling to figure out why their mother hasn't seen the dentist. Calling because they ran out of incontinence products. Calling because they don't feel well and should they go to the ER. These phone calls were a tumultuous mix of both medical and practical concerns—often during the same call.

Norah would address each complaint, writing new problems and tasks on the notepad by her phone. The telephone was not the only conduit for member's concerns. Because the clinic was housed inside a larger center, any time the nurse practitioners left their respective offices, they could be sure to be met with a barrage of requests, yelled out from members sitting in hallways, waiting by elevators, or beckoning from lunch tables. As I followed Norah, I would watch her stop and recognize each request, whether by addressing their concern on the spot in a few moments, telling them to see her in the clinic, or to mentally add solving their problem to her list of things to do.

When I interviewed Norah, I asked her to describe her role in the organization. She responded, "We're like the air traffic controller of the members and their needs. I hear things or

identify needs and then direct it to social work or to PT [physical therapy]. Now, of course, sometimes it works the other way around, but usually, it comes through me. NP's have really taken on that kind of responsibility. It's the nature of the profession." From Norah's perspective, a professional rather than a personal orientation shaped her response to a broad range of member problems. However, in her own telling, the NP refers, rather than responds. In practice, the line between refer and respond was often blurred.

In addition to face-to-face discussion, both clinical and non-clinical staff would regularly participate in team-wide email conversations about member concerns. With so much member-related action occurring throughout a multi-storied building, at members' homes, on center vans, in emergency departments and hospital rooms, staff used email as a primary organizational platform to share information, make decisions, negotiate, and perform expertise. Although I did not have access to private emails directed towards individuals, I had access to the group emails addressed to specific teams.⁹ NPs often took responsibility for organizational problems raised in these emails, as well as clinical problems. One daily organizational problem addressed inside rather than outside the clinic was transportation.

The center took primary responsibility for managing and providing member transportation. The center transported members back and forth from the Center, to specialist appointments, and to hospital emergency departments when EMT services were not needed. The daily movement of 100-150 frail members was an administrative feat. Center vans were literally at the front line, transporting frail and sometimes demented members, not just to social activities,

⁹ Team lists were more public than not. Although the actual multidisciplinary team might consist of only 11-12 people, the number of actual list members was quite high; team lists included all members of administration, most supervisors and managers, clinical and administrative staff who worked across teams, as well as many staff who had once been affiliated with a team and whose name had never been removed.

but to medical care. Demented members sometimes created a practical problem by declining to adhere to a schedule of center attendance or to attend a follow-up appointment.

The reason behind a member's refusal to leave home might itself be a problem: a chronically late home health care aide who fails to get a member dressed on time, a member who isn't feeling well and wants to stay in bed, or a member with dementia who declines out of confusion. Although a member's set of physical and medical needs were often a prominent feature of this organizational problem, transportation itself was neither related to diagnostic medicine nor to the management of disease. Yet, when a formulaic email from the transportation department would make its almost daily appearance over team email, reading, "Mr. Jones declined transportation for his appointment this morning. Please advise," it would not be "the team" who reacted, it would be the NP who added this problem to her list of things to solve. Norah treats transportation as a medical concern—not something she referred, but to which she directly responds. And she responds quickly, sending reply emails to Team Blue can in minutes. Norah's day ran according to clinic time, and clinic time moved faster than other parts of the Center. Although this primary care clinic did not often deal with acute medical concerns, from Norah's perspective, time still mattered. Because in her experience, a timely intervention—her timely intervention—could make a difference.

One morning, I'm standing just outside the doorway to Norah's office, when the blue team's appointment clerk, Marsha, joins me. Marsha has just received a call from transportation. The van had taken Ms. Givens from the Center to her appointment for a biopsy of a lump in her left breast that, according to his list, was at the Hoffman Medical Center. But the driver called in because he can't find the right location. *Hoffman*, Norah repeated. *I thought it was at the Women's Center?* Tasked with managing, scheduling, and rescheduling appointments for 400

members, center staff made errors. However, Norah knew that Ms. Givens often declined appointments to which she'd previously agreed. An appointment missed for an administrative error might not just mean the difference of a day or two, but of the appointment happening at all.

Instead of referring the problem back to Marsha, Norah decides to act. She turns to her computer and looks up the number of the Women's Center. She calls their appointment line and verifies that Ms. Givens has an appointment there—rather than the Hoffman Center—and asks for clarification about where the Women's Center is located. She directly dials the main number for the Center's transportation department, but gets voicemail. She doesn't leave a message but hangs up. She calls the transportation coordinator directly, gives her the correct location, the address, and directions as to its location in the building. Norah, now satisfied that Ms. Givens will get to her appointment, turns back to her list of things to do.

Norah is not a micro-manager. She trusts Marsha and does not hesitate to rely on her knowledge and quick thinking when it comes to scheduling and arranging member appointments. Norah calls Marsha affectionately "her bulldog," because she can get difficult appointments made. But in this moment, Norah made several assessments. The first reflected her experience with the Center's transportation—without quick resolution, the driver would move on to the next transport. The second reflected her experience with Ms. Givens' history of ambivalence. Knowing the importance of *this* appointment, she went with her hunch that transportation was at the wrong place. Norah knew she could solve the problem—and she could solve it when it mattered most: now.

Norah did not consider making sure Ms. Givens got to her appointment to be someone else's job. On a daily basis, Norah made things right for members like Carol's mother, Ms. Robins, and Ms. Givens. However, I also began to notice the ways in which Norah was also

making things right for her employer: the Center. Because the Center manages an extensive array of services, there is a lot of intensive internal communication. The blue team's appointment clerk regularly appeared in her doorway, as did the clinic receptionist, and the Center's caregiving staff. They would deliver information about members' that were not narrowly medical: letting Norah know that Mr. Smith refused to go to his appointment this afternoon, or that Ms. Jones didn't open the door for her caregiver for the third time this week. When the organization had practical problems with members, the problems were taken to the clinic.

One possible explanation is that nurses traditionally perform this kind of role. One might imagine that the division of labor at this site could be such that the physician does the "real" medical work, while the nurse practitioners do a slightly expanded kind of nursing work: dispensing medications, attending to bodily care needs, and monitoring patients. However, despite being a nurse-managed organization, this PACE site is not a nursing utopia, where ideology lifts traditional nursing work to center stage. For any health care organization that relies on third party payment, what counts as medical work is largely defined by the rules of reimbursement. In the case of PACE, whose funding comes from Medicaid and Medicare dollars, the cost of the entire operation—from recreational activities to physical therapy—is legitimated by the documented medical activities that happen inside the clinic.

The clinic dominated center life not just for the patients, but also for the administrators concerned with keeping the doors open. Encounters that resulted in new or updated ICD-9 codes were directly tied to reimbursement levels. The kind of work that generates these codes were new patient enrollments, encounters that resulted in new diagnoses, and encounters that correctly identified exacerbations of old diagnoses. The PACE program also mandated semi-annual

medical assessments of members. Keeping on top of these assessments was indirectly tied to reimbursement; failure to comply would result in losing their contract as a PACE provider. Indeed, after a biannual Centers for Medicare and Medicaid Services survey in April of 2011, this site had their license downgraded to provisional status. Although there were several documented deficiencies, their failure to meet assessment deadlines and to document as regulations specified were the two problems that were publically highlighted in all-center communications and that became the focus of administrative interventions.

Under these constraints, the Center had to financially justify the services of four full time NPs and three part-time NPs. As such, the nurse practitioners were always under pressure to do the kind of work that counted on paper, and on paper, it was medical work, not nursing work that counted. However, what made Norah's day different from published accounts of physician work was the way this medical work unfolded. Instead of the iconic notion of a chief complaint where the physician, after listening to the narrative of her patient, decides and names the complaint, at the Center, both the patients and the organization were part of shaping both the existence of the complaint, and how it should be understood.

Maura and Team Red

Down the hall from team blue was Maura and the red team. Maura was the newest NP in the clinic, having arrived three years before. Although new to the Center, she was not new to nursing. She had 37 years of being a nurse; for 20 of those years, she's had a license as a geriatric NP. However, the Center was an entirely new experience. Prior to that, she taught full-time. She was surprised when the Center hired her. She recalls, "I hadn't taken care of anybody for eight years. And I'd never done primary care before." She had kept her license current by working per diem, every other weekend for a hospitalist who wrote discharge reports. But this

was a far cry from the world she was about to enter. Maura recalled, “Transitioning into primary care from a lifetime of being in long term care and acute care, it sucked. It sucked. There were just stumbling blocks everywhere.” One of those stumbling blocks that Maura remembered having to learn was remembering that she had to deal with patient’s families. Nothing could get done without involving a member’s family.

It’s 2:34 in the afternoon and Maura’s phone rings. She answers on speakerphone. *Hi, it’s Eva. I’m calling about my mom.* Eva was concerned because her mother seemed nervous and shaky. Maura tries to troubleshoot over the phone. Eva’s mother has diabetes, so Maura asks about her blood sugar and which medication she’s taken today. Eva isn’t sure how to answer these questions because she isn’t actually there with her mother. *Can you do me a favor and call my sister who is with my mom?* Maura hangs up and calls Eva’s sister, Debbie. *Hello Debbie? This is Maura from PACE.* Together, Debbie and Maura try to piece together what they know, and what they don’t know. Their conversation, however, takes place within a backdrop of chaos. Eva had reported that her mother was nervous. She appears to be something other than nervous. Over the speakerphone, I can hear Ms. Brady yelling invectives at Debbie. Debbie, struggling to hear, periodically asks her mother to “stop!” Despite the distraction, Maura and Debbie were able to figure a few things out. Ms. Brady depends on daily nursing visits to take her insulin correctly. This type of simple but typically un-reimbursed support that PACE is able to offer helps keeps members like Ms. Brady out of Emergency Departments and nursing home placement. However, Ms. Brady had recently been released from the hospital; it seemed possible that her nursing visits had resumed. Maura tells Debbie to check Ms. Brady’s blood sugar and call her back. After hanging up, Maura turns to her desk. First she sends an email to the home care department to notify them about and possibly fix the root problem. Then,

to deal with the immediate concern, she calls nursing to see if it's possible to send a nurse to see Ms. Brady that afternoon. Maura goes back to her paperwork, awaiting Debbie's call.

From one point of view, this is a classic, acute encounter. The chief complaint is that the patient is nervous and shaky. The first diagnosis to rule out is a problem with her blood sugar. However, this encounter, occurring primarily over the phone, spanned over a much larger geography than the exam room, and over a much larger range of bodies than Ms. Brady's. It began with Eva's phone call. It extended to Ms. Brady's home, which included a second daughter, Debbie. Throughout the phone call, Ms. Brady continued to shout her aggravations at her daughter. Maura knew that Ms. Brady was regularly ill tempered with her daughters. Part of the difficulty with managing her care was that she rejected her daughters' assistance, even though she could not live alone without their help. The problem wasn't simply about managing one woman's blood sugar; it required managing a great deal more.

What I observed was that in these encounters, the NPs saw an expansive, socially and institutionally embedded clinical body. The NP's view of the patient was not bounded by the exam room, but expanded outside the boundaries of a biological body or specific disease state. And it was this body that had difficulties with transportation, taking prescribed medications, keeping specialist appointments, and sometimes, keeping food on the table. And when action could be taken, NPs were inclined not to refer, but to respond. It may have been the organization's mission to manage patient problems—both clinical and practical—but it was often the NP's clinical orientation that dictated how they were managed. An abnormal blood pressure reading led to wading through pharmacy records; securing follow-up care after orthopedic surgery required dealing with nursing home bureaucracy; ruling out breast cancer required getting directions to the appointment; and managing a woman's blood sugar required soothing a

frustrated daughter and troubleshooting transitions between hospital and home. As Maura and Norah made things right clinically, their actions also made the Center's goal of coordinated care a reality. If the coordination happened at all, it happened through the NP.

Still, understandings of expertise cannot entirely be based on individual orientations. While an individual provider's sense of what it means to treat patients may be connected to their personal sense of their profession's expertise and worth, workplaces are arenas in which such calculations transcend individual notions. I've already noted the ways in which organizational concerns with reimbursement makes some kind of clinic work more valuable than others. Administrators could—and at times did—evaluate this work's successful completion in wholly objective ways: counting and periodically auditing completed documentation. However, one of the distinctions between expertise and technical proficiency lies not merely in work's completion, but in how it is understood to be performed.

Early sociologists who studied the professions made prescriptive claims. They spent a great deal of time trying to figure out whether some work should be organized along bureaucratic or professional lines. While that line of research has mostly faded from view, this kind of evaluation still lies at the heart of everyday distinctions between professionals and non-professions, experts, and technicians. In order to understand whether Norah and Maura's performance of "making things' right" was organizationally evaluated as a professional or personal attribute, it's useful to compare how their performance was viewed in comparison to that of another nurse practitioner.

Sarah and Team Black

Sarah was the NP who anchored the black team. Like both Norah and Sarah, her clinical specialty was in geriatric care. By her own account, Sarah had had a long and satisfying career

as a bedside nurse before deciding to become an NP. Sarah began her nursing career in 1960. Twenty-eight years later, she became a geriatric nurse practitioner at the age of 49. Like Maura, however, PACE was her first job in primary care. “I never really did this kind of nurse practitioner work where you’re really in charge. And I wanted to see if I could do it.” Already in her mid-60’s, Sarah came to the Center to see if she could tackle primary care.

As the NP of the black team, she was the primary care provider for a little over 100 patients. Given that their organizational responsibilities and pressures were largely the same, much about Sarah’s day was similar to Norah and Maura. However, Sarah’s orientation to carrying out these responsibilities was markedly different. After spending only a couple of days with Sarah, I was viscerally struck by one defining difference: her telephone was comparatively silent. In that first week, her daily average of calls from members and their families was about seven. By comparison, Norah—designated as “one of the best”—would receive 16-18 such calls. Given that the vast majority of patient calls were directly dialed rather than transferred from a staff member, the difference could not be explained by different staff behavior; the reason had to lie in different patient behavior. Why did Sarah’s patients behave so differently than Norah’s?

After closely observing Sarah’s day, I began to formulate a very simple answer: Sarah did not cultivate calls. Like all of the nurse practitioners’ patients, Sarah’s patients and their families had access to her direct office number. And they *did* call. I witnessed Sarah receiving calls ranging from questions about specialist appointments to problems, to medication delivery, to transportation. But unlike Norah, Sarah made different choices as to how she responded. If a patient had problems with transportation, she would listen to their complaints, but she would address the problem by giving them transportation’s direct number. If a patient called about a

problem with a missed specialist appointment, she would tell them to call the appointment clerk. By not taking on the role as complaint conduit, Sarah's patients never learned to call her first. This difference in responsiveness began even before the encounter. Norah checked voicemail and returned phone calls throughout the day. She behaved as if her phone was just as important as a physical patient encounter. By contrast, Sarah would triage her voicemails and return calls; only urgent "sick" calls would be prioritized. When Ms. Tribble left a message about stomach pain, Sarah would return the call promptly. Other calls might not be returned until the next day or the day after. By not performing responsiveness, Sarah effectively eliminated herself as the first line of defense for patient complaints.

When doing organizational fieldwork, one way to concretely thank the organization is to offer assessments and suggestions of their practical problems. As an outside evaluator, I had been poised to share the different styles and strengths of the three teams, highlighting Sarah as displaying the most skill at delegation. Using the rubric of "personal style," I had viewed Sarah's practice as differing from the other NPs primarily by approach. As the fieldworker, situated both inside and outside the action, I saw Sarah as displaying a kind of expertise that few of the other nurse practitioners possessed. I was struck by how much she relied on the skills of other people in the organization, from her appointment clerk to her primary care nurse, to the occupational therapist. When action could be taken, she would sometimes respond, but she would just as often refer. She did this not only in the case of organizational problems like transportation or appointments, but also with clinical problems that could be addressed by other health care professionals. More significantly, her approach was not to authoritatively delegate tasks but to share authority.

Before I could share my view of Sarah's expertise to the organization, I began to see evidence that the Center had a different understanding of her job performance. One afternoon, I found myself in the third floor hallway, having an impromptu conversation with a member of staff. At one point, it was opined to me that Norah was the person on her multidisciplinary team who seemed to "know the whole case." This pronouncement was not made within a context of praising Norah, but to comparatively criticize Sarah. This staff member thought that Sarah's style was "disorganized." I first took this conversation lightly; to be noted, surely, but no different from the dozens of off-the-cuff opinions and complaints I would hear about a co-worker. But the content of this and other conversations about Sarah was more than idle gossip; it would ultimately manifest itself as an organizational belief.

Almost two months after I had stopped spending my days at the Center, I dropped into the clinic to say hello. I heard the news first from one of the primary care nurses. A few days before, Sarah had been told that administration was switching her primary care nurse with that of another team's. The nurse fumed that administration had called Sarah's team disorganized, unfairly, in her estimation. I walked down to Sarah's office and gingerly approached the subject. Did she know why they were changing her nurse? She repeated the same reason—administration considered her team disorganized. I heard the same explanation from Sarah's soon-to-be-former RN. I was beginning to understand that PACE did not interpret the differences between Sarah, "the disorganized NP" and Norah, "one of the best NPs" as a difference in style, but as a difference in skill.

There was something about how Sarah did her job that the Center's administration found in need of intervention. And it was not, apparently, what she did—directly providing primary care to patients—but how she did it. It is entirely possible that Sarah's clinical skills were not as

good as Norah's, but evidence of this kind was not marshaled. According to the NPs and chief nursing officer (CNO) I interviewed, this kind of data was not collected. The woman who served as CNO in December of 2010 said, *I supervise the NPs, but not their practice. That is their responsibility.* Rather, it was Sarah's "disorganization" and inability to make things right for patients and for the organization that triggered administrative action. Interestingly, after diagnosing Sarah's team as disorganized, the specific intervention was not to modify the behavior of the physician, social worker, occupational therapist, or physical therapist. Nor was it to provide team-wide training in skills of collaboration or delegation. The organizational fix was to give Sarah's team a different nurse. How did this organization practically understand the connection of expected expertise with nursing? Particularly when these expectations normally fell not to the multiple layers of nursing personnel in the organization, but to the nurse practitioner specifically?

Cultivating Expertise

Within this nurse-managed health care organization, which used a diverse interdisciplinary team to provide all-inclusive care, the nurse practitioner was sometimes referred to as the team leader. Although some team members (NPs and others) openly disputed this characterization, arguing that they worked together—no leader needed—this working model is of some use in understanding how Sarah's designation of "disorganized" came to make organizational sense. Norah was one of the nurse practitioners that did describe her role as that of leading. When I first sought permission to attend Norah's team meetings, deciding against jumping down the rabbit hole of asking The Team to decide, I first approached Norah. I hesitantly stood in her doorway and made my request; apologetically ending with "I know you're not the 'team leader' but..." at which point she interjected, *Well, I kind of am the team leader.*

Not officially. I tell member's families all the time "I'm not the president." But the NP, we're sort of put in this role. How did that look in practice?

When I first witnessed the rhythms of Norah's day, I characterized her as beset with "interruptions." I saw the phone calls, emails, doorway intrusions, and patients jockeying for her attention as intrusions on the classic medical encounters I had expected to see. One of my initial hypotheses was that the NPs were inhabiting a slightly updated portrait of the harried floor nurse—called to be responsive to everyone and everything but without the ability or authority to say no to anyone. Given that most practicing nurse practitioners began as hospital floor nurses, one should not be surprised to see some aspects of that professional orientation. However, as I spent more and more time with them, not just in the clinic, but also in their weekly team meetings, I began to see the ways in which the NPs weren't just "doing things," they were cultivating and performing expertise.

Team meetings were an important time for discussing patient concerns. Each team met weekly for 1.5-2 hours. The primary organizational purpose of these meetings was to discuss and approve the comprehensive, PACE mandated assessments that had to be completed for all members every six months. Either an NP or physician may have completed the medical exam. Although I attended these meetings expecting to see NP and physician conflict, my expectations were almost never gratified. The medical assessments were delivered in a pro forma style; in many teams, the notes from the medical exam were simply read out loud, often at a galloping pace. In cases where the physician presented the assessment, nurse practitioners might ask about a point of fact, but neither questioned nor made suggestions.

When NPs presented, occasionally, a physician made a recommendation. On these occasions, there would begin a carefully choreographed dance of civility. The physician would

usually practice restraint, phrasing her recommendations as suggestions rather than orders. *You may want to think about trying a different regimen for her hypertension or I've heard that Paxil is good for uremic itching. It's worth a try.* The NPs responded to physician suggestions with an almost jovial deference, with responses like “Oh, that’s a good idea,” or even more explicitly “See, that’s why you’re [the physician] here.” But these suggestions rarely produced discussion, argument, or conflict. During talk that was demarcated through the structure of the meeting as entirely medical, the nurse practitioners performed deference to medical authority. Within this organization, nurse-managed though it was, physicians had (when they cared to use it) complete control over wholly medical decisions. Although there was variation in how the nurse practitioners understood their practice relationship to physicians, during team meetings when a problem was structurally demarcated as distinctly medical, the nurse practitioners practiced deference to medical authority.

And so, it was remarkable when this did not happen. During the length of my fieldwork, the Center hired two full-time physicians to replace one who had resigned. I had the opportunity to watch how both of them worked out what it meant to be a physician at a nurse-managed practice, and what it meant to be a physician alongside nurse practitioners. One of the new physicians was Dr. Andrea Shelby. While one NP anchored a team, each physician shared two teams. Dr. Shelby was the physician for both Norah and Sarah’s members. Dr. Shelby was a twin balance of tranquility and resolve. She was soft-spoken, but having been a practicing physician for well over 30 years, she also appeared to be well accustomed to the mantle of authority required of her profession. In her first 6 months at PACE, it was often during team meetings that this authority was tested. Usually, this was done in small ways. The

boisterousness of team meetings often overwhelmed her voice and understated manner. But during one memorable team meeting, it appeared in a most atypical fashion.

Norah had just finished reading through the charted notes for Ms. Howard's assessment. Ms. Howard had long-standing swelling or edema in her legs. While she had a number of medical conditions that could cause this edema, its chronic nature was exacerbated by her refusal to sleep with her legs elevated. Like many members with physical limitations, she preferred to sleep in a reclining chair in her living room rather than make her way to the bedroom or engage in the struggle to get into bed. With her legs always in a dependent position, swelling was destined to remain an intractable problem. After listening to this assessment, Dr. Shelby recommended that Norah try taking Ms. Howard off of Gabapentin, a non-opioid medication for pain control. Her reasoning was that one of the side effects of Gabapentin was lower-extremity edema. In an unusual reaction, Norah resisted. *You don't know long it took me to get her pain under control.* For Norah, the complication was that Ms. Howard was a former substance user. Finding a non-opioid medication that adequately addressed her pain had created stability in her treatment regime that Norah described as previously being quite tumultuous. The physician quietly stood her ground, refusing to accede the point. Neither did Norah explicitly refuse to accept the suggestion. In the face of physician certainty, Norah eventually, if reluctantly, performed deference, and moved the discussion onto the next member case.

I stopped by Norah's office later that afternoon to ask, what did she plan to do about Ms. Howard's medications? Well, she said firmly, *I'm going to rely on the fact that Dr. Shelby will probably forget.* And then Norah filled in more about Ms. Howard. *I remember when she was stealing [a family member's] pain medication. She would come in, everyday, crying big crocodile tears.* For Norah, finding an effective pain medication was not only a matter of

balancing the benefits and side effects of a medical intervention, it was also about managing the totality of Ms. Howard's problems—and this totality of problems were not just about her edema, they were both social and organizational. A crying Ms. Howard was not just a patient problem, but also an organizational problem. A stealing Ms. Howard was not a clinical problem but a management problem. *I've been prescribing Gabapentin for years and none of my patients have ever had that side effect. I'm going to do some research of my own. But I'll be damned if I'm going to take [Ms. Howard] off. I know why her legs are swollen, and it's not because of the Gabapentin.*

Although this encounter was an abnormal one, it allowed me to see the normal state of affairs more clearly. When Dr. Shelby produced expert knowledge about side effects, Norah's retort was not to refer to her own clinical experience with Gabapentin, but to begin a narrative of her experience with Ms. Howard. She did not fight medical expertise with medical expertise; she used a different arsenal: her knowledge of her patient. In team meetings, the nurse practitioner would routinely marshal not her general medical knowledge about diseases, conditions, or medications, but her specific knowledge about particular patients. Moreover, she was able to demonstrate a level of patient knowledge that was unique in its depth.

How did Norah come to uniquely know such detailed information? Although some staff members did, in fact, visit patient homes, the nurse practitioners did not routinely do so. Neither did their days, structured by clinic hours, structurally encourage family member visits. The center's medical director, who had spent years working as a community-based primary care physician, was not shy about describing this as a shortcoming in the way the NPs practiced. She believed that the NPs needed to have more face-to-face meetings if they wanted to build relationships with families and include them in clinical decision-making. However, the NPs

were not cut-off from the concerns of patients or their families because they made themselves constantly available to patients as well as staff mediated information about patients. This posture of availability allowed Norah, who spent most of her day firmly ensconced in the clinic, to develop an almost encyclopedic knowledge of her patients' lives outside the clinic. Without referring to charts, she knew who lived alone, who had a difficult sister, and who would never remember to reorder her meds. She could describe the layout of their homes, the contents of a refrigerator, and which neighbor could be called on in a pinch. And she gathered this information not in spite of, but because of the interruptions in her day.

In the case of Ms. Howard, Norah drew not only on her knowledge of her clinical history, but on her knowledge of her daily routine, her relationship with her family members, as well as assessments of her personality. Norah knew that Ms. Howard's bed was never slept in, not because of Ms. Howard's self-report, but because she listened to the stories of others—such as the nursing staff or an aide—who had been inside Ms. Howard's home. This information was not delivered in the context of formal medical reports, but through a mixture of informal storytelling and practical problem solving. In the case of Ms. Howard, as well as other patients, Norah held a particular kind of detailed expertise about patients that few others in the organization knew.

The nurse practitioners also understood themselves as occupying a position distinct from that of the physicians with whom they worked. Norah described what she did as “different” in way that were difficult to articulate because those differences seem to be self-explanatory. About the physicians she said, “I’m sure they are happy to let nursing do what it does.” This view of the NP role as somehow “different” from physician practice was shared among the NPs.

Norah was so convinced that this distinction was so self-evident that she assumed the physicians “were happy to let nursing do what it does.”

As I spent time with the physicians, I wasn’t so sure that the physicians were exactly happy with the state of affairs. Dr. Barnes was a full time physician at the Center. Like the other full time physician, she was the collaborating physician for two teams. I began my fieldwork just a few weeks before she began working at the Center; it was instructive to watch how a physician made a space for herself within an organization where nursing held such a prominent role. About ten months into her tenure, I asked her what has been the most difficult thing she’s had getting used to, she replied, “That they’re not my patients. Usually, as a physician, they’re your patients. Here, they’re our patients. They’re transportation’s patients. They’re the caregiver’s patients. They’re the nurse’s patients. They’re everyone’s patients.” As we continued our conversation, I understood her statement as more lament than complaint. Dr. Barnes appreciated the holistic, team based approach to care. She came to the Center in part because she was attracted to this kind of model. However, there was something professionally unsettling about having multiple decision makers. But not all team members expressed this feeling. I began to suspect that there was something particular to the physician experience. As I observed the teams’ interactions, I came to have a more nuanced understanding of loss of physician control and its relation to the role of the nurse practitioner. In order to understand how this knowledge came to be organizationally centered on the nurse practitioner, we also have to better understand the role of the physician at the Center.

Physician Absence

While each team was anchored by a nurse practitioner, the medical care of patients was shared with physicians. While Norah’s practicing state does allow off-site physician

collaboration, a combination of the additional regulatory constraints of being a PACE site and the medical frailty of the members made physical physician presence a priority for the Center. Although the Center had an organizational identity as a nurse-managed center, with two full-time physicians and a full-time medical director, there was significant physician representation. Curiously, however, representation did not necessarily translate into presence.

One of the first interviews I scheduled was with the woman who served as both the Center's chief operating officer and chief nursing officer. I wanted to get her understanding of how the clinic was organized. She began by describing the role of the NPs, the primary care nurses, and the wound care nurse. And then she moved on to the appointment clerks, medical assistants, and the clinic receptionist. I listened patiently as she began to talk about the dental and podiatry services they also provided in-house. For more than a half an hour, she talked in great detail about their clinical services, but the word "physician" never came out of her mouth. Finally, I had to ask directly: "What is it that the physicians do?" This is a question that I began to ask all of the staff members I interviewed, from the occupational therapists, the social workers, to the clerical staff. I noted a distinct paucity of language to describe what it is that the physicians did. While everyone was sure they did something worthwhile, few people could describe what that something was. In the months I spent in the clinic and attending team meetings, I began to understand that few people knew what the physicians did for a very simple reason: physician work was not a routine part of center life.

I first noted this as a volunteer. Even though my work with recreational activities rarely took me into the clinic, I became conversant with how members saw the clinic: the place to get things they needed. They would glance at their watches and wonder if they had time to see Norah before lunch. They had a question about a medication. Or wanted to see a specialist

about a leg problem. To talk to someone about the home health care aide who shows up late every day. I came to know the nurse practitioners and the nurses by name and reputation before I had even met them. However, there were few mentions of the physicians by name. Gossip about the comings and goings of staff members were a common activity among the members, but when one of the physicians resigned, the news barely registered in patient conversation.

When I moved inside the clinic, I formed a more concrete set of observations. As you walk through the clinic, at the entrance to each team's pod sits a printed list of each team's clinic relevant staff. The nurse practitioner is named. The primary care nurse is named. As is the medication room nurse and the appointment clerk. The physicians are not listed. At first, I choose the simplest explanation to explain this absence. This is, after all, a nurse-managed center. Perhaps the physicians, though a regulatory necessity, were adjuncts rather than full members of the organization. What I was seeing with the missing physician names was, perhaps, a concrete act of exclusion. But that explanation, while not entirely without merit, did not turn out to be complete. Instead, I began to note the ways in which the physicians *absented themselves* from much of center life.

Inattention

This phenomenon could most clearly be seen during team meetings. One of my observations was that in this setting, very little organizational decision-making or action was clearly marked as entirely medical. When I first began attending team meetings, I was initially surprised that the routine assessments—the federally mandated assessments that were the primary organizational purpose of these meetings—were not the most dynamic parts of the meeting. It was only when the agenda switched to the non-routine of “member issues” that opinions were exchanged and conflicting ideas arose. During member concerns, any staff

member could bring up a problem or share anything they considered to be pertinent information about members. They would debate and discuss such issues as what to do about a member's cockroach problem that prevented home health care aides from providing regular care, or how to convince a member who was both blind and had limited feeling in his extremities due to neuropathy that it was best if he no longer lived alone.

These problems were rarely discrete or simple, and conversations about them were long and prone to narrative exposition. Although many team members frequently complained about the length and circuitousness of these discussions, there was a high degree of participation, both through talking and through a posture of engaged listening. Except, that is, for the physicians. During long conversations and debates about member issues, the physicians normally multitasked: signing written orders and doing clinical work through smart phones. When opinions flew or stories were shared, physician attention was usually elsewhere.

When physician time was in short supply due to vacations or competing workplace concerns, team meetings were treated as optional—they arrived late, left early, or skipped them entirely. Their behavior communicated their opinion that little of medical importance happened during these meetings. However, in choosing to ignore conversations that were not wholly medical, the physicians left themselves out of most organizational decisions, conversations, and information sharing about patients. We can differently understand Dr. Barnes' feelings of discomfort. Despite deference to medical authority, this authority was required in a shrinking proportion of patient concerns. By comparison, the nurse practitioner's presence was deemed to be essential to these meetings. If the NP were late, the meeting would wait for her appearance. In her absence, meetings were often cancelled or shortened. However, just because the physicians were not engaged in this kind of work that did not mean that they were not working.

Negotiated Absence

Part of how PACE supports its medically frail members is by providing continuity of care. So although the goal was to keep members out of the hospital and out of the nursing home, both outcomes did sometimes occur. Members recovering from surgery might enter the nursing home for short-term stays. And sometimes, despite everyone's best efforts, the nursing home became the permanent home of some patients. However, no matter where they go, they remain PACE members; PACE continues to be responsible both for managing and paying for their care. Therefore, there were always a certain proportion of members being admitted to and being discharged from the hospital, and a certain proportion of members who resided, temporarily or long-term, within a nursing home. Someone had to do rounds at the nursing home and someone had to do rounds at the hospital. The hospital remains an institution where NP privileges are uncommon; there was no history at this site of NPs routinely seeing their patients in the hospital. However, in the past, the site's NPs and physicians had shared the responsibility for nursing home residents. Until two months into my fieldwork. I was not present at the meeting where the news was delivered, but I was sitting in one NP's office when another called on the phone. The caller had also missed the meeting and wanted to know more about this news. At the meeting we had both missed, the medical director had let the NPs know that the physicians thought it would be best if they took all responsibility for the members in nursing homes. The reasoning was straightforward: when nursing homes called the Center wanting patient information or signed orders, it made sense to have one point person rather than sometimes an NP and sometimes a physician.

The nurse practitioners had different views about the merits of this change. However, as a group, they accepted the decision. No one questioned the physicians' right to make a unilateral

decision without NP input. One could understand this decision as the organizational equivalent of the civil dance between NPs and physicians that I observed at team meetings: although individual NPs may have grumbled in private, in the face of physician certainty, the NPs displayed deference. However, there was more going on here than differences in authority. As these new physicians carved out acceptable, meaningful work in this nurse-managed organization, they began to take steps like stationing themselves in the nursing home, to position more and more of their work outside the Center's clinic. I watched as these physicians began to spend more of their time at the hospitals and at the nursing home and less time being available within the clinic. While this could have simply been a reasonable division of labor in an organization crowded with clinicians, it became clear that for some physicians, this wasn't just a divvying up of tasks; it was also a meaning-filled construction of separate spheres of expertise.

“Sitting in the Clinic”

One such physician was Dr. Barnes. Like all of the current physicians, Dr. Barnes was a relatively new hire. Ten months into this position, I interviewed her as we drove back from rounds at the nursing home. I was curious as to how a new physician would come to understand her role within a nurse-managed organization. I asked what has been the most difficult thing she had encountered about working at PACE. Her response was that part of the difficulty is that “people” expected her to be like the previous physician. They wanted “to be able to email you and have you stand up on your desk, come in and attend to what I’m attending to right now, thank you.” They want the physicians to be “sitting in the clinic.” She elaborated, “No, I’m not going to let the clerk in the front of the clinic say so-and-so does not have time to see these four people who walked in and she told me you would see them.... There’s a certain amount of arrogance on the part of the physician. Yes there is. The thing is that there’s a certain need, at

least on my part, to change the expectations.... I'm really good at what I do [so] please don't throw this or that toe at me because you don't have time."

Although Dr. Barnes remained vague about the "people" and the "they" that had these expectations, some members of this crowd must have been nurse practitioners. Dr. Barnes was making it clear to me, as she had made it to the nurse practitioners, that she would not be like "that other," previous physician who could be found sitting in the clinic. She had come to the point of view that time spent in the clinic, was not, at least for her, appropriate work. Although the previous physician had, in fact, sat in the clinic. And even though at almost every other PACE site in the United States, sitting in the clinic is done primarily by physicians, in this setting, where NPs have reordered what it means to do work in the clinic, sitting in the clinic was not only something she was personally unwilling to do, it was something that she saw as outside the bounds of appropriate work. She expected PACE to recognize what she was good at and to not "throw this or that toe" at her; the implication being that this or that toe was someone else's work. Locating the appropriate work for a primary care physician outside the clinic was not simply about task allocation, it was about a fundamental reordering of what physician work was understood to be. Dr. Barnes wanted to do what *she* was good at and what she was trained to do, and that, in her mind, was distinct from what the nurse practitioners did.

When I spent time with the physicians outside the clinic, I could not help but note how comfortable they seemed in these settings. In settings where the physician's role was clear and unquestioned, the physicians went about their work (and socializing comfortably with nursing staff) in ways that were easy and fluid. Everyone knew what their work was, and everyone knew their role. This contrasted deeply with my observations about what physicians did inside the clinic.

The Physician in the Clinic

I have noted above how physician absence manifested itself in relationship to the routine of center staff as a whole. This absence, however, had a more direct set of effects on those involved in clinic work: the nurse practitioners. The effect of physician absence could be seen most fully when the physicians did spend time in the clinic, because, despite Dr. Barnes' disavowal of "sitting in the clinic," these physicians were required, at times, to do so. But when they were there, it often seemed as if they were on foreign soil. It was not simply a question of whether they had work to do; it was, rather, my observation that they simply did not do what was normally done. When I described the rhythm of Norah's day, you could also understand that as the rhythm of the clinic as a whole. One of the realities that this rhythm upended was the idea of a scheduled and discrete "doctor's visit" during which a singular, medical complaint was addressed. That kind of discrete carving up of patient bodies and time did not match clinic rhythms. Attuned to a different ordering of clinical time, physician practices were literally out of sync with the way work unfolded in the clinic.

The first effect of this different ordering was that physicians' presence did not significantly lessen the workload of the NP. Nurse practitioner patient encounters happened unceasingly, in hallways, through doorways, and through the telephone. This was made possible, in part, through an almost radical availability. Patients and their families had direct access to the phones and voicemails of the NPs, which they used to directly relay their concerns. By contrast, patients did not have the same level of direct access to the physicians. Although some patients had the direct number of a physician, it was not a common practice to provide them. Physician phones did ring—and they did so quite frequently—but the caller on the other

end was usually a nurse or another physician. Physicians rarely fielded unmediated requests from members. This difference in availability was also true for staff.

The physicians were sometimes in the clinic, and sometimes they were not. Spending some mornings at the hospital and some afternoons at a nursing home, their schedules were inconsistent. However, it was more than inconsistency that shaped their availability, it was a refusal to regularly communicate any schedule at all to anyone other than the medical director. No one ever knew when a particular physician would be physically present in the clinic. I witnessed several instances where the clinic receptionist or a caregiver would come back to the clinic and ask a nurse or nurse practitioner about the whereabouts of Dr. Barnes or Dr. Shelby. There would be an ambiguous shrug or a non-committal *I think she's at the nursing home*. Without a schedule, the physicians did not, as a practice, make themselves dependably available for face-to-face contact. Which is not to say that the physicians were not available. Anyone who needed to contact them could and did call their cell phones. However, this meant the physicians got called when *only their particular expertise* would do. Why call the physician when you could talk to the nurse or nurse practitioner, both of whom are regularly stationed in the clinic? Without a regular and dependable presence, the physicians remained only peripheral figures in the clinic.

This peripheral relationship to clinic-based work meant that even when the physicians did see patients in the clinic, there was often work left for the NP to do. I saw on more than one occasion a patient flag down an NP after they had already seen a physician. When physicians saw patients, they were doing something quite different than when NPs saw patients. Physicians did not respond to all manner of requests. The complaints both patients and the organization

were accustomed to getting addressed within clinic encounters were frequently unaddressed in physician-patient encounters.

Despite this spatial negotiation of work, this organization, like most health care organizations, still had a working definition of NP and physician interchangeability. From the organization's perspective, either an NP or a physician could solve clinic problems or do clinic work. However, this orientation was often at odds with the reality of work segregation. Where this could be seen most clearly was when an NP went on vacation. When such an organizational disaster happened, administration would alert all staff that the physician on the team would be "filling-in" for the NP. In the NP's absence, any medical concerns should go to the team's physician. But what actually happened looked quite different.

Clinician Interchangeability

What happened when physicians were asked to "fill-in" and do what was normally NP work? In various ways, they simply did not do it. During one week of a physician filling-in, one of Norah's patients had just been discharged from the hospital. Typically, upon discharge, members are brought to the clinic to be seen before being taken home, to answer questions, and to assess any changes to their treatment plan. In Norah's absence, the patient was added to the Dr. Shelby's schedule. However, Dr. Shelby, having just done rounds in the hospital, had literally been the one to discharge the patient. On seeing the patient's name on her roster, she told the primary care nurse: *I already saw her. She's fine to go home. I don't need to see her again.* The nurse spent a second or two protesting, but eventually went to find someone who would do the work that needed to be done—another team's NP. This NP did see the member. Upon questioning the member, she realized several things that had been left undone: her medication changes hadn't been ordered, and, because of increased debility, the member needed additional

hours with her home health care aide. In this case, because the patient was medically fine to go home, the physician failed to do the work that was routinely done in the clinic, which was to pick up the pieces of transitioning a member home. This NP spent the next 35 minutes making the necessary phone calls, sending the necessary emails, documenting in the chart, and writing and faxing prescriptions for this patient. This was another example in which physician presence did not alter NP workload. The physicians and the NPs were, quite simply, not doing the same job. It is unlikely that Dr. Shelby intentionally left work undone; however, it was clear that this was a kind of clinic work that she was both unaware of and unaccustomed to performing.

The separation of NP and physician work was not simply manifested in physician behavior, but in behavior throughout the organization. Although administration might declare that a physician was filling-in for an absent NP, the embedded, practical logic of the organization declared this not to be so. When either Norah or Sarah were absent, it was not the physician who was treated as filling-in, but their respective primary care nurses. Both the Center and clinic receptionists would forward member calls, not to the physician, but to the phones of the nurse, who would act as the front line fixer of member concerns. On the red team, when Maura was gone for an extended two-week vacation, her nurse had a different strategy. For the first three days of this vacation, the hallway would resound with “Where’s Maura?” as patients came to the clinic in search of fixes to their problems. Maura’s primary care nurse would listen and refer as needed, but her strategy was that if something was not medically acute, instead of forwarding them on to the physician, she would encourage them to wait: *Maura will be back in two weeks*. By the beginning of the second week, there were few if any calls of “Where’s Maura,” and her end of the hallway was uncharacteristically silent. The members, upon learning that Maura was out, simply stopped coming to the clinic and awaited her return.

The Physician's Perspective

When the Center's administration declared that the physicians would fill-in for absent NPs, they weren't just using the logic of interchangeability; they were also relying on the Center's team based model. Within this model, member problems were solved, not by disinterested experts, but by an involved, interdisciplinary team. Therefore, it seemed reasonable to assume that the other medical provider on a patient's team should be turned to when one was unavailable. However, the structure of the physician's work did not make this logic quite so salient.

Placed on multiple teams, asked to see any patient, regardless of team, who needed to be attended to at the hospital or nursing home, the physician's work was not only spatially distinct from normal clinic work, it was structurally distinct as well. For the physicians, then, the division between NP and physician work was much more salient than the divisions between teams. It was this understanding that made the physician's not only sometimes unable, but unwilling to do nurse practitioner work. When an NP went on an extended vacation and Dr. Barnes was asked to fill-in, she publically and rather heatedly announced during the all-center meeting that she simply did not have time, stating that "The NPs should fill-in for each other." For Dr. Barnes, clinic work was NP work. She had other things to do.

Physician: Consultant or Collaborator

The role of the physician at the Center was often in flux. The nurse practitioners had different expectations for the role of the physician in their own practice. Norah describes herself as good with people. I found her charming—almost charismatic. But professionally, Norah calls herself "a lone wolf." She developed this style at her first primary care job as an NP. It was at a retirement community called Sunshine Grove. "I worked with two physicians who were only

there part time. So for the most part the majority of the time probably 60% of the time I was the most experienced medical person there on site.” She worked there for seven years, and gained a lot experience. But this population could be described as the “well” elderly;” Norah described them as educated, reasonably healthy, and having private insurance in addition to Medicare. So when she came to the PACE site in 2005, there were still a lot of things to learn. “There were things here that I didn’t see very often at Grove because again we’re seeing people who...just didn’t have good health care. So I’m seeing the end stages of renal disease. I hadn’t seen that...end stage CHF’ers (congestive heart failure). All of a sudden it was like, holy crap, these people are a mess!” When I asked her how she learned to deal with more complex patients, she said “On the fly!... Look if I’m dealing with someone with end stage CHF and I’ve never dealt with them before well then I’d better find someone who knows how to take care of them. And then once I see how they do it—once I see how it’s managed, I’m good to go.”

Out of the three teams, Norah had the most primary care experience before she came to PACE. Still, all three reported “learning on the fly.” Unlike medicine, nursing has a generalist model. Hospital nurses do specialize, but mostly by position, not by university-sponsored training. Nurses are expected to learn on the job. This model is part of NP expectations as well. However, in a primary care setting, the person who might be turned to is one’s physician collaborator. When I asked Norah how she worked with the physicians she replied: “I don’t think I use them—and this is terrible. I guess I look at them for me personally as almost like consultants rather than collaborators. I grab them when I’m stuck...but if I have a clear direction, if I really know and I think I’m heading in the right direction then I don’t.” Norah defines this relationship as “consultative” rather than “collaborative.” She doesn’t share her patients with the physician; she’s a lone wolf who calls when she needs assistance.

Norah's "lone wolf" style did not necessarily win her any accolades from the physicians: "I have to say some physicians aren't comfortable with that. Dr. Katz hated that about me and made it very clear to me that he was irritated that I never communicated with him. He *really wanted to know what was going on* and he got visibly angry with me, he would start grinding his teeth together. You really don't like me to know what's going on, do you Norah. And no, it wasn't that; it's just that—I didn't think he needed to know."

Sarah from team black described her relationship with the physicians differently. Because PACE was her first primary care position, she felt it was a stretch for her. When I asked her how she learned to manage she said:

Dr. Katz was here and any time I had a question...I'd just go to him and talk it over and then there's Up-to-Date [an on-line resource].... You learn to use the resources. And then after a while you see the same things over again, so. At nurse practitioner school, we are taught to recognize normal. Okay, I don't know what this is but it's not normal. So let me refer. It's like primary care docs refer to rheumatologists. Well, nurse practitioners refer to medical docs.

When I followed Sarah and watched her practice, she would often speak to Dr. Shelby, the physician on her team. Because the black team was the last team I observed, I found their relationship remarkable. Sarah did not just talk to Dr. Shelby when she had a specific question; it was part of her routine. Dr. Shelby's office was in Team Blue's pod. So if Sarah wanted to see her, she had to make a concerted effort. Which she did, at least once a day, usually at the end of a clinic day. She would gather her thoughts and walk down to Dr. Shelby's office. She would share any changes in medication, any abnormal labwork, and sometimes would just share

updates on patients. Based on her behavior, Sarah treated Dr. Shelby, not just as an information source for what she could do for her patients, but as someone with whom she actively shared patients.

No physicians were grinding their teeth at Sarah, but it was unclear if this reliance on physician expertise positioned her to be a better or worse organizational actor. Reliance on physicians required their presence. As these physicians moved more and more of their practice away from the clinic, collaborative care became more difficult. And as physicians more generally absent themselves from primary care, Sarah's model of collaboration may prove to be less sustainable than Norah's lone wolf. September 4, 2012, was Dr. Shelby's last day at PACE. In response to staff murmurings about hiring plans, the medical director sent an email saying that they were looking, but full-time geriatricians were difficult to find. Other practices in the city maintained unfilled vacancies for years. She had no expectation that they would find anyone soon. The clinic would be down a physician for some time to come.

Conclusion

As nursing and physician organizations fight over the terms of nurse practitioner legitimacy on the public stages of state senates, media campaigns, and newspaper editorials, everyday negotiations continue to occur on the smaller stages of the workplace. We should understand these negotiations as not simply occurring between clinicians, but as an encounter between different understandings of what it means to care for patients. But these differences do not come from separate kinds of knowledge: the science that grounds physician and the nurse practitioner practices is shared. Indeed, I observed few disagreements on the grounds of diagnosis and treatment; in this site, the physicians practiced restraint and the nurse practitioners performed deference when it came to the public performance of specific forms of expert

knowledge. However, a shared science and shared western medical tradition was not the same as sharing an understanding of what it meant to care for patients. The nurse practitioners cared for a different kind of clinical body than their physician colleagues. This body's chief complaints were constituted not only by indigenous patient complaints but also by those of the organization. Her skill lay in solving the varied collection of complaints that found their way to the clinic.

The nurse practitioner—the skilled nurse practitioner—actively cultivated local knowledge of each patient. Moreover, this cultivation became important not just in how an individual NP may have personally chosen to carry out her work, but became a key part of her organizational role. The NP skill that the organization relied upon required a professional openness to both patient and organizational expectations. When the NPs did so, they made certain kinds of information visible and *able to be known* within the context of clinic encounters, whether those encounters were with patients or with staff. The NP was not simply the handmaiden for organizational tasks; she became the informational center and resident expert on each patient. The skilled NP used this information to “make things right,” for patients as well as for the organization.

This work demonstrates the role of shop floor negotiations in the working out of not just personal but professional legitimacy. Negotiations regarding physician and nurse practitioner work mattered for how clinical work was defined, organized, and delivered at this site. At this site, it was not only the NPs, but the physicians who had to come to a different understanding of their own expertise. If clinic encounters were successfully completed by nurse practitioners, that kind of work was no longer physician work. Sitting in the clinic became NP work. Although these physicians may have decided that “sitting in the clinic” was no longer physician work, the clinic was still the place where these patients went to receive attention to their concerns, in

whatever way they defined them. There was no NP clinic and physician clinic; there was just, “the clinic.” The nurse practitioners were not simply bringing their practices to the clinic, they were transforming both patient and organizational understandings of what counted as clinic work. And for these patients, their experientially embedded notions of what it meant to be cared for, were radically and fundamentally changed.

If NPs are sometimes *doing something different*, both as professional and organizational actors, then this may challenge exactly what it means to provide primary care. Because whether we call it medical work or nursing work, primary care is the new policy battleground for new forms of organizing, providing, and paying for health care. And an important front of this battle is happening in underserved, rural, and minority communities where physician absence has created spaces, not simply for new clinician “stand-ins,” but for the reordering of work. And while NPs are, perhaps, winning professional skirmishes at these sites, we may also want to think about the consequences for the people who are the sites of NP expertise. While problem solving within the medical encounter turned difficult situations into solvable situations, this recasting of life’s problems as clinic problems sometimes de-legitimated competing locations for problem solving (Trotter n.d.).

At this site, nurse practitioners not only “did something different” from their physician colleagues, they were evaluated differently by the organization in which they worked. Although the Center’s administration explicitly considered some NP and physician work to be interchangeable, there were distinct ways in which they implicitly treated them as different kinds of professionals. When physicians operated within a narrow definition of medical care, there may have been grumblings about them as individuals, but not as professionals. When nurse practitioners such as Sarah tried to operate within this same narrow definition, there was not only

grumbling but administrative censure. While the organizational structure of this site is unique (with NPs as not just one of, but THE primary care provider), the belief that nurse practitioners have different responsibilities to their patients, even though they are hired for their medical expertise, was manifested throughout the organization.

Now that the President's affordable health care law has survived not only a supreme court ruling, but a presidential election, we will continue our national conversation about how to provide primary care services to a variety of communities in need. But the law does set the grounds for this conversation. It not only targets the training of new primary care physicians' it also supports the training of nurse practitioners. More interestingly, the law will also invest money in creating more nurse-managed health care centers, increasing the number of these aberrant, through the looking glass, health care organizations. My work suggests that as we continue to add other kinds of clinicians to medical encounters, we may also need to pay attention to their different kinds of practices. Because ultimately, whether physicians claim or eschew these practices as medical work or not, they are most certainly shaping the present and future of health care delivery.

Chapter 6 - Social Work, Nursing, and Caring Expertise¹⁰

When nurse practitioners are written about in health journals and newspaper articles, the ghost of the physician is never far away. Our yardstick of evaluation is physician practice, so we ask ourselves infinite versions of the same question, “Just how good of a physician is the NP?” I began my fieldwork with my own version of this question: what kind of physician would the medical doctors allow her to be? However, on my first day of fieldwork, I had an encounter that pushed me to look at other sites of intra-professional negotiation.

Although many people at the Center already knew me as a volunteer, I inaugurated my role shift with a formal introduction of my research at the Center’s daily, morning meeting. My introduction was uneventful, but its ending was punctuated by a conversation that changed my understanding of what was going on. As I stood in the hallway, just outside the meeting room doors, a woman whom I’d never met walked over and introduced herself. Her name was Frieda; she was one of the Center’s social workers. She was interested in my research and wanted to share an observation of her own. Frieda wanted me to know that her work in this organization was difficult. She leaned in, with a focused intensity, to say that there were problems with *communication* and with *leadership styles* within the teams. Standing in the hallway, in the midst of her colleagues, she would only speak in vague terms. Months later, during a confidential interview, I tried to get her to speak more concretely about her concerns. However, she remained guarded, hinting at dissatisfaction but unwilling to ever say much directly. I never came to know with certainty what was bothering Frieda. But the intensity of her dissatisfaction

¹⁰ An early version of this chapter was presented at the 2013 Eastern Sociological Society’s Annual Meeting in Boston, MA. Some of the content from this chapter is expected to be published as: LaTonya Trotter. “‘We just do things differently’: ‘Care’ as an Organizing Principle for Constructions of Nurse Practitioner Expertise.” In: *Caring on the Clock: The Complexities and Contradictions of Paid Care Work*. Mignon Duffy, Amy Armenia, Clare Stacey, eds. Rutgers University Press. Forthcoming.

was something that other social workers would convey. And unlike Frieda, they were able to voice their diagnosis of the problem, repeatedly, and with a shared articulation: they were social workers and the Center was a nursing organization.

In previous chapters, I describe how both narratively and through practice, the texture of difference in how nurse practitioners practice was achieved, in part, through attention to the socially embedded “whole” person. However, there is at least one other profession that lays claim to whole person case management and the world of social concerns. At many social service and health care organizations, case management is synonymous with social work. When I interviewed Frieda, she described her role as “coordinating care within the team and developing partnerships in collaboration with families.” Case management is not the entirety of what social workers do, but it is one of their core professional functions, particularly within in-patient, health care settings. Within such settings, one is likely to find social workers in charge of discharge planning for short-term stays at hospitals and rehabilitation facilities, and in charge of ongoing case management for longer patient stays at nursing homes and hospice programs.

The presence of social workers at the Center was atypical for an outpatient, primary care setting, but, perhaps, not for long. Some policy makers have argued that funding for case management should be part of any plan to make our fragmented health care system more coordinated, comprehensive, and, therefore, less expensive. Even though third party payers do not typically reimburse for case management services, hospitals have effectively used case management to lower the cost of inpatient care; those with an eye toward lowering the cost of outpatient care have argued for an increased role for case managers.

The Affordable Health Care Law addresses the role of case managers for precisely these reasons. One of the proposals described in the law is the idea of the “patient-centered medical

home.” These medical homes would, similar to the PACE model, use a team based approach that includes case management (Affordable Health Care Law, Sec 3502). While specifying the activity of case management, the health law does not specify what kind of professionals these case managers should be. If in-patient medical settings are any example, these case managers could be licensed, master’s prepared social workers. However, they could also be nurses.

Medical social work has a historical home in the hospital. In the 1980s, moves toward cost containment raised the acuity level of discharged patients and expanded the importance of discharge planning (Blumenfield and Rosenberg 1988; Holliman, Dziegielewska, and Datta 2001). As the professional who bridged the insularity of hospital systems with community resources and family supports, social workers enhanced and elevated discharge planning to a professional activity. However, social work’s ownership of that role weakened in the 1990s. Moves toward decentralization, cross training and trans-disciplinarity, led toward the closing of free standing social work departments and, accordingly, social work leadership. Social work roles were also increasingly compartmentalized; they did more case management and less direct patient care in the form of counseling patients about the stress and concerns about discharge. Hospital social workers were reorganized into case management departments where they found themselves, increasingly, supervised by non-social workers and competing with both differently credentialed nurses and un-credentialed caseworkers for the roles they had historically filled (Berger et al. 2003; Judd and Sheffield 2010).

Today, both social workers and nurses perform medical case management. While hospitals often employ both, it is notable that in the medical world, case management is no longer a skill to which social work has a unique claim; they are in competition with nursing for the skills that Frieda described as “coordinating care within the team and developing partnerships

in collaboration with families.” The specter of competition is not a phenomenon that only scholars have noted; individual workers believe it to be a concrete reality. One of the Center’s social worker’s told me “social workers use to do all hospital discharge planning. Now nurses have taken that over too.”

In Chapter 5, one of my findings was that nurse practitioners were content to accede to physician authority in matters that were wholly medical, in part because very little of their world in the clinic was seen as wholly medical. The nurse practitioners effectively, with physician acquiescence through absence, limited the scope of physician practice. However, physician absence alone is not enough of an explanation for the success of nurse practitioner legitimacy. We also have to explain how nursing keeps other claimants out. I argue that there was more going on at the Center than simply narrowing physician scope of practice; the NPs I observed were also successful at expanding their own scope of practice through annexing that of social workers. In responding to patient and family complaints, and dealing with the everyday difficulties encountered by their patients, these nurse practitioners (with greater and lesser skill) transported concerns that could be considered social work, into clinic work.

Using the fieldwork from the interdisciplinary health care teams, this chapter tries to explain how these nurse practitioners successfully convinced their colleagues, their employing organization, and their patients that they, rather than the social workers, were the resident experts for solutions to problems that fall outside narrow definitions of medical problems. This chapter pays attention not just to the ways in which nursing is moving into areas that previously belonged to medicine, but to the practical, everyday strategies it uses to keep other claimants, like the social workers, out. I found that in on the ground negotiations over work, the nurse

practitioners I followed engaged in processes that medicalized patient social concerns, effectively expanding nursing's domain and the legitimacy of nurse practitioner expertise.

Gendered Strategies

Questions regarding “who is best suited” to do certain kinds of work are ultimately questions of legitimacy. Studies of occupations have documented a number of strategies that groups used to claim areas of work as their own. While early scholars focused on generalizable strategies—credentialing regimes, occupational closure—later scholars highlight the role of stratification in crafting specific strategies. Witz used the historical cases of nurses and midwives to demonstrate that female dominated occupations use different strategies in their professionalization strategies (Witz 1990). Witz argued that these groups had better success through legalistic strategies and appeals to the state rather than employing the credentialing strategies of male dominated professions. Bourgeault's work on Canadian midwifery built on Witz's work by trying to understand when and why women were able to use the state as a resource (Bourgeault 2006). One of Bourgeault arguments was that there is a gendered order to state activity. She argues that both the female midwives and female consumers were able to influence state politics through appeals to gendered parts of the state that were concerned with healthcare at the same time that they appealed to rational arguments of cost-effectiveness.

What Witz developed and what Bourgeault extended was the idea that female dominated occupations have differential access to both material and cultural resources. Moreover, their work highlights the relationship between the material and cultural realm—midwives had access to state support *through* appeals to gendered narratives of care. Similarly, historians have described the empirical case studies concerning how American, middle class white women in the 19th century appealed to a “rhetoric of domesticity” and the “virtues of womanhood” to justify

entering public work (Ginzberg 1992; Kunzel 1995; Welter 1966). These groups used legitimating narratives that resonated with accepted ideas about women's role in general and with the status concerns of middle-class women in particular. These gendered strategies both served to create new openings in fields of work at the same time that they constrained the appropriate actions of these female workers.

The Dilemma of Nursing Expertise

The case of nursing as a whole has been a 140-year study in the possibilities and the constraints of using a gendered occupational strategy. Since its first moves to reframe sick care done in the family circle as the province of trained nurses in the home or hospital, nursing has sought to elevate “care” as not only a kind of work, but as a specific form of expertise. Florence Nightingale wrote persuasively in 1860 about the need for formal instruction for tasks previously done by any female—kin or servant—attached to a household. For the 19th century nurse, such work involved explicit methods for observing patients, responding to their needs, airing out bedding, and achieving appropriate “body ventilation” by cleaning the skin. For the 21st century nurse, this work still involves ever more complicated and technology mediated methods of observing patients, appropriately perceiving and responding to their needs, and attending to bodily hygiene.

High tech or low tech, science based or skill based, nursing work continues to be narratively joined by a professional commitment to care. But the claim behind this commitment isn't simply *that* nursing cares, but that it has expertise *in how* it cares. When slogans profess “nurses care,” they are not simply asserting nurses' emotional connection to patients, but are referring to actual work, specific practices that are carried out through ever more complex technologies of care. However as nursing stretches up the professional ladder, there are ongoing

tensions between its desire to be seen as a respected profession while retaining its identity as a fundamentally and uniquely caring one.

While this tension has been evidenced throughout nursing's history, it has arisen anew in the case of the nurse practitioner. As nurses who seem to be called both to cure and care for patients, how do they reconcile this seeming contradiction in ways that are both rhetorically and practically convincing in the material worlds of work? The nurse practitioner becomes an interesting case through which to understand how nursing reconciles these tensions—not through position papers or internal politicking—but through performative practices of expertise. As nurse practitioners move into the realm of diagnostic medicine, they challenge both the practical and rhetorical boundaries of what it means to be a caring worker. How do NPs actively and rhetorically perform “nursing care” within these arenas while in their role as primary care providers? And how do they care in ways that are understood to be different from other kinds of care workers?

Competing Forms of Care

The specter of “other kinds of care workers” must be analytically attended to. In his field changing work, Andrew Abbot argued that in order to understand claims to occupational legitimacy, it is less useful to study them as isolated cases; rather, we should study relationships with related groups within the same occupational field (Abbott 1988). The obvious comparative group for nurses is often the physician. As the NP moves into the sphere of diagnostic medicine, scholarly and popular accounts alike are obsessed with comparisons between the two (Harris 2011; Laurant et al. 2005; Lenz et al. 2004). However, in terms of the marketplace, nurse practitioners are rarely jockeying for position directly with physicians. The space for nurse practitioners was opened not through direct competition, but because of physician absence in

primary care specialties. Demand for physicians remains high and their status as “the” medical expert remains structurally unchallenged by hospitals, insurers, and regulators. However, as physicians continue to move ever farther away from direct bodily and social care of patients, this vacancy has opened the door for many possible occupants to attend to these needs.

While understanding how nurse practitioners gain access to medical authority is an important line of work, we also have to explain the ways in which nursing is able to stave off competing claims of competence from other occupations. In a competitive marketplace, why are nurses in general and nurse practitioners specifically sometimes more convincing providers of these skills than other kinds of workers? In a workplace that contains both nurse practitioners and social workers, in what ways was nurse practitioner expertise in patient management, family negotiation, and practical problem-solving accepted as more legitimate than that of their social worker colleagues? In this particular site, I will answer the question: how did decisions get removed out of the realm of social work and into the realm of the clinic?

Social Work Gets No Respect

It was the middle of November, and the social workers had gathered for what had become a routine, bimonthly meeting to discuss their department’s issues. One of the things on the agenda was social work month. April was social work month and Mary, the social work supervisor, led a brainstorming session to get some ideas on the table as to what they should do. *It should be something that picks up our visibility. Something that pushes our work out to the staff.* Jocelyn, the social worker for the black team, wondered aloud, *how can we let the staff know what we spend our time doing?* Over the next few minutes of discussion, the suggestion that captured their collective imagination was forms. *Why don’t we count up how many 1768 forms we do in a month? And display it? Like on a bulletin board?* This brief conversation

captures one concern that always seemed to be on the department's mind: respect. For this group of women, social work month was a time not simply to celebrate the profession generally, but a time to wage a public relations campaign to rehabilitate what they felt was a tarnished image for themselves, specifically.

Jocelyn was the social worker for the black team. And she was often frustrated by how she was treated. *Social work gets no respect*, she would say to me, again and again. I knew she had her personal difficulties with the organization's perception. Jocelyn was, after all, on Sarah's team—the disorganized team. But I wondered if it were possible for an entire department to get no respect, organizationally. “We are a critical, crucial part that makes this program work cohesively and all the rest of it. But at the top level, we're not recognized.” This was the assessment of Emily, a social worker who had been working at the Center for ten years. While Jocelyn marshaled subjective experience, Michelle offered specific evidence. I interviewed Emily right after they had hired Mary, the new social work supervisor. The *social work supervisor*, Michelle informed me, *was not part of upper management*. While the clinic director, the chief medical officer, and chief nursing officer were all upper management, the social work supervisor was not. In meetings of senior management, the clinic was represented, but not social work. There were also markers of status difference. When I interviewed Mary, I asked her, what is her official job title? “Social work supervisor. Which,” she said lowering her voice, “is a little bit of an issue. There's inconsistency across the agency with that.” I asked her to clarify. “Certain positions are Directors, which are at a higher salary grade. Which I didn't know until I got here.” But Mary told me, it wasn't so much the money that bothered her, it was the feeling that her years of experience weren't respected. “The system didn't respect that. They want somebody highly qualified but don't want to pay for the highly qualified.”

Money may not have mattered to Mary, but it mattered to some of the other social workers. As one social worker put it bluntly, “we’re not paid.” But for others, it wasn’t literally the amount of money that bothered them, but the seeming lack of parity. One social worker, who asked that I not identify her team, has been advocating for administration to review their department’s salaries for possible adjustment. The administration periodically chooses to review one department’s salary. “I have no way to prove it, but I think that another department meeting less educational requirements is probably making more than the social workers.” Her advocacy, however, was not successful. She reported, “When it came to making a decision about which discipline should get a salary adjustment, it was nursing.”

Lyla, the social worker for the red team, offered an example. “A few years back, our then supervisor nominated every social worker for the excellence award. And we didn’t get it. None of us got it. The caregivers got it. And caregivers are always being acknowledged and praised. As are the nurses.” One doesn’t have to believe the subjective assessments of individuals; the organization’s view of social work as less essential than clinic functions could be read through the lines of structural authority, internal regimes of prestige, and, of course, money. Some disciplines, however, are low in status and pay, but are highly praised as a kind of alternative payment. Carework occupations like primary school teachers, day care workers, fall into that category—as do the caregivers, who Lyla believes were “always being acknowledged and praised.” Social workers, however, do not fall into that category. Far from being praised, they were often seen as replaceable.

Anyone Can Do Social Work

In Chapter 5, we saw how not only members, but staff would stand in the doorways of the NPs. They would come, not to deliver commands, but to present problems. Whether they

were perceived to be good at their jobs or not, the NP was treated as the appropriate expert for complex member problems. The social workers, however, had the opposite problem. There often seemed to be a lack of recognition that what the social workers possessed qualified as expertise. While noting the pivotal position of NPs in this organization, I began to wonder about the role of the social worker. Much of what the nurse practitioners claimed as their unique area of expertise could also be claimed by social work: knowledge of the social situation, understanding an individual's social history and family dynamics. However, in ways both small and large, the social workers were not treated as having a unique expertise. A constant complaint by several of the social workers was about how they were treated. One complained about the way the Center's receptionist would "tell her how to do her job." Another expressed frustration when a woman from the marketing department talked to a member of administration in order to circumvent her decision about a member. This was not simply a persecution complex; in the Center's daily, morning meetings, the only public discussion I ever witnessed about staff decisions was about those made by social work. But sometimes, the slights were more subtle.

"Sally's my social worker," one nurse practitioner quipped with a laugh. Which was an odd statement to make, because Sally was not a social worker, but the team's occupational therapist. The NP explained, "Social work doesn't pick up on things...when there's some question about how much help [the members] need or communicating with them in relation to the help. The OT will say well, I'll do it because maybe the social worker didn't offer." One of the things that struck me as I sat through team meetings was the role of occupational therapy. From my view, they seemed to do many of the things that I imagined social work might do. A new staff member familiar with rehab health care facilities made the same observation. "I don't think they're doing any traditional OT work. Like I don't think that they're like—you hear

very little about like hand splints and dexterity exercises and things like that that you would normally hear from an OT; it's more home safety kinds of things."

At the Center, home safety covered a lot of ground. I watched the OT's problem-solve pets, negotiate with members who wanted to cook, be instrumental in getting a member to open an account at the credit union instead of making his way to a check-cashing organization, and arrange for delivery of a new washing machine. In my observations I noted an important geographic divide between OT and social work. The occupational therapists routinely made home visits. Social workers did not. In team meetings, OT had information to offer. They could describe the state of a house—what was in the refrigerator, who else was in the home during the day. "The OTs just seemed to know things," I gushed with admiration to an NP during a recorded interview. She responded rather matter-of-factly, "It's like things that they [OTs] see because they went out. And social work didn't go out." Social work did not routinely make home visits. They only knew the member through their center interactions. However, this isn't necessarily a barrier. The nurse practitioners did not routinely make home visits either. So why did the NPs seem to have information about their members that the social workers lacked?

The Geography of Social Work

Nurse practitioner expertise did not simply happen but was actively cultivated. Some NPs invested more time in developing local knowledge of members than others. However, the social workers did not seem to cultivate this kind of knowledge much at all. One reason was that they were not positioned to do so. One of the first things one notices about the Center's social workers was their physical location. While the Center spans four floors, the heart of center activity is on the second floor. The second floor is where the morning's large group activities occur, as well as smaller groups that play dominos, crochet, or make crafts. The second floor is

also where the clinic resides. There is a steady flow of members in and out of the clinic from 9 a.m. until 3 p.m.—seeing primary care, getting labs drawn, receiving wound care, or seeing the rotating ancillary services like the dentist or podiatrist. If one wanted to find the social workers, however, you have to leave the action on the second floor and go up to the third. Sarah, the NP for team blue, noted that this was difficult for her: “If a person wants to see social work, it’s so much trouble. Like I have to make the call, I have to tell them to wait...sometimes it’s frustrating because if you call and then they’re not at their desk then you’re left with this thing to do. Sometimes [the social worker] will come down, and sometimes she won’t.” If making a call was a barrier for Sarah, it was more difficult for the members.

Transitioning from the second to the third floor was a feat for most members. Most of the Center’s population had problems with mobility. To stand and wait for one of only two available elevators was not an insignificant task. To get off of the elevator and walk down the hallway was laborious. And when one arrives, one finds not at a waiting room with chairs, but the door to an office. For most members, the elevator alone—and needing a staff escort to get on the elevator—was enough to discourage unplanned visits. For those who made the journey and found a closed door to an already engaged social worker, they were discouraged from repeating the journey. As a result a high proportion of social work encounters were initiated by a bureaucratic prompt. Many of those prompts were forms.

Encounter Forms

Why don’t we count up how many 1768 forms we do in a month? And display it? Like on a bulletin board? When faced with trying to capture just how much work they did, the social workers seized on the idea of forms: counting and displaying forms. For these social workers, the filling out of form 1768 was a salient metaphor for their work. Form 1768 had to be filled

out whenever a member experienced any change in their program status. Any time a member joined or withdrew from the program, changed residence, moved in or out of a nursing home for respite or rehabilitation, transitioned into hospice, or died, this form had to be filled out. And in this organization, it had to be filled out by a social worker. Like the nurse practitioner, each full time social worker was assigned to a team of members. In the general population, this gave each social worker a caseload average of about 100. Among 100, medically frail members, 1768-defined transitions were a common occurrence.

The filling out of forms was both a kind of work and a metaphor for how many of the social workers experienced their days at the Center. When the social workers referred to form 1768, they did not simply mean the literal filling out of the form, but were also referring to the work required. When a member moved, any member of the team could have the new address, but it was ultimately social work's responsibility to verify and document this information. When a member went to a nursing home, the social worker had to make the phone calls to find an open bed and had to collect and fax over the appropriate paperwork.

However, the filling out of forms was not unique to social work. Health care is a highly bureaucratic endeavor; the physicians, the nurse practitioners, and the nurses all spent hours each day charting documentation, completing encounter forms related to billing, signing, and faxing prescriptions and lab orders, and filling out an assortment of "medical eligibility" forms for members that asked for a physician's signature (although an NP's would often do). Forms were a part of center life from which social work was not exempt.

However, paperwork was not just something that social workers did, it was how much of their work was generated. For these social workers, the routine and texture of their day was not structured by member problems, but by the requirements of paperwork. One of the requirements

of being a PACE site, were required assessments. For the clinic staff, the organization's concerns about completing these assessments were prominent. However, in Chapter 5, we saw that NP work was primarily generated by "clinic problems." Social work concerns most often came through intermediaries rather than directly from patients. For the social workers, geographically cut off from direct member interaction, a significant amount of their work was generated by form. Not just the incident of the encounter, but the content itself.

Lyla's Encounters

One such prompt were the state mandated, six-month social work assessments. When I spent time with Lyla, the social worker for the red team, her day of activity began when a caregiver would appear in her office doorway to ask, "who do you want to see today?" Lyla has a list of people who are due to have social work go over their six month care plan and assess whether their mental status or needs have changed. The list is where Lyla begins. *Oh, I already saw Mr. Thomas. And let's add Ms. Sealy to the list. I didn't get to see her last week.* The list will determine whom Val will bring up to Lyla today.

Twenty minutes later, Ms. Thompson arrives. She sits in a chair opposite Lyla, who remains behind her desk. Part of Lyla's task is to do a series of short scales for mental health or emergent social issues. *Do you ever have feelings of sadness or depression? Do you sometimes have feelings of anger?* These short questions often elicit longer stories. They did for Ms. Thompson. *Do you sometimes have feelings of anger?* Ms. Thompson replies, *I do. I have problems with my son. I've given him hundreds and hundreds of dollars and it doesn't go for his kids or his girlfriend. And Dr. Peters told me, you can believe me or not, but every cent you give him goes toward drugs.* Ms. Thompson tells Lyla that she was going to give him her last \$500.

Well, Lyla replies, maybe you should think about that some more. You can't go down with him. That's not going to help him. But, I have some other questions.

Another goal of this assessment is to see if the member understands their care plan. Lyla reads from her screen, "We're addressing your pain." To which Ms. Thompson replies, *I have a lot of pain. I have arthritis in my spine. But they don't want to do much for my pain in the clinic.* Lyla moves on. "We're addressing your urinary function. We're addressing your bowel health.... Do you have any questions about your care plan that you'd like me to share with the team?" The social worker is meant to be the advocate for the member; the person who translates the plan of care and directly asks if, from the member's perspective, the program is addressing their concerns. However, this meeting has an organizational function. The care plan cannot be reviewed by the team and marked as completed until the social worker has reviewed it with the member and the member signs. Lyla feels pressured to get through the assessment.

Ms. Thompson's problem with her son perhaps cannot be fixed. But perhaps they could be more consistently listened to. Ms. Thompson has pain that perhaps could be differently addressed, or at least better understood. But Lyla can't get sidetracked. The organizational problem that social work is addressing is getting documentation of member approval. The purpose of this meeting is to get through the care plan. Lyla, like most of the social workers, is not lacking in interest or compassion for her member's problems. Still, there is a disconnect between the role of advocate and the tools these social workers possess. It doesn't, perhaps, help their relationship with members that part of their job is to deliver bad news.

Dirty Work

"We get left with the dirty work." One of the roles that social work filled was to send out and sign denial letters. The center was not only the administrative manager of their members'

health care needs; it was also the financial manager. The center had to approve all member services and durable medical equipment. Often this was a straightforward process regarding the evaluation of medical need. However, other requests had to be balanced cost, safety, or a more qualitative assessment of appropriateness. How many pairs of glasses could a member lose before the Center would stop buying new pairs? A typical insurance plan would have a defined benefit. However, PACE was designed to allow programs more leeway in how it used its funds. A third pair of glasses might seem a frivolous expense, but if the member was legally blind without glasses, the third pair might make stave off a more expensive fall. These murkier issues were a team decision. The whole team had input, but if a request was denied, a letter of notification was sent out, under the social worker's name. If the member was upset about the denial, the person the letter instructed them to contact, was the social worker. In this case, it was not a form, but a form letter that shaped a potential member encounter.

Social Work in a Nursing Organization

The concern with paperwork is not necessarily indicative of social work as a profession, but of these social workers in this organization. This was a unsatisfactory state of affairs for some. One of the people I interviewed was a social work intern, Tammy. Tammy was 24 years old. When I interviewed her, she was only two months shy of graduating with her masters in social work. She had been an intern at the Center for four months and had formed a strong opinion about how the work she did here compared to her other internships. "It's basic surface work." The only thing they do, she reported, was case management. "You're just making sure the member is surviving and has basic needs. It's all surface work. With social work, the way we learned is a more therapeutic model. You're more interested in how the person is doing, biologically, psychologically, and socially."

When I asked her understanding of why social work here worked differently she gave two reasons. The first was the sheer volume. “With a caseload of 127, the amount of interactions that I would normally get with a client I don’t necessarily get here.” But she had another observation. “A lot of times when I worked within the social work department at other agencies, social work issues took precedence.... There was a social service—usually the social worker was the leader of the interdisciplinary team.... With the social workers here, it’s a completely different model.”

Different Problems, Different Solutions

On a Tuesday morning, the Alzheimer’s Team met in the conference room for their weekly meeting. One of the more organized teams, they always followed the same agenda: Assessments came first, and then member issues. After 45 minutes of going through the assessments, the facilitator opened the floor, “who has member issues?” One of the first to respond was Katie, the occupational therapist. She had received a call from the daughter of a Mr. Flack. *When I talked to her, she really sounded like she was at her wit’s end.* Mr. Flack has dementia, a condition of cognitive decline that often creates behavioral problems. Mr. Flack often lost his temper and sometimes turned violent. Katie posed the question to the team: *Do you think emergency respite [a brief stay in a nursing home] might be a good idea?* Her question ignited a rather furious discussion. A debate ensued between the two nurse practitioners present and the social worker. The social worker argued against emergency respite, retorting that the problem was more fundamental, and that the team “can’t change their family dynamics with respite.” While everyone on the team had the opportunity to share their opinion, some opinions came to matter more than others. When the social worker introduced “family dynamics,” one of the nurse practitioners countered “Yes, I’ve known that family for a long time,” and then began

to describe her own history of conversations and interventions with the Flack family. This conversation was part of a larger narrative contest that I saw repeated again and again within team meetings: who knew the patient and the family better? Who had the appropriate knowledge to diagnose the real problem and provide the appropriate solution? In this case, the requisite knowledge was not about a medical understanding of dementia, but about knowledge of Mr. Flack and his family.

The lengthy discussion was ended by a nurse practitioner, who said in a rather definitive tone of voice, *I will call the daughter and recommend emergency respite from both a safety and behavioral health perspective.* This problem of Mr. Flack's family, that involved neither medication changes nor specialist referrals, was a problem that was not perceived as wholly medical. Dr. Barnes, the physician who was present, did offer an interested opinion, but it was the nurse practitioner and social worker whose ideas were in conflict. The heat behind this discussion was not indicative of team meetings. However, this interaction does make plain the grounds upon which decisions in the murky world of "not wholly medical" were often decided. Decisions about whether Ms. Jones should still cook for herself, or whether it was time to call Mr. Stein's sister about the state of his apartment were made in free ranging discussions that included everyone—from NPs to PTs to caregivers. But when there were competing plans of action, the nurse practitioner would use her knowledge of the patient—their history, their family connections, and their conditions—to achieve an NP-led consensus. In the case of Mr. Flack, the nurse practitioner explicitly made the decision. However, it was more usual for a discussion to be more subtly ended by the NP making a suggestion of action to another team member, such as "Why don't you call Mrs. Jones' daughter and see if that will work for them." These suggestions

for action had a clear hierarchy—they were often delivered from NP to social worker, rarely from social worker to NP.

Conclusion

Because of the frailty of the Center's population, all medical complaints were urgently assessed. Accordingly, patients themselves generated a significant proportion of clinical work by walking in or calling in to make their concerns, clinic concerns. When I spent time with the social workers, I noted a different rhythm. Much of this work came filtered through administration. Social workers were responsible for filling out paperwork required by the state whenever a patient moved between home, rehab stays, to an assisted living facility, or to long term care. Similarly, whenever the Center declined a patient request for treatment, device, or service, it was the social workers who had to send out the denial letter. Even in team meetings, member issues were rarely brought up by social work. However, the social worker would often be left with a member-related task generated by the team. Although social workers provided patient care, in the carrying out of their work, they had much less direct patient interaction than most of the team members, especially the nurse practitioners.

However, I also posit that it mattered that NPs knew what they knew about patients through clinic encounters rather than through social work encounters. Nurse practitioners have been able to transform everyday knowledge into specialist knowledge through medicalizing social problems and social knowledge. Medicalizing the social was a way for NP's to re-interpret how the problem should be understood. It may not be a "medical problem" by physician definition, but it was also not a "social problem" that anyone could solve. The social workers might have been asked to address these problems, but they were not perceived as having specific

expertise. Everyone, it seemed, had access to their reasoning. They could not claim an expertise that appeared sufficiently different from the aide, the medical assistant, or the clerical staff.

This work provides a way of understanding the interactional processes through which nursing is able to attain a measure of success that other care work providers find illusive. The phrase “Doctors Cure, Nurses Care” isn’t a simply a slogan that makes lower status workers feel better about their organizational position; it is also a staking out of turf. The NPs were better able to leverage their knowledge of the social needs of their patients, in part because the organization has created a situation in which they have more opportunity than others to garner this expertise, but also because of the context in which they come to know these needs, which is from within the medical encounter, rather than from within a social work encounter. Nursing has been successful in making the case that its provides care in fundamentally different than the ways in which not only family members might care, but also aides, social workers, sonogram technicians, and a host of other care workers in the health care domain. Individual nurse practitioners acceded to physician authority in questions of medical diagnosis or intervention, but they were also able to wield that authority convincingly in the domain that physicians have long absented: the embodied problems of everyday life.

Chapter 7 – Conclusion

For a nurse to assist a physician is a phenomenon as old as the nursing profession itself. In the face of a post-WWII physician shortage, choosing to train nurses to assist primary care physicians was not a radical idea, but an extension of preexisting pattern. However, these new kind of nurses proved to be an altogether different kind phenomenon. Fighting, and often winning, the right to practice autonomously, nurse practitioners quickly became more than medicine's able assistants. But what, exactly, they were proving themselves to be has been largely unexamined. In the popular press, nurse practitioners are written about as more or less capable stand-ins for physicians. In scholarly accounts, nurse practitioner work is measured as varying quantum of physician work. Rarely is the subject of nurse practitioners approached on own terms. Through a multi-sited ethnographic investigation, this dissertation began by taking seriously the introduction of the nurse practitioner into the medical encounter, not as physician stand-in, but as herself.

The work that any profession does has both material and symbolic boundaries. I began my investigation by trying to understand the cultural tools that NPs used to craft a sense of expertise and internal, professional identity. To do so, I spent 12 months with nurse-practitioners-in-training in the classroom. Following in the tradition of Renee Anspach, I analyzed the routine, formal talk about patients in an educational setting as a way of understanding the beliefs and values of the nurse's professional world. An essential finding was that talk about nursing practices emphasized skills of *difference* from physician practice. The primary way in which this was achieved was through different constructions of patient problems and case complexity. In these accounts, patients were constructed in ways to be socially, rather

than medically complicated. I found that medical knowledge was assumed to be technically attainable, but that true nurse practitioner expertise required special knowledge *of each patient*.

Successive chapters of my dissertation are based on a second field site. I completed 16 months of fieldwork at a PACE community practice. Here, I investigated not just NPs rhetorical claims, but their on-the-ground negotiations of meaning with other clinicians, in the context of their employing organization. My dissertation provides evidence that, in medical spaces that contain multiple and competing claims over patient care, nurse practitioners engage in processes that medicalize the social as a unique area of expertise. In responding to patient and family complaints, and dealing with the everyday difficulties encountered by their patients, these nurse practitioners (albeit with greater and lesser skill) transported concerns that could be considered social work, into medical work. I found that shop floor negotiations clearly mattered for how medical work was organized and delivered at this site. It was not only the nurse practitioners, but the physicians who came to different understandings of their own expertise. These different understandings of what it meant to provide primary care also mattered for patients. There was no NP clinic and physician clinic, there was just, “the clinic;” the clinic was still the place where these patients went to receive attention to their concerns, however they defined them. But what happened inside the clinic depended upon whether the patient saw an NP or a physician. The nurse practitioners cared for a different kind of clinical body than their physician colleagues. And for these patients, their experientially embedded notions of what it meant to be cared for, were radically and fundamentally changed.

I also found that by doing very different kinds of work from their physician colleagues, the nurse practitioner became a radically different kind of organizational actor. The clinical body attended to by NPs was constituted not only by indigenous patient complaints but also by

those of the organization. This organization relied on the nurse practitioner to “make things right,” both for patients, as well as for the itself. Cultivating local knowledge of each patient, and making this knowledge visible became necessary to the organizational performance of NP expertise. While these processes provided the nurse practitioners with a language of authority, there were important consequences for how competence was assessed, as well as for how patient problems were defined. This work suggests that moves to medicalize the social may have unintended consequences for both the professional aspirations of nurse practitioners and the patients they serve.

If NPs are sometimes doing something different, both as professional and organizational actors, then this may change what it means to provide primary care. Whether we call it medical work or nursing work, primary care is the new policy battleground for new forms of organizing, providing, and paying for health care. And an important front of this battle is happening in underserved, rural, and minority communities where physician absence has created spaces for the reordering of medical work. And while NPs are, perhaps, winning professional skirmishes at these sites, we may also want to think about the consequences for the people who are the sites of NP expertise. Because the arsenal of solutions contained in the clinic has its limits. I often found the physicians to out of sync with how the NPs reordered clinic time. However, it is also possible that the clinic may also be out of sync with domestic and community based rhythms. While problem solving within the medical encounter turned difficult situations into solvable situations, this recasting of life’s problems as clinic problems sometimes de-legitimated competing locations for problem solving. This conflict was made specifically visible in the organizational clash between social work expertise and nursing expertise within the PACE workplace.

Implications

There are many things that ethnographic evidence cannot do. It cannot provide counts, generalizable estimates, or be used as evidence of causation. However, one thing at which it excels is to allow us to see if our accepted theories hold up against the reality of social life. When I first began my work with nurse practitioners, I spoke with a noted sociologist of work who dispensed the following advice: *You know, Abbott pretty much explained everything we need to know about the professions. Everybody since then has just been publishing case studies of processes we already understand. But they don't really have anything new to say.* Perhaps we might learn something in the specificity of how one group engages in contests of legitimacy against others—but no new knowledge is gain.

Similarly, most of the sociological work on the professions literature that mentions nursing is primarily concerned with telling tales of woe. Nursing, we're told, is a failed profession. In jurisdictional contests with physicians, nurses are perennially outgunned both in terms of material and cultural resources. Legitimate claims of professional expertise are rooted in an abstract knowledge that can be marshaled in domain expansion. Nursing has no such knowledge. It draws from the same knowledge as the physician, who will forever be its unquestioned master.

But nursing has, in fact, made very creditable claims to particularly gendered technologies of care, based not on abstract knowledge, but on forms of knowledge that are local, particular, and rooted in concrete practices. I would argue that far from being only a tale of woe, theirs is a story of modest success. In an era when physician dominance and autonomy has been under assault, through their being dragged, kicking and screaming into bureaucratic organizations; nursing autonomy has grown. At a time when almost other female dominated

occupation has waned in prestige, nursing's status has grown. While female dominated professions like social work continue to be deskilled and their domains of work shrink, nursing domains have expanded. Those who write about workers in other caring professions tell us reliance on a gendered logic of work is the chief reason why these positions remain low in status and low in pay. But nurses, while continuing to embrace a gendered, professional logic of care, have secured middle class wages and rising prestige. Perhaps nursing may never be successful in achieving an ideal-type of professional legitimacy, but they have certainly been successful on their own terms. Those who study the professions have to come to grips, not with the professional failure of nursing, but with its very real successes.

So how should we understand the implications of these successes? What new understandings of the medical world and of medical practices are brought into being through negotiations over their work? How do these new understandings challenge competing conceptions of what constitutes medical work? When new occupational groups enter a particular jurisdiction, they are not only potentially transforming notions of who can do what kind of tasks; in fighting to erect new boundaries, they are potentially transforming the meaning of the work itself. When nurse practitioners do medical work, they become a boundary object, shifting the boundaries of what not only nurses should do, but of what physicians should do.

And these shifts in work are inextricably linked to gender and class. Nursing continues to be a female and working class—albeit well paid—occupation. Even though nurse practitioners are an example of nursing continuing to stretch up the credentials ladder, the stories of women like Maura, who began with a two year degree, continue to be replicated in the stories of women like Hana, who was in the graduating family nurse practitioner class of 2009. These “Cinderella stories” are not just of exemplary individuals, but are indicative of the structural opportunities

available in nursing that are not available in medicine. Structural opportunities, not individually-oriented incentives, are what are drawing a new category of professionals into an arena that medical students are abdicating.

However, the movement of NPs into primary care raises some questions. My dissertation demonstrates how shop-floor negotiations over work have the potential to be consequential not just for constructions of worker identities, but over what constitutes the content and meaning of the work itself. When NPs enter the clinic, they are clearly changing the kind of work that gets done. There is also the possibility that they are part of a set of forces that is changing our evaluation of primary care as being medical work at all. Nurse practitioners are not the only new entrants to primary care. Medical students as a population may be leaving primary care, but those who are choosing to go into primary care specialties are disproportionately female (Cohen, Jeffrey 2013). One cannot generalize from one field site, but the Center's full-time physicians—two geriatricians and an internist—are representative of a trend: all three were female. Nurse practitioners are not only a part of a professional shift in who provides primary care, but also a gendered shift occurring throughout medicine. Nursing's existence as a predominately female occupation has important implications not just for itself, but for the further gendering of lower-status, primary care work.

The rise of the nurse practitioner may also signal a broader class shift in primary care. Nursing allows for the kind of Cinderella stories contained in Chapter 4 because it has remained at least somewhat responsive to the concerns of its working class members. These are workers who are grudgingly satisfied to receive less pay than their physician colleagues. The basic distinction between themselves and physicians seemed not only defensible, but right. Practicing NPs and NP students spoke respectfully of “the years of residency” that physicians received.

“I’m a nurse practitioner, not a doctor,” was Maura’s sincere opinion. However, as NPs and the physicians who are left meet in the clinic, one has to wonder how long these accepted distinctions will last. Particularly when the career paths of NPs and primary care physicians appear to be on a course of convergence. In terms of credentials, there is a battle within nursing to have the entry to practice be a doctorate rather than a master’s degree. Many (but by no means all) well-respected schools of nursing no longer offer a masters degree for nurse practitioners. In terms of demographics, we see that it is not only women who are more likely to choose primary care specialties, but those whose class background looks similar to aspiring nurses. First generation college students and those who come from medically underserved communities are more likely to specialize in primary care (Cohen, Jeffrey 2013). Gender and class not only mark individuals within a socially stratified society, but occupations. Perhaps NP status and salaries may rise. But primary care physician salaries and status might stagnate.

This study of the nurse practitioner can add to our sociological understanding of medical practice. However, it also makes possible a practical critique. Current discussions on the shortage of primary care physicians are characterized by urgency. Still, nothing has been able to stop the exodus of medical students away from primary care specialties. The nurse practitioner, differently trained, taught different conceptions of clinical practice, and implementing different technologies of care, may offer an alternative. Whether a nurse practitioner, a physician, or some other clinician should perform these practices is an open question. However, our attention to them has the potential to show us different possibilities for what it can mean to care for the sick - not in an imagined future, but through viewing what some nurse practitioners currently do.

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