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Lived Experience of the Advanced Practice Provider on the Burn Surgery Service

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Abstract

The purpose of this qualitative dissertation study was to examine the lived experience and meaning making of challenges, benefits, satisfaction, and professional sustainability for the advanced practice provider in the burn surgery specialty service. The problem addressed was the knowledge gap resulting from a lack of literature describing aspects of the advanced practice provider role in the burn specialty. An interpretive phenomenological analysis, informed by the philosophy of Dr. Martin Heidegger, was undertaken. Participants were solicited from the American Burn Association Advanced Practice Provider (APP) special interest group site. The results provided a thick description of the lived experience of the Burn APP offering, illuminating commonalities and distinctions to promote role gratification and fulfillment leading to professional success and prolonged engagement.

Keywords: advanced practice provider, nurse practitioner, physician assistant, interpretive phenomenology, hermeneutics.

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Chapter 1: Problem and Domain of Inquiry

Advanced practice providers (APPs), including nurse practitioners (NPs) and physician assistants (PAs), represent a group of health care providers who share professional similarities and differences. While the PA is educated under the medical model, NPs are first trained as registered nurses (Kartha et al., 2014). Unlike PAs, NPs are subjected to significant interstate variations in scope of practice (SOP) that greatly influence the role as it is experienced by providers in countless practice locations (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). Ultimately, the legislative practice guidelines form the overarching practice structure. The unique details of clinical responsibilities for each APP within their legal scope are defined within individual practice settings. There is no national consensus on the substance either role should entail. Both the NP and PA have been shown to be effective providers, offering quality of care similar to that of physicians (Kartha et al., 2014). The NP role has been defined in countless ways, such as according to geographic location, organization, and individual provider attributes. The diversity and resultant confusion has led to frustration and has been reported to affect job satisfaction (Hurlock-Chorostecki, Forchuk, Orchard, van Soeren, & Reeves, 2014). Educational preparation, procedural skills, and past experience have all been cited as important prerequisites for APP utilization in various hospital settings rather than licensure as an NP or a PA (Luckianow, Piper, & Kaplan, 2015; Ruel & Motyka, 2009).

Despite a dearth of literature that addresses the performance of both NP and PA in numerous health care settings, only a paucity of published literature exists describing the role of these professionals in the burn surgery specialty. One dissertation from 2006 was identified in which the author investigated the role of NPs in burn centers. Those findings indicated that NPs were employed in a wide variety of treatment settings and possessed differing educational and

experiential backgrounds. However, no clarity was provided by the survey and interview results to the depth and breadth of those roles (Myers, 2006).

Edkins, Cairns, and Hultman (2014) examined implications of incorporating APPs into the burn critical care setting. Although the need for and the potential benefits of APPs were affirmed, no coherent vision for role integration was developed (Edkins et al., 2014). Yet, Owens, Palmieri, and Greenhalgh (2014) presented survey results from 2006 (published in 2014). They found some insight into the APP utilization in burn practice settings; however, they found only a general overview of possible responsibilities (Owens et al., 2014).

In addition to educational preparation, specialty training, responsibilities, and utilization, job satisfaction is an important consideration in the overall experience of being an APP. Pasaron (2013) identified intrinsic and extrinsic factors essential to job satisfaction. Autonomy, opportunities for advancement, and recognition of professional contribution are among these influences. NPs were only minimally satisfied with their level of professional challenge and autonomy (Pasaron, 2013). Galicyznski (2006) discussed her experiences as a trauma NP and confessed that her number one reason for continuing to practice was that the role kept her "grounded," leaving her with a greater appreciation for her family. The insightful response was supported by the assertion that each professional approaches his or her roles with differing motivational forces and personal meaning. Although literature in which PA faculty satisfaction was examined does exist, none was noted to address the individual experience of the PA in clinical practice.

There are few studies addressing the burn APP role. After a review of literature, the results showed a limited view of utilization from the perspective of staffing needs, budgetary concerns, and procedural skills. An academic gap was exposed that was deficient in a succinct

representation of the lived experience of the APP on the burn surgery specialty service. Individual perceptions of the many components of the profession include (a) priorities, (b) challenges, (c) influences, (d) benefits, and (e) stressors that have yet to be determined (Edkins et al., 2014; Myers, 2006; Owens et al., 2014).

In 2003, the Accreditation Council for Graduate Medical Education instituted strict regulations, mandating a reduction in resident work hours (Edkins et al., 2014). Additional changes to resident supervision and scheduling followed in July 2011, further limiting the availability of providers, thereby increasing the utilization and responsibilities of APPs (Owens et al., 2014). Today, the health care delivery system in the United States (US) is continuing its dramatic transformation, this time as the result of the Affordable Care Act of 2010. Now, more than ever, APP's provide a valuable option for the delivery of effective, efficient quality care to patients of all ages (Marsh, Diers, & Jenkins, 2012). Burn centers also are sharing in the shortage of specialized providers with nearly 90% of centers surveyed having reported that they anticipated difficulty in locating a new burn surgeon for their facility. Burn patients require multiple treatment modalities and the integrated efforts of a dedicated burn staff to achieve meaningful recovery. Burn care occurs in numerous settings and includes specialized expertise with empathy and patience. Shortages in skilled burn providers could have devastating effects on this vulnerable population (Ortiz-Pujols et al., 2011).

Competency domains for APPs include knowledge, skills, education, clinical practice, and collaboration, all representing quantifiable variables (Ruel & Motyka, 2009). Although the information may be valuable in formulating job descriptions, Benner (1994) discounted "objective knowing" in pursuit of true understanding (p. 55). Satisfaction and the personal lived experience of being an APP, specifically in the burn surgery specialty, cannot be measured by

using standardized metrics. Common practices and experiences were anticipated among the participants because burn surgery is a unique specialty practice. The goal of the phenomenological approach was to extract the individual's meaning and significance to being in the role. Interpretive phenomenological analysis adds discernment made possible through in-depth review of intimate accounts of the experience under study. The domains of inquiry were guided by the participants. In order to seek the deeper understanding necessary for a hermeneutic interpretation, the domains were expanded from the practical aspects of the profession to the unique goals, aspirations, emotions, and relevance to each practitioner (Benner, 1994, p. 55; Sanghi, 2012, pp. 153-161).

Problem Statement

Little is known about the unique role of the APP in the burn specialty setting. Much diversity exists in training and experiential requirements, according to the requirements of each institution and practice setting. Individual professionals may be motivated by autonomy, variety within the role, or by a sense of altruism in caring for this challenging patient population. Research is imperative to develop potential strategies for approaching the burn provider shortage. The problem addressed was the knowledge gap resulting from a lack of literature describing aspects of the advanced practice provider role in the burn specialty that present challenges, offer benefits, and nurture satisfaction and the imperative to understand these influences to promote sustained professional engagement (Pasaron, 2013; Ortiz-Pujols, 2011).

Purpose of the Study

The purpose of this qualitative dissertation study was to examine the lived experience and meaning making of challenges, benefits, satisfaction, and professional sustainability for the advanced practice provider in the burn surgery specialty service. Critical role elements and

individual motivators and detractors were explored. Documenting the perceptions and experiences of participants indicated meaning for the individual provider and common themes with implications for the professional group as a whole. The ultimate goal was to move beyond structured job descriptions and guidelines to gain insight into the essence of being a burn APP (Wojnar & Swanson, 2007).

Research Questions

1. What are the experiences of advanced practice providers in the burn surgery specialty service at designated burn centers in the United States? (core question)
2. What do advanced practice providers describe and understand as challenges and benefits as a burn APP?
3. What meaningful aspects of the burn APP role serve to promote satisfaction and support professional sustainability?

Significance of the Study

Over one million burn injuries occur annually. There are only 123 designated burn centers in the United States in which inpatient and outpatient and acute and chronic burn care are provided to adult and pediatric victims. While the number of reported burn injuries continues to decrease annually, hospital admissions remain steady (Holmes, 2008). APPs responsible for the care of burned patients represent a specialized minority. There was insight provided by the dissertation study results into practice as appreciated by the professionals themselves, leading to a better understanding of the challenges and benefits that may be incorporated into job descriptions to enhance performance, improve satisfaction, and aid in structuring retention efforts (Pasaron, 2013).

Describing the experience of the burn APP adds to the growing body of knowledge, which supports a record of safe, efficient service to the public (Kartha et al, 2014). Both PAs and NPs face strict regulations about their ability to practice independently that are largely not evidence-based (Pasaron, 2013). Another benefit was the discussion of core competencies as defined by the APP. These competencies differed from those defined by the medical staff or at the organizational level, leading to potential educational opportunities. Education based on competency may lead to standardization across settings and was prioritized as essential to improving patient safety by the Institute of Medicine (Fater, 2013).

Learning more about the experience of being a burn APP may lead to increasing scope and responsibility for professional practice, thereby expanding the ability to care for this underserved population. The intensity and diversity of needs inherent to burn patients has described care for this specialty group as emotionally stressful and professionally challenging. The burn APP functions in several diverse capacities, such as (a) inpatient rounds (intensive care units, step-down and medical/surgical floors), (b) outpatient clinic, and (c) perioperative settings that treat burn-injured patients of all ages (Barnett, 2005, Edkins et al., 2014). Burn care includes scheduled painful wound debridement, hemodynamic, nutritional and emotional support, surgical intervention, rehabilitative and restorative care. The burn APP coordinates with the multidisciplinary team to facilitate meaningful recovery. Coping with the physical and psychologic challenges indigenous to burn care is a source of emotional distress for the patient and their families but also can have a significant influence on health care providers (Serio-Melvin, Yoder, & Gaylord, 2010).

The roles of the NP and PA were created in the 1960s to fill the gap created by an evolving shortage of primary care providers as a result of health care policy. Legislation on the

state and national levels has provided structure and guidance for advanced practice since that time. Increased awareness of burn APP practice will support future initiatives to revise regulations to increase independence and expand scope (Gillard et al., 2011; Rounds, Zych, & Mallary, 2013).

Research is another area in which a gap exists. Only a paucity of studies is available that specifically examine any aspect of the burn APP. The literature was examined for any current literature in which the role and opportunities for improved utilization, increased practice independence, and documentation of quality and positive patient outcomes were described.

Philosophical Underpinnings

Epistemology presents the foundation for knowledge attainment, first by delineating the knowledge that is sought, then by describing the manner in which knowledge will be acquired. It serves as a philosophical structure by elucidating the basis for and scope of the journey (Smith, Flowers, & Larkin, 2009, pp. 46-47). The epistemology of constructionism presents the foundation for understanding and knowledge attainment by which meaning is "constructed" through engagement and individual interpretation. The subjective and objective intertwine as the individual interacts with the world and comes to realize unique meanings through their own experiences (Crotty, 2012, pp. 42-66). Each individual's perception forms a distinctive truth, resulting in the coexistence of multiple realities. Thus, each person must develop "multidimensional knowledge" and his/her own personal reality with the building blocks of his/her own life experiences in order to best understand the world around them (Hunter, 2008).

Constructionism is subsumed intentionality through the union of subjective experience and the reflection on objective realities. The marriage of these is manifested in the philosophy of phenomenology as "existentialism" (Crotty, 1998, pp. 45, 61, 151). Human beings must

disregard any preconceptions whether originating from social, cultural, or religious belief systems and relate to the world in an immediate and genuine fashion for meanings to materialize. In this way, human beings can move beyond "what is known" to the primacy of self-discovery of the primordial "thing itself" (Crotty, 1998, pp. 78-86). Yet, the question remains whether experiential reality can truly be represented. The finally revealed reality is understood on an individual level for each person living the experience (Crotty, 1998, p. 211).

Research Traditions

Edmund Husserl, regarded as the founder of phenomenology, viewed the scientific world as highly ordered and rigid, standing in direct contrast to the unpredictable nature of daily life experiences in the "lived world" (Crotty, 1998, pp. 27-28). Husserl's epistemology sought cognitive meaning derived from text and non-cognitive meaning as intuitively appreciated by the researcher (Converse, 2012). A protégé of Husserl, philosopher Martin Heidegger asserted that the world we know is ever present and is essentially meaningless. Individuals must construct meaning as they proceed through their lives to build an "experienced reality" (Crotty, 1998, p. 44).

Heidegger placed the origins of the quest for meaning in "being" back to the works of Plato and Aristotle. The founding concepts from the Greeks supported three core beliefs. First, from the perspective of ontology, "being" is a transcendent, universal concept. Next, there is no way to objectively define the concept of "being." Finally, Heidegger asserted that the concept of "being" is self-evident, but must be formulated (Heidegger, 1962, pp. 21-23). The intention of the inquiry and presuppositions determine what will be answered (Heidegger, 1962, pp. 24-27).

As the experience of "being" in the world, Dasien exists in numerous domains. Heidegger proposed that the essence lies in the fact that the Dasein understands itself as an

existential entity. Knowledge is predicated on the predetermined idea of "being" followed by the ability to discard this notion and achieve a primordial understanding (Heidegger, 1962, pp. 29, 33). Heidegger provided the structure for detailing interactions between the "Dasein" being and their world. Existential components include temporality (to provide context) and language (to articulate practice). The goal of phenomenology is to make sense of the unique experience of existence within "the world of our concern" (Wilson, 2014).

In the nursing literature reviewed by Norlyk and Harder (2010) reviewed the nursing literature and found that the term "essence" was used to represent and describe the meaning of the lived experience. Essence has the assumption of ethereal qualities, an intangible something that is realized and defined through individual perception. Although no concretely defined, the term phenomena is an embodiment of the "what" that research questions will seek to answer. Experience is framed by the setting and by others co-existing within that environment. The lived experience is the result of individual participation in a particular occurrence at a certain time in history (Norlyk & Harder, 2010).

The purpose for presenting the essence of a phenomenon is to "show itself-in-itself" (Heidegger, 1962, p. 51). With the process, there is a need for a self-revealing that is beyond the concept of appearance to more of a multi-layered unfolding. Through showing itself and moving past all the ways that a phenomenon can be disguised, interpreting and understanding the Dasein becomes possible. However, meaning is situational and conditional. Time is a critical determinant of the meaning of "being." The past is described as "property" that exerts influence on the Dasien in framing all future occasions. Insight is structured further by tradition. Ultimately, "being" can only truly present "itself" as it relates to a specific point in time (Heidegger, 1962, pp. 50-71). Here, Heidegger disagreed with Husserl's cognitive

phenomenology and the abstract representation of consciousness in which the "being "is revealed. Instead, Heidegger proposed that meaning occurs within the confines of tangible existence in that exact reality and in that instant (van Manen, 2014, pp. 137, 231).

Heidegger's pursuit was a primarily ontological pursuit of the way of being in the world (van Manen, 2014, p. 231). With his interpretive approach, he directs the researcher to an understanding of a phenomenon as it uniquely relates to him or her (Converse, 2012). Husserl's descriptive ontology presents a phenomenon whose existence is de facto, but can only be fully realized by the researchers after they have rid themselves of all preconceived notions. Rather than "bracket out" these assumptions, Heidegger advocated reflexivity as a method for facilitating self-awareness. Unlike Husserl, he did not agree that it is possible to eliminate the influence of perspective and presumptions (Converse, 2012). For the purposes of phenomenology, experiences can be imagined or real; their only significance is the meaning that the being derives from them (van Manen, 2014, p. 249).

According to Heidegger, Benner described "the clearing" as the union of inter-related perceptions gathered together to clear away old assumptions and lead to the discovery of a new realization of a shared being (Benner, 1994, pp. 69-70). The co-creation of meaning is supported by the genesis of inter-subjective understanding (Standing, 2009). Van Manen (2014) further defined reflective methods for uncovering the meaning in the phenomenon being examined as involving the analysis of themes and concepts in the cultivation of insights (p. 319). The resultant themes are structured representations within the texts that result from the interview. Concepts are deriving meaning from the intent of their uses. The historical review of phenomenology is supported in that meaning is the unique result of individual perception of a

multitude of influences and situations expectations within the professional environment (van Manen, 2014, pp. 319-323).

Definition of Terms

1. Advance practice registered nurse. An advance practice registered nurse is a category of licensure for NPs, certified registered nurse anesthetist, certified nurse midwives, and clinical nurse specialist who are registered nurses with advanced training in the diagnosis and management of acute and chronic illness, and provide nursing and medical services prioritizing health promotion and disease prevention (Kleinpell et al., 2012).
2. Advanced practice provider. Advanced practice provider is an inclusive term for nurse practitioners, nurse anesthetists, clinical nurse specialists, nurse midwives, and physician assistants as a group of providers who are nationally certified and state licensed to provide diagnoses, treatments, and follow-up and who work collaboratively with physicians in a variety of clinical settings (UK Healthcare, 2015).
3. Interpretive phenomenology. Interpretive phenomenology is a qualitative approach to research in which the focus is on exploring and describing the individuals' understanding of their own life experiences (Smith et al., 2009, pp. 3-4).
4. Hermeneutics. Hermeneutics is a theory designed to facilitate the discovery of underlying meanings in human existence through reflection and analysis (Smith et al., 2009, pp. 21-22; van Manen, 2014, pp. 26-27).
5. Physician assistant. A physician assistant is a health care provider trained to provide medical care in collaboration with a supervising physician (Hooker & Everett, 2012).

6. Reflexivity. Reflexivity is a process for the researcher to identify and critically examine his/her own biases, values, and conceptions (Clancy, 2013).

Summary

There is limited literature that exists in which the experiences of the APP in the burn specialty setting are examined. Knowledge about the experience of the burn APP has contributed to the significant effect that this provider has on the care of the unique burn population and has led to valuable insight for fellow health care professionals, administrators, and health policy makers. Constructionism has served as the philosophical underpinning for this interpretive phenomenological analysis. Historical foundations of phenomenology were derived from the founding works of Heidegger and Husserl with the contributions of van Manen and Benner offered for further clarification and enlightenment.

Chapter 2: Review of Literature

Introduction

Chapter 2 has an historical background and literature review of NPs and PAs to support the importance and potential influence for the dissertation study. The evolution of burn care is recounted. Previous literature is discussed to chronicle the development of the NP and PA roles. Health-care-related phenomenological studies are detailed to provide a review of past studies and to serve as a foundation for further exploration of the lived experience of APPs. The paucity of studies describing the burn APP is described, bolstering the need for further research to delineate issues unique to this specialty role.

Historical Perspective and Overview of the Advanced Practice Provider

In the 1960s, physicians throughout the US were moving to more specialized practices. APPs arose in response to the ensuing disparity between supply and demand (Gillard et al., 2011). The anticipated shortage of primary care providers has led to development of both the NP and PA role. Routine tasks previously considered under the domain of medicine were identified as appropriate for delegation in order to avert disparities in health care provision (Percy & Sperhac, 2007). The goal was to have these new non-physician providers provide health care services primarily to the underserved or uninsured (Rounds et al., 2013).

Title VII, Section 747 of the Public Health Service Act funded the Health Professions Act of 1963 in an attempt to meet the health care needs of underserved populations. Specifically, this Act has provided the support for the expansion of the fledgling PA role through financial support of educational programs to fill the gap of qualified medical providers for this population. Hooker (2009) highlighted national data that NPs and PAs are the primary providers of care for

the poor and uninsured. Thus, Hooker asserted, these health care professionals provide a "social good for America" (Hooker, 2009, p. 12).

As the population ages and medical innovations increase the life expectancy of the chronically ill, the impetus to expand the health care work force becomes increasingly more urgent. The Patient Protection and Affordable Care Act of 2010 was developed as a way of significantly improving access to health care for all U.S. citizens. The increase in people with health insurance coverage is increasing exponentially due to the governmental mandate. These ongoing efforts to address the primary care needs of the medically underserved have also worsened the existing shortage of trained specialists. Whether the APP is working independently or collaboratively, NPs and PAs in the US are well positioned to fill this gap (Holmes, 2008; Ulrich, Zhou, Hanlon, Danis, & Grady, 2014).

While the vision for both NPs and PAs was quite similar, there were differing origins for these professions. A group of medical and nursing professionals at Colorado University Schools of Nursing and Medicine are credited with developing the NP role in 1965 (Dalton, 2013). The early conception of a physician assistant incorporated nurses as well. Eugene Stead, MD, developed the original program, which was unsuccessful in securing support from the nursing profession, and went on to pioneer the PA movement. He enlisted military personnel, primarily corpsman and medics, returning from foreign service with extensive skills and independence related to their roles during the war. Dr. Stead's idea won the support of the American Medical Association (AMA) in 1968. Standards and accreditation criteria for the "Assistant to the Primary Care Physician" were developed by the AMA in 1971(Cawley, Cawthon, & Hooker, 2012). Around the same time, at the University of Washington, Richard Smith, MD, was

launching his MEDEX program. As the Vietnam War wound down, these programs attracted more individuals with backgrounds as medical technologist and nursing (Cawley et al., 2012).

Physician assistants may enter their two-year postgraduate training with a diversity of backgrounds in education and experience. By 2020, all will be required to have master's degree certification program. Nurse practitioners must complete the educational requirements for licensure as a registered nurse and complete a master of science in nursing postgraduate program. The Doctor of Nursing Practice (DNP) is a clinical doctorate that has been endorsed as the entry level NP education by the American Association of Colleges of Nursing, effective 2015; however, not all programs have made this conversion (Waldrop, 2015). The DNP program is designed to provide doctoral-level education in evidence-based clinical practice and leadership, offering an alternative to more traditional research-oriented programs (American Association of Colleges of Nursing, 2016). Luckianow et al. (2015) concluded that the heterogeneity in training programs for NPs and PAs prohibit a single licensure examination; however, training and education similarities are such that practice proficiency is felt to be largely equitable (Luckianow et al., 2015). Both NPs and PAs are competent to autonomously diagnose illness, order and interpret diagnostic tests, prescribe medications, and perform specific procedures within their scopes of practice (Crowe, 2014).

The ongoing dubiety regarding APPs is evident in the multitude of descriptive titles associated with the role. NPs continue to lack consistency in professional titles with the majority of the nation's NPs being categorized as advance practice registered nurse (APRN). The terms physician extenders, mid-level providers, and advance practice providers are used synonymously. These terms group together NPs, PAs, and clinical nurse specialists as non-

physician providers of health care traditionally provided as medical services (Bevis et al., 2008; Owens et al., 2014; Watson & Hillman, 2010).

Disciplinary Perspective

The literature describing the roles of APPs was decidedly more abundant for the NP. Investigations of role, scope and job satisfaction were limited for the PA. The review of literature failed to locate any phenomenological analyses of PAs. Due to the similarity in roles and practice settings, for the purposes of this dissertation study, the literature will be considered relevant to all APPs.

Gonzalez-Colaso, Moloney-Johns, and Sivahop (2013) conducted a national survey of PAs certified by the National Commission on Certification of Physician Assistants. Respondent demographics were mostly employed full time with 63% female respondents, and 67% having more than 6 years of experience in practice. More than half were employed in outpatient settings, and 21.6 % practiced in a surgical specialty (Gonzalez-Colaso et al., 2013). Regardless of the practice setting, the addition of PAs decreases physician work hours, improves resident working conditions, and overall patient outcomes (Gillard et al., 2011).

Serio-Melvin et al. (2010) reported that their facility, the United States Army Institute of Surgical Research utilizes PAs to manage patients in their outpatient burn clinic. The PA collaborates with the attending burn surgeon, the clinic nursing staff, and military personnel in an attempt to provide multidisciplinary patient care management. Scott Blow (2009) described a day in his life as a burn PA. His duties included rounding on hospitalized burn patients, operating alongside the burn surgeon, covering the burn clinic, and answering calls and questions throughout the day. He participated in research as well in addition to his clinical activities. His

account of the diversity and intensity of his role is a reflection of the unique characteristics of the burn specialty (Blow, 2009).

The advanced practice nurse is defined as a registered nurse with graduate-level nursing education who has completed both didactic and clinical educational requirements, encompassing health promotion and disease prevention, diagnosis, and treatment. While this general description is a broad overview for the numerous titles and roles that fall under the umbrella of advanced practice nursing, confusion has resulted from the lack of a "core definition" (Ruel & Motyka, 2009). Advanced practice nurses are separated into four main categories: (a) certified registered nurse anesthetist, (b) clinical nurse specialist, (c) nurse practitioner, and (d) nurse midwife. NPs may specialize in (a) family, (b) adult-gerontology, (c) neonatal, (d) pediatric, (e) women's health, or (f) psychiatric (mental health) specialties for purposes of national certification (Rounds et al., 2013). Great variability exists within and across these areas of specialization, much of which is dependent upon the practice location and setting. Institution variations in role delineation confound attempts at competency standardization. Interstate variances include educational requirements, certification, scope of practice, and prescriptive authority (Chakravarthy, 2008; Watson & Hillman, 2010).

The burn center NP role has evolved alongside the expansion of education and professional independence across all nursing practices. Al-Mousawi, Mecott-Rivera. Jeschke, and Herndon (2009) included the burn NP as an integral member of the burn multidisciplinary team. The experience and knowledge of the burn NP has led to the creation of many opportunities to practice in this specialty setting. The authors identified nurse-led clinics, perioperative care, performance of procedures, and research as advanced practice areas of greater autonomy for the burn specialty practitioner (Al-Mousawi et al., 2009).

The advanced practice burn nursing role also occupies a critical role in staff education and care coordination (Al-Mousawi et al., 2009; Zaletel, 2009). Zaletel (2009) described successful collaboration between the burn unit and the emergency department in order to provide education and guidance for the appropriate resuscitation of the severely burn-injured patient. Indeed, advanced practice burn specialty nurses can triage burn patients and begin life-saving treatments without potentially costly delays, providing immediate skilled care in addition to serving as valuable resources and educators (Zaletel, 2009).

In 2008, The Advanced Practice Nursing Consensus Workgroup and the National Council of State Boards of Nursing formed the Advanced Practice Registered Nurse Joint Dialogue Group. Together, they developed the *Consensus Model for APRN Regulation, Licensure, Accreditation, Certification, and Education*, which has been embraced as the regulatory model for the four primary advanced practice nursing roles. The goal was public protection by ensuring ethical, safe, and competent professional practice (Rounds et al., 2013).

Beyond the regulatory issues, the lack of definitive practice parameters adversely affects the efficiency and success of collaborative practice relationships. Although traditionally hierarchal, Herrmann and Zabramski (2005) asserted that this dynamic relationship is dependent on a foundation of mutual professional respect and should be complimentary. In 2013, in a survey of physicians, half were unaware of the legal scope of practice regulating NP practice. Because of the lack of knowledge about the scope of practice, physicians were concerned that NPs might be marketing themselves as physician equivalents. Only 10% of the physician respondents reported that they understood the difference in licensure between NPs and PAs (Soine, Errico, Redmond, & Sprow, 2013). Ultimately, knowledge gaps have resulted in barriers

from physicians that impede role integration and achieving full practice authority for all APPs (Pasaron, 2013).

Improved efficiency, accessibility, and decreased overall costs are benefits realized by the physician/practice group when APPs are included. The benefits of improved patient outcomes and satisfaction are well established in the literature. Reductions to length of stay, lower costs, and decreased incidence of hospital-acquired infection are widely documented. Because of the presence of NPs, clinic wait times have been reduced, access to care has been improved, and overall quality of care has been improved (Gillard et al., 2011; Herrmann & Zabramski, 2005; Pasaron, 2013).

The deficit of health care providers continues to grow. The need for skilled practitioners has led to APPs being utilized as physician extenders, which may have expanded the medical team's ability to provide services, but does not support autonomous practice for the APP (Bevis et al., 2008). Crowe endorsed professional growth and clinical challenges as appealing aspects of the role and cautions against employing NPs as "staffing solutions" (Crowe, 2014).
Van Fleet and Paradise (2015) provided an updated estimate on the number of people living in areas underserved by primary care providers in the US, estimated at over 58 million. The authors offered the Institute of Medicine (IOM) recommendation for NP full practice authority as a vital component in the plan to improve health care delivery. Both, the IOM and the World Health Organization support a collaborative team approach to care. Sullivan et al. (2015) listed the imperatives for the shift toward interprofessional practice (IPCP) as resulting from quality and safety issues, the shortage of health care workers across disciplines, and the call for the development of core competencies. Improvements in costs and quality have resulted from combining the efforts of diverse health care professionals coming together to deliver patient-

focused, holistic care. It is essential that efforts should be focused on optimizing the contributions of each member by removing restrictive legislation that unnecessarily impedes full practice authority (Sullivan et al., 2015).

Dontje, Corser, Kreulen, and Teitelman (2004) described the relationship between NP and patient as both mutually empowering and satisfying. The dynamic relationship is said to develop based on complex patient-specific factors, maintained through trust and open communication. Roles within the team and budgetary concerns constitute important components of the APP employment relationship. A "sustained partnership" shows reciprocal respect, nourished through empowerment and shared decision making (Dontje et al., 2004).

Providing health care can be demanding and stressful. Roles are uniquely varied, according to setting, patient population, and the individual provider's skill and experience. Job satisfaction for the APP will be realized on distinctive personal and professional components.

Pasaron (2013) reviewed the literature describing NP job satisfaction. Extrinsic and intrinsic influences were felt to be of primary importance. These elements included acceptance by the supervising physician and establishing a collaborative relationship, autonomy, optimal integration of the role, ability to participate in leadership decisions, and incentives linked to the practitioner's contributions to the practice. Secondary components have emphasized more concrete issues, such as orientation and transition into the role, expectations and variations, and type of practice. The NP-specific variables were competency discrepancies, years of experience, NP certification, and type of employer. The final aspects are outcomes-based, which include quantifiable variables, including length of stay, health care costs, readmission rates, and resource utilization. Quality outcomes felt to be important to job satisfaction were continuity of care and

patient access. A rich understanding of the numerous, diverse, and evolving components of each APP's unique practice domain is necessary to identify key aspects of job satisfaction (Kleinpell & Hravnak, 2005; Pasaron, 2013).

Poghosyan and Aiken (2015) emphasized the importance of organizational support, which was perceived as insufficient. Inconsistent regulations were another source for dissatisfaction. While they found that 74% of the NPs surveyed were generally satisfied, 26% reported some dissatisfaction, and 15% expected to quit (Poghosyan & Aiken, 2015). Ramis, Wu, and Pearson (2013) found that the diversity of the role was felt to be "overwhelming." Serving as a clinician, educator, and administrator is complex and involves characteristics of the individual, role, and organization. Intuition is a personal characteristic that guides judgement (Ramis et al., 2013).

The quality of care provided by APPs is important to patients, employers, and to national regulatory agencies. The Agency for Healthcare Research and Quality and the Joint Commission on Hospital Accreditation have developed metrics useful in quantifying the quality of APP care in order to protect the public safety. Productivity targets have been established. Yet, applying outcomes-based criteria to APP performance remains challenging due to role diversity (Kapu & Kleinpell, 2012). Onus for quantifying contributions then becomes the practitioner themselves. Suggestions for success involve ongoing education, self-motivation, and confidence. Negotiation, networking, assertiveness, and being open to new opportunities has created professional possibilities and has fostered confidence and satisfaction (Kleinpell & Hravnak, 2005).

Job satisfaction represents an essential consideration all APPs. Ramis et al. (2013) asserted that there is a high risk for burn out inherent to this level of professional responsibility.

Role performance and job satisfaction are intimately linked. The APP can be confronted with emotionally traumatizing issues and suffer negative professional experiences, influencing them on the personal level. The long work days, requiring work beyond normal hours, is described as "draining" and was reportedly resented by responding NPs. Lack of time to complete tasks also resulted in role stress (Ramis et al., 2013).

History of Burn Care

Shortly after man discovered fire, he must have experienced the pain of a burn injury. Ancient Egyptian doctors offered the first accounts of specialized care for burns. Magic, religion, plant, animal, and even human products were all employed in early burn treatment. Some of these early remedies, with the obvious exception of excrement, have continued to be utilized for burn wound care (Pecanac, Janjic, Komarcevic, & Miskovic, 2013).

The first book on the subject of burn care was written in 1607. Wilhelm Fabry, author of *De Combustionibus*, introduced the three stages of burn classification in his sentinel work. During the 1800s, extensive advances in the care of burn injuries were a result from autopsy findings. The concepts of fluid resuscitation and surgical management were first introduced and burns were no longer viewed as a "local affliction" (Hattery, Nguyen, Baker, & Palmieri, 2014, p. 237). Reconstruction for burn scars also began to be considered as an option during the 1800s (Hattery et al., 2014).

Referral to a burn specialty center is a relatively new concept and is documented in historical records from the United Kingdom as early as 1944. The devastation of World War II has resulted in countless burn injuries and has led to a more aggressive approach to wound care and surgical treatment. Prior to this time, reconstruction was not considered until much later for those seriously burned patients who were lucky enough to survive. In the past, generalists were

responsible for the care of burn patients, providing only local wound care and some analgesia. Because of World War II, there was increased interest in trauma care, which led to research into the unique physiologic needs resulting from burn injuries. The foundational research continues to provide the impetus for ongoing transformative developments in the burn specialty field (Hardwicke, Kohlhardt, & Moieman, 2015).

Al-Mousawi et al. (2009) summarized the intensity of burn care by stating, "The management of severe burn injuries may present the surgical field with the greatest integration of health professionals, and benefiting the most from the influence of truly multidisciplinary care (p. 547)." A variety of skills sets are needed and specialty-care knowledge is critical. Although distinct in many ways, unfortunately, burn care is not exempt to a problem common to all general and specialty health care fields: the problem of wide-spread provider shortages. Shahrokhi, Jindal, and Jeschke (2012) discussed how burn centers everywhere are faced with burn care provider shortages, resulting from problems in the areas of both retention and recruitment. These authors offered strategies to improve success and satisfaction with burn training, which was aimed at the educational process. There has been a paradigm shift towards fostering the learning process, embracing care delivery through a team approach. Widely held as successful in the nursing profession, structured mentorship programs were offered as a way to engage the learner and provide support and encouragement. The forward-thinking format was based on the concept of interprofessional education. Improvements in communication, understanding, competency, accountability, and, ultimately, trust form the goals for the team approach. Through this beneficial collaboration, the contributions of all team members will be optimized and appreciated. The team approach will be instrumental in the addition of a diversity

of care providers to fill the gaps with an expansion of the burn care team and blunting the effect of the burn surgeon shortage (Shahrokhi et al., 2012).

Table 1
Summary of Burn-Specific Acute Care Requirements

Term	Definition
Fluid resuscitation	To replace massive insensible losses
Early burn excision	To prevent infection from necrosis of burn wounds
Nutritional support	To meet the demands of critical hypermetabolism
Topical antimicrobials	To prevent infection while awaiting re-epithelialization or surgery
Infection control	To prevent sepsis in this at-risk population
Maintenance of temperature-controlled environments	Due to loss of protective integument

Note. Adapted from "The Importance of a Comprehensive Team Approach to Burn Care," by A. Al-Mousawi, G. Mecott-Rivera, M. Jeschke, & D. Herndon, 2009, *Clinics in Plastic Surgery, 36*(4), pp. 547-554. Copyright 2009 by Elsevier.

Experiential Context

The principal investigator (PI) has greater than 17 years of experience as a burn surgery NP, preceded by 10 years in burn and critical care nursing. As a member of the American Burn Association (ABA), the PI has also encountered many of the burn APPs in the US at past professional meetings. Additionally, the PI served as the chair for the burn APP American Burn Association Special Interest Group (SIG) for 2016. Membership in the largest national NP organization, the American Association of Nurse Practitioners (AANP), has also brought the PI into contact with countless other NPs. The PI endorses professional association memberships as important to the advancement of scope of practice. Having served as a fellow in the AANP demonstrates my imperative for research propagation. Being elected as 2016 President-Elect to my local NP organization is illustrative of my support of professional activism. Passion for burn care and support of independent practice for NPs everywhere was the impetus for this dissertation study.

Summary

Chapter 2 presented a review of literature describing the development of the NP and PA professions. Their gradual integration into the health care system was chronicled. Critical developments in medical education and health care funding were reported and related to burn care delivery. Key practice and professional issues were discussed. The history of burn care was reviewed and distinctive aspects were outlined. Finally, the PI's experience and motivation were offered for consideration.

Chapter 3: Methodology

Introduction

In this chapter, the dissertation study methodology is presented. There is a detailed discussion of the interpretive phenomenological analysis (IPA) process. Previous studies utilizing phenomenology to investigate nursing processes are reviewed. Specific aspects, including participants and procedures, are detailed. Ethical issues are considered and trustworthiness of the findings are supported. The chapter concludes with a deliberation of strengths and limitations of IPA as they apply.

Research Design

The dissertation study utilized a qualitative, interpretive phenomenological analysis design to represent the lived experience of the burn APP. The qualitative approach captured, described, analyzed, and interpreted the lived experiences of these professionals, leading to understanding and meaningfulness to the challenges and benefits, motivators, and stressors that influence satisfaction and sustainability for the burn APP (Paige & Smith, 2013). The qualitative methodology is appropriate when spontaneous, unformatted data are sought in hopes of enlightenment (Richards & Morse, 2013, p. 25). The researcher initiated dialogue during semi-structured interviews, which were equivalent to “guided conversations” regarding experiences of the burn APP to evoke thick descriptions essential for interpretation leading to the construction of meaning (de Marrais & Lapan, 2004, p. 54).

Interpretation is a facilitator of the discovery of the hidden insights, which indicates the previously concealed meaning. Smythe (2012) listed the hermeneutic process in four steps: reading, writing, thinking, and rewriting (p. 8). These steps were completed not only by the researcher but detailed and offered to the participants. The interview transcripts were returned to

each participant to engage them in the process by assessing for accuracy. They were encouraged to add any addendums or changes necessary to facilitate understanding (Smythe, 2012). The results of each interview were compared and contrasted to illuminate shared practices, common situations, and overarching themes (Wojnar & Swanson, 2007).

The IPA methodology began with phenomenology and the accurate, rich documentation of the individual burn APP's personal meaning and experience of being in a professional role. The burn APPs shared their unique stories, unencumbered by judgment and obtained through interviews. Interpretation occurred subsequently during the reflection phase (Maggs-Rapport, 2000). Interpretation was a multi-layer process, resulting from the culmination of accepting preconceptions, immersion, moving away from subjective experiences, and allowing the phenomenon of the burn APP to show itself (van Manen, 2014, pp. 186-187).

There were several examples of phenomenological analysis involving nursing care. Carolan (2013) completed a phenomenological analysis of pregnant women with newly diagnosed gestational diabetes and how they coped with disease self-management. Her work listed steps that were followed in the dissertation study and were essential to thematic analysis. These steps included listening to the interviews numerous times to detect subtle inflections and rereading the interview transcriptions to show common themes and emerging meaning (Carolan, 2013).

Dunn (2012) conducted an IPA to show nurses' motivation to remain in the nursing profession. Framed by the "nursing as caring" theory, she interviewed eight participants to examine the effect of providing patient care and their perceptions that encouraged them to continue in nursing. Diekelmann and Allen (as cited by Dunn, 2012) provided instruction for continuing the journey beyond the process for identification of themes to interpretation of the

results, imperative to the IPA format. Heidegger said that interpretations acknowledge preconceptions and are accepted as ever-present; therefore, they are consciously considered for any potential influence on the findings (Dunn, 2012). The nursing role was shown as filled with numerous stressors. Although nurses value their ability to contribute to recovery, themes included burn out and compassion fatigue. Aging, physical demands time constraints, and the physiologic effects of stress were all determined to exert negative influences on nurses' outlook on remaining active in the nursing profession.

Fackler, Chambers, and Bourbonniere (2015) explored hospital-based nurses' experience of power in the work place by way of interpretive phenomenological analysis. Social theory was a guide for the search for meaning with power being viewed as it applied to patient advocacy and as agents of change within the health care system. In previous studies, there was support for negative experiences that demonstrated when nurses perceived that work environments interfered with the ability to provide quality patient care. The authors acknowledged that individual experience is inextricably intertwined with the experience of those with whom the person has dependent interaction with throughout each day. Fourteen hospital nurses were interviewed face to face at a location of their choice. The themes that emerged were relevant to APP practice. It was imperative that the APP is familiar with the unique attributes of each burn patient and is a staunch patient advocate. The work also indicated that positive interdisciplinary relationships benefit the patient.

Burn recovery depends on the ongoing and cooperative efforts of many disciplines, such as nursing, physical therapy, clinical nutrition, and social work. Being "heard" as a vital member of the team was important to participants and essential for patient advocacy. The patient was the priority and the feeling of power was valuable as it could support quality care delivery. The

component of power is impactful for burn APPs as they are often the one constant in a rotating surgical team (Fackler et al., 2015).

Cronin (2001) investigated the effect caring for burn patients had on the emotions of burn specialty nurses. Several role-related stressors were identified that are unique to the burn setting, such as the physical and emotional stress of performing painful daily dressing changes. Five registered nurses were interviewed to assess how they dealt with the emotions elicited by their work on the burn unit. Cronin asserted that nurses interpreted the strong emotions evoked by caring for burn patients very differently. Furthermore, they did not feel that their employers helped them deal with their emotions. The participants surmised that, ultimately, they were responsible for finding support systems to deal with work-related stressors (Cronin, 2001).

Research Assumptions

Phenomenology is a methodology appropriate to investigate how people derive meaning from their experiences. The focus of reality is directing intentional behavior and emotions at something specific. The lived experience is formed by the intentionality of interacting with the personal objective world of the individual. Phenomenology is a facilitator of awareness. The desired outcome of phenomenology is to capture the everyday experience of a person in his/her everyday world as it is lived before any framing or analysis. The goal is the essential, basic nature of the being, represented as an uncensored depiction. Connelly (2015) described four key concepts, proposed by Merleau-Ponty and van Manen as “lived” space, body, time, and relationships, which are guidelines for IPA questions to promote learning and knowing. These conceptual entities exist as part of our “life world,” representing the “situated-context” of the human existence, embracing our culture and timing in history. The body has meaning through sensations and feelings. Physical surroundings include space, both tangible and perceived. The

concept of time is dynamic and incorporates past, present, and future events. The final concept of relationships is subjective and interdependent, resulting in differing perceptions, depending on who is queried (Connelly, 2015).

Ivey (2013) described IPA as a process for processing multiple realities leading to interpretations with universal applications. No one interpretation conveys the entirety of an experience. The deeper essence is revealed when perceptions are intermingled with individual backgrounds of history and culture. The knowledge revealed by a phenomenological analysis should enlighten, transform thought, and inspire action (Ivey, 2013).

Reflexivity is a process of self-evaluation whereby the researcher considers his/her own "positionality" relative to the research. In this way, biases and preconceptions can be acknowledged and addressed. Van Manen endorsed the use of a researcher journal to provide an audit trail to document decision making, thereby reducing potential bias and illuminating personal conceptions (Barss, 2012). Reflexivity of personal and professional biases will occur in a narrative format through journaling for the duration of the proposed project. For the purposes of the dissertation study, the investigator examined the potential for bias due to shared experiences, peer relationships, and professional designation (Clancy, 2013).

Benner (1994) offered a synopsis of hermeneutic assumptions, according to Heidegger. These assumptions are constructed on a structural foundation of understanding wherein a practical familiarity exists. It is this background that guides the "fore-sight" for interpretation based on the expectations of the researcher's pre-existing suppositions (Benner, 1994, pp. 71-72). The researcher must continuously identify possible influences as they are recognized in order to offer valid interpretations, untainted by prejudice (Touhy et al., 2012).

Crotty (1998) defined hermeneutics as the articulating of individual perceptions and solitary knowledge with others (p. 91). The hermeneutic circle follows an immediate experience from inception through application of previous knowledge and arrival at fresh insight, which is then applied to the next moment in time, perpetuating the subsequent presuppositions and resultant knowledge acquisition (Crotty, 1998, p. 92). It has been suggested that the researcher should have personally experienced the phenomenon himself/herself as was the case for this dissertation study. Thus, experience is essential to interpretation realized by entering the hermeneutic circle (Converse, 2012).

Two distinct aspects of the hermeneutic approach have critical roles in achieving the "insider's perspective." The interpretive process necessary to access the participant's unique world is significantly influenced by the researcher's own beliefs. According to Barss (2012), with IPA, the importance of the investigator is recognized as a contributor to the process of knowing and even "embraces" them. Smith et al. (2009) described the researcher's active role as "dynamic" with integration of the conceptions necessary to this elucidatory journey. Researchers must critically analyze the participants' narrative to exam for intentionality. Through this iterative approach, the discovery of themes is facilitated, which the participants themselves may not be consciously aware of (Smith et al., 2009, pp. 35-36). Constructions are subjective based on observations that are imperfect and fallible. Realization is an inductive, iterative, and personal process, continuously emerging from experience. Accessing these interpretations through interviews with the participants in a specific setting (reality) is critical to constructing an understanding the phenomenon of interest (Polit & Beck, 2012).

Reality is appreciated immediately as we participate in the world around us as individuals. In the present, meaning is prereflective. Reflective meaning only occurs after

engagement with the world. The experience is assessed through our ethical, social, and cultural views. The result is a framing of the moment that changes the lived experience even as it is actively being lived (van Manen, 2014, pp. 28-29, 60-61). The three components of the researcher's "fore-structure" are felt to be integral to the interpretive process, directly contrasting the stance that bracketing all preconceptions is imperative to appreciating the essence of a phenomenon (Touhy et al. 2012). The "fore-having" represents innate knowledge of "being." The "fore-sight" is way a researcher orients the approach to a particular phenomenon. It directs the position of entry into the hermeneutic circle. Finally, the potential influence of "fore-conception," a pre-existing notion of conceptual importance, must be identified and acknowledged (Benner, 1994, p. 57)

Setting

The qualitative dissertation study was conducted by way of distance communication in real-time and face-to-face interviews. The participants were asked to participate in video conferencing using their own computer or interview in person. The actual setting was entirely of their choosing. They were encouraged to select a time and physical location at which they will be free from distractions. The investigator established an account with a transcription service, and the account number and organization's security policy and service information were submitted to the Institutional Review Board (IRB) and were made available to participants. The investigator conducted interviews both from the privacy of her office and in person. No one else was present in the investigator's office at any time during the distance interviews. The door to the office was locked with a "meeting in process" sign on the door to enhance confidentiality. The interviews conducted on location were all conducted in conjunction with a burn meeting that the participant was already planning to attend prior to accepting the invitation to be interviewed. Private

locations were selected, according to the choice of the participant. In addition to the informed consent at the beginning of each interview, participants were asked if they were satisfied with the setting and security of the interview format prior to proceeding.

Sampling Plan

The plan for this dissertation study was a purposive sampling of currently practicing APPs, specializing in the care of burn-injured patients (Richards & Morse, 2013, p. 221). Participants were recruited through the burn APP SIG group site for the American Burn Association. The ABA is a national organization dedicated to the care of burn patients through research, education, and prevention efforts (ABA, n.d., para 1). Electronic mail communications are available at the group site and are automatically sent to all members who have provided their e-mail addresses and voluntarily registered for the group. Only active members of the ABA have access to the site and access is password protected. The Web-site offers an "opt-out" option with each generated notification. The organizational administrator for the SIG group site has provided written authorization to issue the email soliciting participation. All members of the burn APP SIG had an equal opportunity to respond in the six-week time frame that it was actively posted. The first nine to respond were contacted for inclusion to ensure that at least eight interviews were completed.

Participants

Inclusion criteria. Inclusion criteria for participation included currently practicing NPs and PAs who work full time in the US and specialize in the care of burn-injured patients as their primary patient population. In order to blunt the effects of care setting variations on role, all included participants had inpatient (hospital) care responsibilities. They also were all enrolled in the ABA special interest group site for APPs. They were responsible for either adult, pediatric,

or both burn-injured patient populations. Both NPs and PAs had an equal opportunity to participate. The selection process continued until nine qualified participants had committed to the project.

Exclusion criteria. Any APP was excluded who did not have access to a computer with video conferencing available, if he/she chose not to conduct the interview in person. Interviews were conducted verbally and in the English language as translation could have resulted in loss of intent or misinterpretation. The participants were requested to accept their transcript for review, although no changes or actions were required. Finally, it was necessary for participants to be available for electronic communication during the time necessary for participation.

Sample Size

Smith et al. (2009) supported that IPA is best approached through an intense analysis of relatively few cases. Between four and 10 interviews are recommended as a sufficient commitment to provide adequate detail concerning a specific phenomenon. An in-depth focus of the unique reality of few select subjects can yield substantial insights (Smith et al., 2009, pp. 48-52). There were nine participants accepted. There was no set quota of NPs or PAs.

Protection of Human Subjects

According to federal and institutional regulations designed to protect the public from unethical research practices, approval was granted from the IRB at Nova Southeastern University (Richard & Morse, 2013, pp. 237, 260-261; de Marrais & Lapan, 2004, pp. 343-344). The participants were required to sign a standard Nova Southeastern University institutional consent prior to participation. Subjects were informed of the intent of the interview and that the study designs included a request to review and revise (as indicated) their own transcripts for thematic

clarification. Each participant was educated about their right to withdraw from participation at any time during the research (Smith et al., 2009, pp. 53-54).

Confidentiality is an essential ethical consideration. No names were associated with the transcriptions; they were simply numbered according to the order in which they occurred, which did not correspond with the order in which they responded to the invitation to participate. The participants were not aware of the sequence of the interviews. No names were mentioned during the interviews. All electronic communications were conducted securely. Designation as an NP or PA and location of practice setting were discussed in general but not associated with any direct comments. Only geographic regions, not specific states or cities were identified (Miles, Huberman, & Salana, 2014, pp. 56-58; Richard & Morse, 2013, pp. 237, 260-261; de Marrais & Lapan, 2004, pp. 343-344).

Risks and Benefits of Participation

The potential risk associated with this dissertation study included the breach of confidentiality resulting in the potential for psychological and emotional harm, compromised privacy, and negative implications for current and future employment. These factors were felt to be of minimal likelihood due to the security of storage for the actual interview transcriptions and de-identification of findings. Risk minimization for adverse influence on employment involved de-identification of demographic information from results, thus no regional affiliation, gender, or professional designation as either an NP or PA were associated directly with the participant when describing experiences. The success of the interview was directly related to trust. Every effort was made to ensure that the participants felt at ease socially and safe to speak freely (Brinkmann & Kvale, 2015, pp. 19-20).

Additional risks included stress related to both the interview process itself and stress resulting from emotional responses to participation. Interview revelations have the potential to alter personal perceptions. Approximately 15 minutes were allotted at the conclusion of the interview to facilitate debriefing for interested participants. All recording equipment was turned off and no information shared during this time was utilized in any manner (Brinkmann & Kvale, 2015, pp. 85, 155).

The principles of autonomy and justice were honored. Each participant was treated with respect for his/her values, beliefs, and practices. The concept of justice was refined to the idea of fairness. All qualified respondents received equal consideration for participation, avoiding discrimination. Informed consent was obtained, providing study details, and facilitating full disclosure (Jonsen, Siegler, & Winslade, 2010, pp. 47-49, 162-163).

While there were no tangible benefits for participation, the participants expressed that they found gratification in sharing their personal experiences and contributing to a study designed to offer unique and rich perspectives. Interpretive phenomenology provided increased understanding and practical knowledge with the potential for future benefits, including improved role appreciation, leading to advancement of the profession (van Manen, 2014, pp. 260-261).

Data Storage

The project consisted of face-to-face interviews and computer-based video conferencing. Interviews were securely transcribed by a professional service. The video, audio, and computer-based copies of all study-related materials, including transcriptions, were encrypted and stored on the password-protected computer of the investigator in a secure, password-protected cloud storage site and securely forwarded to the participants for their review. The written transcriptions were stored in the locked desk of the investigator. A list of identifiers was stored

separately from all data on the password-protected home computer of the investigator. All data will be stored securely for 3 years as required by the IRB, then any documents will be erased from the computer system and any paper documents will be shredded. Only the investigator has access to the study documents.

Procedures

Following successful proposal defense and approval from the Nova Southeastern IRB, the following steps were taken to identify recruits, secure their participation, and complete the research data collection process.

1. An invitation to participate in this research was posted on the American Burn Association APP SIG group site. Permission for the posting was obtained from the ABA blog administrator and documented for the IRB. See Appendices B and D.
2. The projected time for recruitment was 6 weeks and the invitation remained posted during this time.
3. Each APP who expressed interest received a personalized response by electronic mail to the email address he/she provided to the ABA. The purposes for this response were to share introductions, answer questions, and provide a general overview of the process and to confirm eligibility.
4. Once a participant's interest and eligibility were confirmed, consent was forwarded through to the electronic mail that the participant established for all study-related communications. None of the participants requested that the consent be sent as a hard copy through registered U.S. mail, but this option was available.
5. After the participant signed the consent, a date for the individual interview was mutually established. There were 2 weeks allotted between initial contact and

confirmation of the plan to participate, sign the consent, and set an interview date and time.

6. The interviews were conducted in two ways. The first option was utilizing a Web-based video conferencing service. The second option was through face-to-face interviews. These interviews were recorded on a digital audio recorder. The audio was transcribed through a secure transcription service. The video interview was also saved to a secure cloud site to remain until project completion and then will be deleted. A copy of the transcription was sent to the participants via encrypted email at the site of their choosing and to the investigator for review.

Data Collection

Phenomenological interviews rely on a prereflective account of the experience as it was lived rather than a general recollection lacking the richness of deep and meaningful insight (van Manen, pp. 315-317). Philosopher Martin Heidegger asserted that phenomenology should be approached through one-on-one interviews focused on extracting the unique personal experience and meanings of the individual participant (Converse, 2012). Accordingly, data were collected during one-to-one interviews with information recorded verbatim by a secure audio transcription service as previously described. Questions are included in Appendix A. The process for development of interview questions addressing the unique phenomena of the burn specialty APP is detailed below.

Demographic data. Any demographic information collected was maintained separately from any other data. It was only used to identify the participants' pseudonym identity to serve as proof of their eligibility. Name, professional designation (NP or PA), description of their current practice and patient population were securely stored away from all other data. Personal

characteristics, such as age, were impactful in the lived experience of burn APPs and were captured to provide additional details contributing to individual meaning making.

Interview questions. Professional challenges, benefits, satisfaction, and sustainability were explored in the interview. The essence of the burn APPs was shown through anecdotes and narratives detailing their unique experiences. Interview preparation consisted of steps designed to ensure that the participant knew the expectations. The timeframe for questions (1 hour) and debriefing (15 minutes following completion of the interview) was established. The actual time varied from 40 minutes to 1 hour for the actual interview. The debriefing times varied from 15 minutes to greater than 30 minutes. The purpose for the interview was described. The investigator had a list of questions in the form of an interview schedule; however, the interviews were guided by interviewee's responses (Smith et al., 2009, pp. 64-69).

According to constructionist philosophy, the questions were designed so to facilitate a journey of discovery seeking meaning and knowledge generation to be shared by the interviewer and the interviewee (Brinkmann & Kvale, 2015, p. 172). Dr. Steiner Kvale offered 12 points (see Table 2) to serve as a guide to the phenomenological exploration of "nursing and the human experience of the human body (Thomas & Pollio, 2002). Kvale's subsequent book provided further structure and direction for development of the interview questions for this dissertation study (Brinkmann & Kvale, 2015, pp. 160-164). The questions underwent expert review prior to being finalized for dissemination to participants. The expert evaluated the questions against the guidelines provided in Table 2 as they were applied to the experience of the burn specialty APP. Her expertise improved the likelihood that the questions captured the essence of the population under study, rendering the responses more trustworthy (Portney & Watkins, 2009, pp. 328-329).

Following revision of the interview questions, a pilot interview was undertaken to vet the questions and guide any final revisions prior to beginning the formal research. The sample size was nine participants with eight participants actually qualifying, and one pilot study participant participated as a representative sample. The results of the pilot study provided guidance for final revisions to the format, processes, and interview questions (Portney & Watkins, 2009, p. 330).

Table 2.
Phenomenological Interview

Phenomenological interview question format	Types of interview questions
Questions must be centered on study participant	Provide an introductory question to begin with rich description of main aspects of phenomenon under study
Questions seeks understanding of lived-experience	Follow up questions with appropriate probing, clarifying, indirect or direct questioning as indicated.
Qualitative, descriptive and specifically focused design	Structure questions to guide and maintain the flow of the interview
Interpersonal exchange during which the interviewer remains cognizant of the emotions of the participant	Use additional questions or statements, such as rephrasing an answer, to prompt further discussion or add clarity

Note. Adapted from *Interviews: Learning from the Craft of Qualitative Research Interviewing* (3rd ed., pp. 160-164), by S. Brinkmann & S. Kvale, 2015, Los Angeles, CA: Sage. Copyright 2015 by Sage.

Journal

The investigator used reflective journaling throughout the process, which supplemented the interview transcripts and assisted in capturing thoughts and observations throughout the study. Questions, concerns, and impressions were recorded in writing and reviewed. In this way, preconceptions were formally identified. As the dissertation study proceeded, the unstructured documentation was considered as supplemental to transcripts when identifying codes and formalizing themes (Saldana, 2013, p. 42). Journal entries were completed

immediately after each interview to preserve impressions regarding the experience, including specific observations of both verbal and nonverbal responses (Thomas & Pollio, 2002, p. 29).

The investigator journaled perceptions to achieve "critical self-awareness" and to expose prejudices, preconceptions, and expectations. Illumination of assumptions included intense personal reflection to unburden the pursuit of meaning from the rigid structures of conformity (van Manen, 2014). Reducing each experience in this way freed the burn APP's Dasien to be actualized, unencumbered by presuppositions (van Manen, 2014, pp. 224-225).

Data Management and Organization

Transcription. The interviews were recorded with a digital audio recorder for the face-to-face interviews and through the Zoom conferencing service for the video interviews. The audio recordings for both types of interviews were both forwarded securely utilizing the commercial audio transcription service (Audiotranscription.com). A copy of the verbatim transcription was sent to the participant and to the investigator as an electronic mail attachment for review. Accuracy of transcription was confirmed through a member check, which allowed participants to review their transcripts for omissions, make revisions, and to add any additional thoughts he or she deemed pertinent. The member checks were requested after his or her transcript was received by the investigator (Miles et al., 2014).

Data Analysis

Interpretive phenomenological analysis occurred in two distinctive phases. The first phase was the presentation of the phenomenon. The study was designed, questions were developed, a sample was chosen, and interviews were conducted. Transcriptions of the interview underwent a member check to assess the accuracy of the representation of the phenomenon as lived by the participants who shared their stories (Smith et al., 2009, pp. 40-78).

The next phase was the interpretive process. The six-step process guided this investigator through the review of each individual interview, culminating with the identification of themes common to all participants. These themes presented insight and a new way of knowing the experience of the burn APP.

- Step 1. Reading and re-reading. Microscopic analysis of each transcript, one line at a time to reveal the unique understandings of the individual participants (Smith et al., 2009, pp. 79, 82).
- Step 2. Initial noting. In-depth exploration of the participants' way of telling. Identification of important matters, the context it occurs, and why it matters. The investigator began the process of interpretation by describing the meaning for the experience. In this step, exploratory comments were used to begin the analysis of concepts (Smith et al., 2009, pp. 79, 83-90).
- Step 3. Developing emergent themes. Developing the hermeneutic circle of interpretation, taking the view of the part in relation to the whole, and the whole in relation to the part. Here, the participants' description of the phenomena began to blend with the investigator's evolving interpretation. (Smith et al., 2009, pp. 79, 91-92).
- Step 4. Searching for connections across emergent themes. Various methods exist for establishing relationships between and across themes. Examples of these include abstraction, subsumption, polarization, contextualization, numeration, and identification of function (Smith et al., 2009, pp. 79, 92-100).
- Step 5. Moving to the next case. Each transcript was treated as a new experience free of any preconceptions resulting from the previous one (Smith, 2009, p. 101).

- Step 6. Looking for patterns across cases. Patterns were demonstrated through multiple levels of interpretations to identify the larger commonalities forming overarching themes (Smith et al., 2009, pp. 101-109).
- Step 7. Writing the analysis. Smith et al. (2009) described this final step as an iterative process that requires flexibility, creativity, and persistence (pp. 55, 110-113).

Trustworthiness and Integrity

Standing (2009) provided criteria for establishing trustworthiness in phenomenological studies: clarity of concepts and process, confirmability, and auditability. Validity, also known as trustworthiness, was established through "persistent observation" with demonstrated concentrated depth of focus and "prolonged engagement" to substantiate dedication (Maggs-Rapport, 2000). Salmon addressed validity, trustworthiness, and goodness, concluding that member checks and participant audits established accountability (Salmon, 2012). Validation of interpretations and revisions have improved the trustworthiness of the findings. The iterative process of re-examination may be helpful in facilitating the discovery of unidentified presuppositions. Their influence can then be attenuated, enabling perspicacious reflection and promoting vivid interpretation congruent with the IPA methodology (Galletta, 2013, pp. 30, 127, 173).

The audience has the final determination of validity. When considering qualitative research, especially IPA, the value of the results may be an individualized experience for those who find meaning in the phenomena under consideration (Pereira, 2012). Van Manen (2014) posited that a single process for validating a phenomenological does not exist. Establishing the originality of accounts and appropriateness of the interpretive process is essential for the critical appraisal (pp. 348-349).

For the purposes of this dissertation study, clarity of concepts were a result of a review of the investigator's personal journal, transcripts, and member checks (Standing, 2009; Salmon, 2012). Transcripts and member checks were used to provide documentation to confirm results and be an audit trail to support rigor. The interviewees had the opportunity to review the entire transcription and be encouraged to make any changes or additions they deemed appropriate (Brinkmann & Kvalle, 2015, pp. 206-214).

Strengths and Limitations of the Research Design

The unparalleled contribution of phenomenology is in its representation of the complexities of "being" in the world as experienced personally by the individual. The essence of emotions and insights are unique and abstract. A strictly scientific approach will force structure on responses, limiting disclosure. IPA presents a deeper understanding, and the rich meaning of the phenomenon under investigation is exposed (Trochim & Donnelly, 2008, pp. 142-143).

Interpretive phenomenology does have its limitations. Attenuation of presuppositions is certainly achievable, but elimination is not a reasonable expectation. There was a small sample size selected for this IPA. The investigator's position as a colleague and peer may have prohibited disclosure. However, the investigator is the only burn APP at her institution and does not have a professional relationship with any other burn APPs or their supervising physicians, greatly reducing the possibility of any potential influence (Barss, 2012). The dissertation study was limited to the participants actively enrolled to receive emails through a single organization's SIG.

Summary

Chapter 3 outlined the methodologic process for study completion. Ethical principles of justice and autonomy were considered. Trustworthiness and integrity of research findings were

discussed. The procedures included in this IPA were detailed. Interview questions were developed and expert review was sought. The steps included in completion of an IPA study were listed and described. The chapter has a concluding discussion, considering various attributes of interpretive phenomenological analysis.

Chapter 4: Results

Introduction

Results of the individual interviews guided by semi-structured questions capturing the lived experience of the Burn APP are presented. Responses to these questions and the subsequent spontaneous dialogue disclosed both unique reflections and emergent themes. These themes were viewed individually and across cases to provide a presentation of comments unified by shared expressions and interpreted into phrases that speak the essence of the burn APP as an entity (Smith et al., 2009, pp. 92-95).

The purpose for this dissertation study was to develop a thick description of the lived experience of the burn APP by gaining insight into the essence of being a burn APP through descriptions of the experience and insightful reflections. The essential meaning of being manifested through eight emergent themes:

1. The role of the burn APP is not well understood.
2. Regulatory issues and organizational constraints create prohibitive practice disparities.
3. Burn patients are uniquely challenging.
4. Team approach is essential to quality burn care.
5. Burn APPs are trusted and valued by burn team members.
6. The patients are the reason for what we do.
7. There is never enough time.
8. Personal and profession stressors affecting commitment to current APP position.

Chapter four begins with participant demographic and practice description, followed by details of the interview process. Themes were found to be rooted in numerous similarities among all participants, despite differences in age, gender, location, and professional designation.

The participants included seven White and one African-American, thus any racial or ethnic influences could not be assessed. Through the phenomenological method, interpretation was used for the identification and fusion of central themes (van Manen, 2014, pp. 320-323). The statements and commentary are included as exemplars to accurately chronicle the individual participant's thoughts and expressions (Heidegger, 1962, pp. 148-150). All quotes were extracted from final transcripts that were approved by the participants.

Participants

A total of nine APPs agreed to participate in interviews by responding to the invitational posting on the SIG Web site. One of these interviews was not recorded in its entirety when it became apparent that the participant no longer met inclusion criteria. Of the remaining eight, four were NPs and four were PAs. Demographic data was limited to preserve anonymity as there are so few APP members of the ABA. Burn region rather than actual location of practice was documented.

The average age was 39.5 years. Three of five burn regions were represented, which included the Southern region, housing 24% of the nations' burn centers. The invitation to participate was posted on a national burn forum, and there was no obvious cause for the lack of representation in the Northeast and Midwest regions (ABA, n.d.a). All participants were employed full time and were responsible for the care of hospitalized patients. Three APPs were responsible for adult patients only, and five cared for both adults and pediatric patients. The participants' areas of responsibilities are detailed in Table 4.

Table 3.
Participant Demographics with Burn Region

Participant	Gender	Ethnicity	Age	Designation	Burn region[a]
1	F	White	37	NP	Southern
2	F	White	31	PA	Western
3	F	African-American	33	NP	Southern
4	F	White	61	NP	Western
5	F	White	39	PA	Southern
6	F	White	40	PA	Eastern Great Lakes
7	F	Hispanic	45	PA	Southern
8	M	White	30	NP	Southern

Note. [a]Burn region based on regional map by the American Burn Association (http://ameriburn.org/public-resources/burn-center-regions/).

Data Collection

Four interviews were completed using video conferencing. These were recorded through a Zoom conferencing system and stored in a password-protected cloud site. All remote interviews were conducted from both the home of the participant and the home of the investigator. Four in-person interviews were scheduled based on the participant's availability and held during regional burn meeting associated with the ABA. Private locations were selected to ensure confidentiality and anonymity. Isolated tables were selected in all cases.

Table 4.
APP Patient Care Areas of Responsibility

Participant	Floor	Intensive care	Operating room	Outpatient
1	x	x		x
2	x	x	x	
3	x	x	x	x
4	x			x
5	x	x	x	x
6	x	x		
7	x	x		x
8	x			

Themes

The IPA process showed the following themes. Their structure was "data-driven," proceeding as an inductive process permitting themes to emerge naturally from the interviews (Schreier, 2012, pp. 80, 87-88). The individuals' way of being was shared through descriptions of their everyday "situatedness." Each participant recounted meaningful experiences, providing vision into the self-understanding of being a burn surgery APP (Benner, 1994, pp. 76-78).

The role of the burn app is not well understood. The burn APPs in this dissertation study reported many positive experiences in their roles. In fact, all participants prioritized providing excellent patient education as a critical defining factor in their role. Additionally, all described their role as unique because education of the entire burn team, especially surgical residents and nursing staff, was integrated into their clinical duties.

Unfortunately, a lack of knowledge concerning the education and experience of the APP among the medical and nursing staff resulted in some instances of resistance when the valuable information was offered to them. Two participants commented that they occasionally encountered resident physician who were not receptive to education from the APP with the inference that the information was viewed as inferior. Even the nursing staff was reported to have sought out the inexperienced rotating resident physicians at times because they were

unfamiliar with the APP role or scope of practice. One stated, "[Educating residents] can be a challenge because with some of them, you meet a little resistance" and another reported similar issues, "Sometimes you meet resistance with the nurses because you are a mid-level."

The burn APP role was described by one participant as "ever-evolving." The ambiguity associated with defining the role presented as a source of frustration. One participant opined, "I don't really know what I am supposed to be doing, I am just doing what needs to be done." Another remarked that he/she did not feel that the attending physicians knew the job APPs are capable of "doing." The APPs all reported having to adapt to alterations in the way care is delivered, according to the specific physician in charge at the time. Each surgeon utilized them in different ways, requiring some degree of change to assigned duties. Lack of autonomy and inability to affect change were related to the confusion and frustration, potentially affecting patients and their families.

There were no appreciable differences between NPs and PAs in the experiences of role ambiguity. One hospital administration was cited as holding the APP responsible for meeting evaluation criteria established for staff nurses when in fact the role differed greatly from the scope and responsibility. One of the NP participants lamented "They grade me on things that a floor nurse does that I don't. That is not my job description, which is not very fair . . . they just don't know what to do with us." Another PA participant summed up his/her frustration this way: "I definitely feel that lack of autonomy . . . I think it would be nice if we could all be on the same page."

Regulatory issues and organizational constraints create prohibitive practice disparities. Regulatory agencies, such as state boards of nursing and state boards of medicine, were the source of role disparities for several APPs, both for PAs and NPs. For example, burn

NPs are certified in a variety of specialties. Individual states or the employing facility may also enforce limitations on practice settings based on the NPs' certification. These barriers led to challenges for three of the four NPs in organizing patient care and interrupted continuity of care. An example shared by one NP described frustration encountered after seeking clarification from the state board of nursing: "They [the hospital] said that they would not allow me to go to the operating room . . . it was sort of devastating to me and my boss that I was not going to be able to do that anymore."

It was apparent that regulatory practice restrictions presented a more formidable barrier to NPs. Certification issues additionally limited the ability to care for patients based on their age and acuity. Specifically, five APPs reported not being assigned patients in the intensive care unit. However, both groups experienced constraints on their ability to perform certain procedures outside the operating room. One PA commented that "PAs cannot monitor moderate sedation and that has been a real defining portion of the job that I can't do."

While practice restrictions were a significant source of frustration for all participants, the breaks in continuity of care also caused anxiety to patients who had developed a relationship with their APP. A patient encounter was detailed as an example: "I explained to some of my patients that I'm not going to be in the operating room with them, but that I would be there when they come out and explain what was done to them and take care of them when they come out." Regulatory restrictions had a tangible effect on practice, and the APPs indicated that they felt powerless to realize any changes.

Despite the stress and frustration resulting from role constraints, all eight APPs admitted that the variety unique to this specialty was an important contributor to their job satisfaction. One APP offered that "the role is what you make of it." All APPs functioned in multiple patient

care areas that included the inpatient hospital setting, outpatient clinic, emergency intake, stepdown acute care surgical floor, intensive care unit, and the operating room.

As one APP pointed out, the multitude of practice areas and diversity of skills separates the burn role from that of other specialties: ". . . I know that I am getting a good variety, a good skill set of being able to do lines, being able to do first assist, being able not just to cover just the step-down patients." Another spoke of there being only a few grey areas, but in the end, the APP reported that "my surgeons support using me in the full capacity that I can under (state) law."

Burn patients are uniquely challenging. There were several patient care challenges reported as impactful by all participants. Pain management, lack of financial resources, and difficulty motivating burn-injured patients to eat and participate in therapy were challenges common to all. These issues were described as "difficult" and "stressful." One APP provided this example:

> If you compare, let's say a trauma patient, the care can be vastly different. Often with trauma patients, they come in, you fix the injury, they go home and often require very little follow-up care. With burns, especially major burns, their lives are forever changed . . . they are very complex patients, sometimes the sickest patients you will ever run across in a hospital.

Obstacles to effective pain management included resistance of other staff members to accept the patient's report of pain. A participant pointed out, ". . . even though their wounds are healed, they are still in so much pain." As one APP noted, pain was not the only issue: "Also the anxiety along with the pain . . . it is always a struggle of just making sure that they are comfortable." The emotional toll on the participants was obvious as they all expressed grappling

with the judgements of other providers while trying numerous modalities in their attempt to effectively treat burn pain on a daily basis.

Lack of resources for medications and dressing supplies made discharge planning very difficult. Even with team support, due to lack of resources, there was conflict for some participants due to pressure from the organization to decrease length of stay. The guilt of sending people home without adequate resources for some APPs led to feelings of helplessness as expressed by one APP: ". . . this population of patients often does not have the resources to care for them, financially, socially, emotionally, etc." Beyond supplies and medication, burn patients often have to rely on someone to assist them with the mechanics of their wound care. The burden is often shared by the burn victim's family. One APP lamented, "Family? Will they have support? We have to make sure that they have the ability to take care of themselves, to do the dressings." Another participant repeated this concern, "Finding out the family dynamics is incredibly important because–how is this person going to go home, who is going to help them? And do they have reliable help?" When queried for a possible reason to leave his/her current position, another APP responded, "If I felt unable to provide for patients the way they need with the resources provided at the institution, this might be a turning point in my career."

Participation in treatment was the aspect of care in which the patients exerted the most direct control. Having patients consume enough food to meet their nutritional needs was reported as a "daily struggle." The effects of pain medication and the struggle for mobility further complicated efforts to encourage patients to eat. The emotional and physical exhaustion was best described by a participant as "They don't want to eat, they're done . . . " Another milestone to recovery was mobility. A sentiment shared by all participants was "One huge

challenge is getting patients motivated to participate in their therapy and to understand that every day it is going to hurt a little less."

Team approach is essential to quality burn care. All participants detailed the importance of the "team." The "team" consisted of the group of health care professionals designated to coordinate and manage the care of hospitalized burn-injured patients. Multiple disciplines participated in these teams, and each was unique in structure and function. Despite these differences, all participants shared positive reflections about their experiences as members of the team. The expertise of other team members positioned them as easily accessible resources for the entire staff. The collegiality and support gave the APP confidence in performing their own role.

> The team approach is used throughout the country in burn centers and is key to the patient's success in recovery. Burn patients take a whole multidisciplinary team looking into each aspect to ensure optimal outcomes and get them back on their feet.

The burn team was touted as a trusted resource by all eight APPs. The multidisciplinary team formed the foundation of strong professional relationships based on mutual respect. The ability to "bounce ideas off" their burn APP colleague was attributed value by one participant. The nursing staff contributed extensively to the teams, delivering consistent high quality patient care and prompt communication of needs. A sentiment shared by all APPs was that "If you don't have a good team and people that work together and trust each other, it's not worth it."

The clinical and emotional support of the burn multidisciplinary team sustained all participants and was a resoundingly positive theme throughout all the interviews. The trust and collegiality among team members exerted strong positive influences. All participants echoed the

statement of one APP: “I would not be there, doing the job that I do, if it weren’t for the people that I work with and the relationship I have with those people.”

Burn APPs are trusted and valued by the other burn team members. An important source of fulfillment for all APPs as members of the team was being able to educate other staff members. The majority of medical residents and interns relied heavily on the participants to guide them throughout their burn surgery rotations. In turn, the APPs felt that they were “valued” as a resource. The more experienced burn APPs described being able to share their wisdom with their newer, less experienced colleagues. One participant reported that it was fulfilling to help them become comfortable in the burn specialty and provide new hires with a better orientation than they had.

Educating the burn nurses was a source of fulfillment expressed by the four burn NP and one PA participants. The group all shared similar stories about “jumping right in” at the bedside and feeling pleased that they could assist the nursing staff in a unique way because of their backgrounds and experience. An APP offered, “I go to the bedside. I help the nurses do the patient care. I show them the little tricks of the trade.” The confidence of the nursing team was the basis for a trusted partnership, greatly valued by all participants. Each confidently expressed similar satisfaction with his/her relationship with the nursing staff. As stated by one, “They definitely come to me to address issues and know it will be resolved.” One participant described himself/herself as a “problem solver” and the point of contact for the team, stating “I definitely don’t have even half of the answers most of the time, but I usually know how to find them.”

The attending physicians may be inconsistent in utilization of the APP, but were overall very reliant on all participants. They appreciated that the APP was the constant presence with

the patients. Trust was established with most and developing with newer physicians to the groups. One participant conveyed the following:

> The surgeon that is new to me . . . you know I think he's seeing that I have a lot of independence, that these families trust me, I am the person they see every day and that I'm the one who's going to bring their concerns to him. And so, I think he sees value in that as well.

The patients are the reason for all we do. The strength of the burn patients throughout their struggle against the multitude of adversities they face in their journey towards recovery inspired each participant to persevere, despite long hours and the many challenges associated with their roles. The APPs described feeling of partnership, both with the patients and their families throughout the painful process and ownership of outcomes. The emotion was best expressed by a participant who stated, "Yes, you are tired, it is hot and you just want to get the case over with. Then you realize that they will have to live with it (the outcome of surgery) for the rest of their lives."

The challenge of successful burn patient reintegration along with the support of the burn team served as powerful motivators, sustaining the participant in the burn surgery practice. Participation in burn camp, reconnecting with patients and being able to see the difference that the APP made in the patients' recovery were all very meaningful. The experience of following the patients through to their return to their families was both professionally and personally fulfilling to all participants. The gratification was evident in the statement of one APP who offered, "My ultimate satisfaction is when patients come back to see us and thank us for what we did and to see how we have impacted their lives."

Patients' expressions of gratitude and obvious trust supported the value of the APP. Two participants specifically mentioned having patients ask for them by name. A burn patient was reported as stating, "You are the one that I see here every day; you are the one who talks with the nurses and helps everyone do their job." Another burn patient was quoted as stating, "You know we would never have been able to make this without you, coming into the room and talking to us about it and letting us know what's going on."

There is never enough time. According to all participants, time management posed a significant challenge and a profound source of stress. The primary concern was the extended work day. One of the most experienced APPs shared concerns about the hours required of newer colleagues. "There are times where they are in the operating rooms until 7:00 o'clock at night even though I tell all the attendings you should not allow that to happen . . . " Long hours were cited as challenging, and one participant reported having difficulty balancing family obligations and extended work hours, "I try not to take work home. I try to finish work at work." Another echoed this concern by stating, "You know, you have to balance family . . . and (work) hours because the hours are not short."

Six APPs described not being able to complete all tasks by the end of the day and struggling with handing off duties or having to leave things incomplete. One statement attested to this challenge: "I don't have enough time in a day to finish everything I want to do."
Time was a limiting factor for other aspects of burn care. It was difficult to predict the time required for burn procedures due to numerous characteristics unique to the patient. Time for research and conference attendance was also reported as limited and verbalized by an APP as a source of disappointment. "I would love to have more time to be involved in research, but I just don't."

Personal and professional stressors affect commitment to the current APP position. Six of the eight participants had plans to leave or would consider leaving the burn surgery specialty. Commitment to family meant possibly changing to a part-time position to raise children for one participant. For another, it meant planning for retirement to spend more time with family. Commitment to the organization was professed by two participants as related to years invested into the organization prior to completing advanced degrees. However, one participant had already served notice and another was uncertain whether he/she would remain at his/her current organization. The reasons for leaving were offered the following:

> Sometimes it is hard not to feel like just a discharge note writer . . . I also feel like our institution tends to be somewhat conservative . . . I think my joy and talents lie in more a big picture, more quality improvement type of role . . . I think someone with more of that day in day out, like detail oriented mind set, could do a better job than me.

Four participants stated that they were committed to being APPs, but possibly not in the care of burn patients. A lack of support from the physician in charge left one APP with doubt about staying in her current role: "Maybe I don't feel supported by my boss; he doesn't acknowledge everything that I do; it gets discouraging sometimes." Only two of the eight participants were emphatic about their commitment to the care of burn patients and seemed to share the feeling stated by one: "I am completely happy. I wouldn't change anything. I will continue (in burns) for the rest of my career. I have a lot of goals to work toward in the future."

Summary

Chapter four provided an overview of the study results. Responses from all APPs revealed the lived experience of the burn surgery APP. Thoughts, impressions, and ideas were found to be extensively homogenous, leading to emergent themes. Regulatory and individual

organizational constraints were impactful sources of stress, both professionally and emotionally. The burn team was a trusted resource that provided support with patient care and coping with the challenges to the burn-injured population. The participants were not solidly committed to their current positions. Finally, an overwhelming feeling of fulfillment was derived from the many successful patient recoveries. Burn APPs have a good sense of their profound contributions to the team, their organizations, and most importantly, to the recovery of the patients they treat.

> "Burn care is a specialty that only a few people can do, but those people who do, do an excellent job, and they are not going to do anything else."

Chapter five will discuss these finding and offer interpretations on these themes, summarizing the experience and suggesting opportunities for future research.

Chapter 5: Discussion

Introduction

Chapter five presents each of the eight dominant themes individually as described in Chapter 4 and includes interpretations supported by medical and nursing literature. Each theme is aligned with the ontology of Martin Heidegger, and rather than focusing on epistemology, importance is placed on the meaning of being a burn APP and the unique knowing of his/her experience of the world (Benner, 1994, pp. 43-53). Comparison is made to existing literature culminating with recommendations for practice. Finally, lessons learned from this dissertation study are offered as the starting point for future research.

The essential meaning of being was manifested through eight emergent themes:

1. The role of the burn APP is not well understood.
2. Regulatory issues and organizational constraints create prohibitive practice disparities.
3. Burn patients are uniquely challenging.
4. Team approach is essential to quality burn care.
5. Burn APPs are trusted and valued by burn team members.
6. The patients are the reason for what we do.
7. There is never enough time.
8. Personal and profession stressors affecting commitment to current APP position.

These themes reflect experiences of frustration, (regulatory) constraint, emotional and professional challenges, collegiality, gratification, stress, and uncertainty. Although similarities across themes were evident, the individual realities were varied, according to professional background and personal identities. There were experiences, both positive and stress-inducing, that emerged as a window into the burn APP world. Literature that describes the APP on the

burn surgery service continues to be sparse, contributing to poor understanding of the role. There were insights from the results, which were added to this limited body of knowledge.

Interpretations

Team approach is essential to quality burn care. The structure of the burn team was described by Ortiz-Pujols et al. (2011) as including medical, nursing, nutrition, pharmacy, social work, and rehabilitative therapy specialists. Al-Mousawi et al. (2009) concurred with the expressed importance of the team approach to burn care and asserted that these patients are uniquely complex and their care requires services from many differing specialties. Serio-Melvin et al. (2010) further supported that coordination of the multi-specialty group leads to provision of the highest quality care and the best hope for long-term burn survival. Each participant collaborated with other burn team members on a daily basis and described themselves as a member of the burn team. Their experiences with the other burn team were noted as collegial and interdependent. The APPs relied on the representative from each discipline to carry out their part of the treatment plan. Thus, it is imperative that all members are fully engaged in the care of the burn patients.

The value placed on the team approach was clear. The pharmacist, clinical nutritionist, therapists, and social workers were all described as integral to patient care planning and delivery. However, it was evident that the team approach was an imperfect system because of the diverse responsibilities of each team member. The participants described each team member and their responsibilities, but not how they accomplished goals together. The burn team members often covered other hospital services, dividing their efforts. There was no doubt that quality care was delivered by individual professionals; however, it appeared to occur through coordinated, although essentially independent efforts. Although the terms “collaboration” and

"interdependence" were used, the reality of the team relationship was much less a joining of forces and more of individual efforts to assist the same population.

Burn APPs are trusted and valued by other members of the burn team. The burn APPs' relationship with their multidisciplinary burn team was a described as supportive and motivational. Furthermore, the participants assumed a leadership role within these teams and believed that they were held in high esteem by other team members. They described themselves as the stabilizing force on the team with ownership of burn patient outcomes. Several participants used the term "go to person" when discussing their roles within the burn team. With physician residents passing through the service on a monthly basis and a different burn attending surgeon each week, the burn APP was the constant (Hurlock-Chorostecki et al., 2014).

For the most part, the unofficial leadership (or coordinator) role was appreciated by other team members, especially nursing staff. The burn APPs prioritized being a readily available resource, facilitating improved responsiveness to the needs of team members and patients. There was consistency in the literature that APPs, in addition to being accessible to the team, are approachable, trustworthy, knowledgeable, and possess strong communication skills (Soine et al., 2013; Paton et al., 2013). In contrast, resident and attending physicians were not attributed similar value within the team. Despite remaining positive in their descriptions of the contributions from medical colleagues, most especially the burn surgeon, the understanding was that burn team physicians were not readily available nor were they easily approachable.

The role of the burn APP is not well understood. The issue of role recognition was integrated into all of the practice-related themes. Each participant indicated that he/she faced barriers as the result of a lack of understanding of his/her role, training, and scope of practice among their supervising physicians, administrators, and other team members. This disconnect

was a source of discontent for all APPs as documented in the literature. Additionally, limited autonomy and poor collaboration has been shown to result from this knowledge gap (Pasaron, 2013; Dalton, 2013; Hooker & Everett, 2012). The participants experienced a lack of understanding as both prohibitive and vexing, expressing feeling unfairly excluded from participating in important care decisions. They resented being treated as scribes or relegated to mundane tasks. The PA role was developed according to the medical model and is likely better understood by physicians (Hooker & Everett, 2011). The burn APP role is an uncommon specialty and even the providers themselves are not completely clear on the exact nature of their role. One participant echoed this uncertainty by stating, "We have never had anybody before that has set precedence, and so it's like I don't really know what I am supposed to be doing."

The literature is clear that the onus is on the APPs to adequately communicate their qualifications and skill set to fellow health care providers and employers (Kleinpell & Hravnak, 2005). They did not report any attempts to educate administrators or burn physicians, thus no changes were anticipated. Reasons for failure to open the lines of communication were not specific. Fear of being labelled as a "problem" or "not a team player" by the medical staff was apparent.

Regulatory issues and organizational constraints create prohibitive practice disparities. One reason for the lack of role clarity was variations in regulatory practice restrictions originating from individual employers to state and national legislation. The APPs experienced regulatory issues and organizational constraints that created prohibitive practice barriers. These included legislation that limited the ability to administer certain treatments, prescriptive authority, and choice of practice setting. The results were consistent with other studies, substantiating the belief that regulatory restrictions affect all APPs to some extent and

vary according to practice settings (Kartha et al., 2014; Poghosyan & Aiken, 2015). The APPs were frustrated by limitations that interfered with their ability to provide care in all settings. For example, inability to administer conscious sedation prevented participation in important dressing changes, and restrictions for providing care to the critically ill or in the perioperative setting disrupted continuity of care. Although all described their roles as fulfilling, the practice constraints were burdensome and inhibited their ability to realize their professional potential. These restrictions were a significant barrier, discouraging ingenuity and negatively affecting dedication to burn care.

Personal and profession stressors affect commitment to current APP position. In addition to professional stressors, such as organizational and regulatory constraints, job-related issues and personal commitments profoundly affected the burn APPs long-term professional plans. These finding were consistent with Biscardi et al. (2013) who described the important contribution of a positive balance between work obligations and personal life. However, in this dissertation study, burn APPs indicated somewhat different levels of satisfaction and commitment. A majority of the participants shared that they had made some definitive plans for a change in their careers and, in fact, one has since left the specialty. The fact is especially worrisome when considering the time needed to adequately train an APP. There are no simple solutions for helping the APPs achieve the balance necessary to keep them in the burn specialty. Implications for employers are clear. An open discussion with APPs about their goals, both personal and professional (not just the organizational goals), is needed to nurture their success. The APPs share a responsibility in communicating their needs. With the costs of training, all would benefit from efforts toward retaining dedicated, skilled specialty professionals (Waddimba et al., 2016).

There is never enough time. The importance of the concept of time was documented by Bourne et al. (2012) who reported that the expectation of traditional working hours was a "strong motivating factor" for choosing the PA profession. Nevertheless, all participants lamented that "there is never enough time." Specifically, time to complete the great many tasks involved in the complex care of burn-injured patients was often lacking. The detrimental effect of constantly fighting against inadequate time was experienced as a constant albatross. One participant shared, ". . . whatever they tell you your hours are going to be, add at least 20% more; you're never going to get out when they say you are going to get out." Frustration and even resentment were evident. The APPs indicated through their responses that they felt that they had somehow let the patient, team, or themselves down by not being able to complete all of their identified tasks each day. Beyond that, time for research was also limited or absent for most participants. The resultant experience was that of being out of touch with the latest innovations in burn care. Finally, time to attend meetings and meet with other burn APPs was insufficient, leading to a sense of isolation and the absence of a group identity. Powerlessness against the daily struggle against time and always coming up short were reasons for some to lose motivation and satisfaction in their roles (Stewart et al., 2008).

Burn patients are uniquely challenging. There are several reasons for the overwhelming, hectic, time-consuming obligations experienced by the participants in burn care. The common thread was the inordinately labor-intensive care inherent to burn-injured patients. The experience of pain and suffering by the patient was a cause for the APP to be at risk for compromised mental and physical health (Dunn, 2012). Dr. Holmes' (2008) description of burn patients as "a considerable challenge to the healthcare system" was consistent with the theme that "burn patients are uniquely challenging." Despite the enormous advances that have occurred

in medicine, burn patients continue to be an especially labor and resource intensive population with complex dressing changes, intense physical therapy, multimodal pain management, aggressive nutritional support, and extensive emotional support (Al-Mousawi et al., 2009). The participants experienced stress from being pulled in numerous directions to meet these needs. They were all responsible for providing burn education to a wide variety of professionals in addition to their clinical responsibilities (Edkins et al., 2014). Discharge planning for this population was another aspect of the participants' role and was uniquely difficult due to their therapy and wound care needs (Shahrokhi et al., 2012). All APPs were in charge of coordinating discharge plans and held responsible for ensuring that the hospital lengths of stay were reflected positively on the unit while making sure that the plan was successful, and patients did not have to be re-admitted. APPs were universally frustrated by the lack of funds available to burn patients and expressed helplessness when attempting to help the large number of uninsured patients.

The APPs experience with caring for burn patients was gratifying, stress-inducing, and disconcerting all at the same time. Several opined that convincing patients to participate in painful therapy was a daily struggle, positioning the APP as the perceived cause of pain. Burn patients also frequently present with pre-existing complex, untreated medical problems. The APP was often further responsible for the untenable task of diagnosing diabetes and heart disease as part of the evaluation for burn treatment. Disbelief and anger at the added burden of the new diagnosis was reflected back onto the APP in many direct and indirect ways. The result was the requirement for more time and effort in assisting these patients to a safe discharge, being prepared to handle their extensive burn care, now complicated by a new chronic condition. The coordination of care was overwhelming at times and the pressure to help this needy population remained intrusive long after the end of the scheduled work day. One sequelae of

caring for the complex patient population was ownership of a 24-hour obligation to their successful recovery and all the personal and professional stress it entails.

The patients are the reason for what we do. Despite all the challenges and barriers, burn care remained professionally and personally rewarding to study participants and the patients themselves are the reason for their all of efforts. Burn APPs, similar to their colleagues in other specialties, appear to agree that career satisfaction is strongly linked to the gratification derived from being able to help people (Biscardi et al., 2013). Each participant experienced fulfillment from playing a key role in the successful recovery of his/her burn patients. The participants were emotionally invested in their patients and the families. Unlike attending physicians or the resident physicians in training, the APPs prided themselves on being able to care for patients from hospital admission through outpatient follow-up and into survivorship. The painful battle to regain function and recovery as described by Al-Mousawi et al. (2009) inspired dedication among participants, despite challenges inherent to their role. Burn APPs shared many positive experiences that motivated them to continue in the burn specialty. Their expressions of pride in the patients' recoveries were evident through words and gestures. It was obvious that the burn patients were thought of as a unique population and one that the APPs were invested in not only professionally but also emotionally.

Implications of the Findings

There were many lessons learned from this qualitative journey with implications for changes in the approach to education, practice, public policy, and research affecting the burn APP. The shortage of burn providers and unique demands of their specialty is the imperative for incorporating these findings into practice. The lived experience of the APP on the burn surgery service is one of professional fulfillment, challenges, and stressors. Successful patient care is

only possible through a coordinated effort with the members of the dedicated burn team and support of hospital administration.

Implications for education. Currently, no structured burn educational program exists for APPs. The diversity of role responsibilities apparent among the participants and absence of a formal orientation process noted in this dissertation study bolsters the assertion that burn APPs would benefit from the establishment of core competencies. Ruel and Motyka (2009) supported education based on competency could improve practice standardization and patient outcomes. The development of a structured orientation program or burn fellowship has viable options for educational uniformity (Edkins et al., 2014). Standardized competencies will facilitate a better understanding of the APPs' invaluable contribution to burn care, leading to more appropriate and efficient utilization (Fater, 2013).

Implications for Practice and Public Policy

The integral role of the APP in burn patient recovery was described in the dissertation study, which adds to the limited published literature. As previously stated, increasing awareness of the experience of being in this role may lead to a more concrete understanding of the scope and responsibility of burn specialty practice. With burn providers remaining in short supply and given the challenges inherent to this specialty, the need to optimize the contributions of all burn team members continues to be paramount (Edkins et al., 2014; Ortiz-Pujols et al., 2011). Thus, support must originate from attending physicians and the members of the burn team as well from administrators responsible for APP staffing of these burn units.

APP roles were born out of the shortage of physicians and predicted future need for primary care providers (Timmermans et al., 2016). State and national legislation are responsible for structuring the ever-expanding practice of APPs. The participants provided scenarios

detailing how restrictive regulations directly interfere with the care of the uniquely complex burn patient population. Specific examples involved limitations on scope that prevented APPs from participating in the care of burn patients on the ICU and in the OR. The experiences support future initiatives that are aimed at revising regulations to remove these unnecessary barriers (Gillard et al., 2011; Rounds et al., 2013). Furthermore, improving knowledge of legislation guiding practice will equip APPs with the specifications necessary to clarify institutionally-based restrictions. The ultimate goal would be to increase practice autonomy so that it is equivalent with training and experience and consistent with regulatory authority.

Implications for research. The results of this dissertation study will add to the paucity of existing literature describing the burn APP. The meaning making of participants illuminated, impactful issues will serve as a foundation for future research into the effective utilization of the burn APP and recommendations for retention. Research to support the findings of positive patient outcomes is critical to meeting national patient safety standards (Fater, 2013). Therefore, the burn provider shortage means that skilled APPs will remain in demand (Holmes, 2008). Future studies should be aimed at quantifying role responsibilities and qualifying the overall burn experience to encourage future APPs to enter this rewarding specialty.

Limitations and Delimitations

The major investigator-imposed delimitation was that enrollment was restricted to the participants who were active in a single organization's SIG. Thus, only a small representation of all burn APPs was reached. It was selected because it was the only identifiable clearinghouse for targeting potential participants. The ABA's general membership could have been queried, thereby potentially reaching more APPs. Alternately, registration lists from national and regional burn specialty events might have led to contact with a much wider audience.

Of those who responded to the invitation, several were not employed full time, which made them ineligible for participation. Many of these professionals had years of experience and could have shared valuable insight through their experiences. The research did not fully appreciate the number of part-time providers and resulted in lost potential opportunities.

Video-conferencing was conceived as a way to make the interview process as convenient as possible. Also, it was thought that being in their own environment might place participants more at ease and best secure their anonymity. Surprisingly, half requested to be interviewed while attending burn meetings outside their home states. Although the IRB protocol was revised, potential participants may have been lost due to the solicitation with only video-conferencing as a possibility.

Recommendations

The themes demonstrated by participants indicated meaning making in their daily experiences as burn APPs. Interpretation of their personal stories unveiled motivators and barriers. Recommendations were born out of these interpretations, encompassing interactions with administrators, physicians, and burn team colleagues. Finally, the recommendations of the participants themselves were detailed.

The role of the APP is intimately connected to the team of incredible professionals with whom they collaborate on a daily basis. Ongoing and open multidisciplinary communication is imperative. Burn team members should be dedicated exclusively to the burn population. It is not always possible if they are responsible for several different services at once due to budgetary constraints. It is important for hospital administrators to allow the burn specialty professionals through the allocation of adequate resources to focus on the care of this complex population in order to achieve quality outcomes, both for the patient and their institution.

Finances alone do not ensure that APPs can deliver optimal care to burn-injured patients. Regulatory barriers restrict practice and originate from national, state, and institutional guidelines. Addressing inappropriate and unfair practice restrictions has required action from both individual professionals and groups. Both PAs and NPs are required to meet predetermined criteria for licensure and certification. As stated previously, knowledge of existing regulations is paramount and will arm the APPs with vital information should they fall victim to inappropriate restrictions on their practices. APPs should provide these specifications, including any additional skills or specialized knowledge that they possess to their employers. Annual practice reviews or recredentialing meetings have afforded the opportunity to discuss the APPs role and establish an open dialogue about utilization to the full extent of their education and training. The next step is becoming engaged in the legislative process and participation in professional organizations to assume an active role in achieving regulatory change. Unfortunately, allocating time for political activity can be challenging for the burn APP.

Indeed, time is always at a premium for these professionals. The oppressively busy schedules, simultaneous obligations, and encroachment on personal time have led to role stress and contribute to burn APP attrition. Professional and personal stewardship mean that the APP has to establish reasonable expectations and open the lines of communication with both administration and attending physicians. Employers can demonstrate support by increasing the perception of value to soften the negative influence of the working conditions. Administrative days to catch up on outstanding paperwork and support of continuing education provide opportunities for decompression. The APPs play a critical role in the success of burn care delivery, and the increasingly tangible recognition of their contributions by their employers and the ABA is vital to ongoing engagement.

As the participants offered insight into their meaning making and experience of being a burn APP, they detailed recommendations that held profound significance to them. The majority recommended a more formal acknowledgement of the APP's role and contribution to burn care by the ABA. There should be more educational offerings specific to needs of APPs, such as procedural skills and increased representation among presenters at the regional and national meetings. Improved utilization of the SIG is vital to encourage dialogue among burn APPs regarding practice issues and to develop and disseminate research. Participants also requested the establishment of a burn specialty certification to validate practice. Burn orientation should be standardized to fit the needs of the institution and serve as a foundation for developing a practice where all team members have a clear understanding of the role.

Summary

The dissertation study demonstrated the professional and personal lived experience of the burn APP as guided by the philosophy of Dr. Heidegger. Accordingly, the participants' existence was exposed as multimodal engagement with the role, including (a) social interaction with the team, (b) temporality as it relates to accomplishments of tasks and achieving a healthy work-life interface, (c) self-awareness of actual and potential contributions to burn care and patient outcomes, and (d) affective reflection through meaning making on a personal level (Smith et al., 2009, pp.16-25). The burn APPs shared details of their schedules, their day-to-day experiences, and their joys and stressors. Consistent with Dr. Heidegger, their way-of-being left some meanings hidden or unrecognized. Through the IPA process, interpretation was an illumination of the bricolage of experiences within the role. Exciting role diversity, gratification, and team comradery was in ongoing conflict with practice barriers and time obligations (van Manen, 2014, pp. 220-222).

Important implications for current and future practice were illuminated by the experiences shared. Burn care requires a specialized skill set for which no formalized training currently exists. The burn APP begins providing care shortly after injury and continues throughout the extended treatment course well into survivorship. An important aspect of the APP role is consistent leadership of the burn team in the face of rotating resident and attending physicians. Although viewed by all as extremely gratifying work, burn injuries exact a significant emotional toll on these providers. Despite the amazing and inspirational resilience of burn-injured patients, rigorous time demands and regulatory barriers led the participants to question their future commitment to the burn specialty.

The work is confirming of the unique needs of burn patients and the skill and professionalism of the burn APP. Strong feelings of dedication, pride, and conflict were demonstrated. With the IPA format, the participants were allowed to disclose experiences encountered in the burn specialty. The primary contribution of this dissertation study was to give the burn APP a voice. Frustrations and discontent related to specialty-specific practice stressors and regulatory barriers were not shared with key decision makers within the APPs' organizations. Burn APPs are essential to their burn centers, the burn team, and the burn-injured patient. No current literature has provided a concise description of this professional. The dissertation's foundational work has illuminated many aspects of the role. Full understanding and acknowledgement of the burn APPs' contributions will serve to improve patient outcomes while increasing job satisfaction and retention.

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Appendix A

Semi-Structured Interview Questions

1. What are the experiences of advanced practice providers in the burn surgery specialty service at designated burn centers in the United States?

    a. What are the meaningful aspects of the burn APP role that serve to promote sustainability in the field?

    b. What aspects of the burn APP role lead to professional satisfaction?

2. What do you describe and understand as challenges and benefits in your role as a burn APP?

    a. What do you see as your role responsibilities?

    b. Describe how well you feel that these responsibilities are defined?

3. Can you discuss how you identify value in your role (for yourself and your organization)?

    a. Discuss how your position supports (or does not support) a sense of professional fulfillment?

    b. What, if anything, makes caring for burn-injured patients different or unique from other specialties?

4. Can you discuss your commitment to your profession, burn-injured patients and your current position?

    a. What motivated you to accept your current position?

    b. What keeps you in your position and what would make you leave?

    c. Are there any lessons learned that you would like to share?

* Further details may be sought using elaborating and clarifying probes to include (but not limited to): (a) “Would you elaborate on that?”, (b) “How did that make you feel?”, (c) “What

does (term) mean to you?" and (d) "That is very interesting, please continue." Responses may also be acknowledged through non-verbal communication, such as head nodding.

Appendix B

Request for Participation

The purpose of this communication is to request your participation in an interpretive phenomenological analysis examining the lived- experience of being an advanced practice provider (NP and PA) in the burn surgery specialty. To qualify you must work greater than thirty-two hours a week in an inpatient acute hospital setting. Burn patients must represent the fifty percent of your patient population.

Procedures: Should you agree to participation, you will:

1. Participate in a one hour long video conference or in-person interview that will be recorded and transcribed.
2. Be offered an additional 15 minutes following the interview for reflection and debriefing.
3. Review the transcription of your interview for accuracy of representation. You will be asked to submit any comments or corrections that you deem appropriate.

What are the Benefits? There is no anticipated direct benefit to you for participating in this study. It is hoped that the findings will lead to a better understanding of and appreciation for the role of the burn APP.

Risks- While there are no anticipated risks related to completing this study, the possibility for loss of anonymity.

Confidentiality- Each participant will be assigned a pseudonym to protect their anonymity.

Compensation- There is no compensation offered for participation in this study. You have the right to withdraw from the study at any time.

This research (will be) reviewed and approved by an Institutional Review Board. The findings will be utilized for completion of a PhD dissertation

Contact: Susan Smith, ARNP-BC, PhD(c)

srainey@nova.edu

Cell: 407-484-9224

Appendix C

Informed Consent Process

1. Electronic communication will be placed on the American Burn Association Special Interest Group Advanced Practice Providers Nurse Practitioner/Physician Assistant group site.

2. Anyone who replies to the PI will receive a personal email to confirm that they qualify for inclusion and to answer any questions that the prospective participant might have.

3. The consent form will be sent by email.

4. All consents will be sent with the following message:

Thank you for considering participation in this phenomenological study. There is no compensation for your participation, however, it is hoped that the information obtained with yield important insight into our unique specialty.
I have attached the consent for your review and completion. You have the option to sign and scan the form back or print it out and return the hardcopy by mail. The consent is not binding and you have the option to withdraw from participation at any time. Please feel free to contact me with any questions or concerns.

5. The time for deciding to participate and completing consent will be two weeks. This may be extended an additional week for special circumstances, such as vacation, illness or other emergency.

Susan Smith, ANRP-BC, PhD (c)
3234 Wald Road
Orlando, Florida
32806
407-484-9224
srainey@nova.edu

Appendix D

Consent Form

Funding Source: None.

IRB protocol #: Pending

Principal investigator
Susan Smith, PhD(c), ARNP-BC
407-484-9224
srainey@nova.edu

Co-investigator- None

For questions/concerns about your research rights, contact:
Institutional Review Board
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

Site Information – Distance audio conference by way of telephone conversations

What is the study about?
The purpose of this study is to examine the life experiences of the burn specialty advance practice provider. The goal is to determine which factors encourage sustainability and support professional satisfaction.

Why are you asking me?
You were solicited for participation on the American Burn Association Advance Practice Provider Special Interest Group site because you are either a Nurse Practitioner or Physician Assistant responsible for the care of burn-injured patients as your primary focus.

What will I be doing if I agree to be in the study?
You will be asked to participate in one hour long videoconference or an interview in person. These video recordings and face-to-face interviews will be transcribed. In the interviews, you will be asked to describe you experience as a burn APP. The interview does not follow a rigid structure and will be guided by your comments. All the interviews will be digitally recorded and notes will be taken. The video interviews will be conducted in private locations to maintain privacy. You will be given a false name (pseudonym). You will be asked to review the transcripts for accuracy and you can make any additional comments that you see fit at that time.

Is there any audio or video recording?
This research project will include video and audio recordings of the study interviews. These recordings will be available for review by the researcher, the IRB, and the following: dissertation chair and/or committee. The audio recording will be transcribed. The recording will be kept securely on a password-protected computer, or if downloaded for media storage, stored in the locked office held by the principal researcher. The hard copy of the transcriptions will be

kept for 36 months and destroyed after that time by being erased from the principal researcher's hard drive on his computer.

What are the dangers to me?
There are no anticipated risks to your participation; there is a risk for breach of confidentiality. This will be minimized through the use of pseudonyms and the presence of only one researcher.

Should you have any questions or concerns about the research, your research rights, or have a research-related injury, please contact Susan Smith at the address or phone number indicated above. You may also contact the IRB at the numbers indicated above with questions as to your research rights."

Are there any benefits for taking part in this research study?
You will not directly benefit from your participation. However, your participation in this study has the potential to illuminate the experiences of the Burn APP, revealing sources of stress and dissatisfaction and positive factors that encourage sustainability.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made for participating in this study.

How will you keep my information private?
All information obtained in this study is strictly confidential unless disclosure is required by law. The IRB, regulatory agencies, and the dissertation chair may review research records.

There will be no information obtained in connection with this study that can be identified with you. Your name, address or other information that may identify you will not be collected during this research study.

The information collected about you will be coded without any identifiable information. You will be asked to review/edit your interview. All handwritten notes, data, video and audio recordings will be stored and locked in the office of the principal investigator (Susan Smith). All data stored on a computer will be secured by a password. When the results of the dissertation are discussed, no information will be included that would reveal your identity. All data will be stored for three years after the study has been completed and then destroyed.

Your name will not be published or shared with anyone outside of the research.

What if I want to stop participating in the study?
You have the right to withdraw your participation from this study at any time. If you decide to leave, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected from you will be destroyed and/or deleted from study records.

Voluntary Consent by Participant:
By signing below, you indicate that

- this study has been explained to you
- you have read this document
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled:

"The Lived-Experience of the Advanced Practice Provider on the Burn Surgery Service"

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____

Appendix E

ABA Letter of Authorization

American Burn Association

311 South Wacker Drive, Ste. 4150
Chicago, IL 60606

Phone (312) 642-9260 • Fax (312) 642-9130
Email: info@ameriburn.org

Nova Southeastern University
PhD in Health Science Program
Re: Susan L. Smith, PhD (c), ARNP-BC
May 3, 2016

Dear Committee Members,

The website for the American Burn Association Advanced Practice Providers special interest group is accessible to all ABA active members who choose to participate. This access is password protected. Receipt of electronic communications from other members is optional. Susan Smith is the co-chair of the burn APP SIG for 2016 and an active member of the American Burn Association. Since there are no requirements for or benefits to participation, Susan has permission to post a request for volunteer study participants for her phenomenological study examining the experience of the burn APP to this site. Feel free to contact me with any further questions.

Sincerely,

Larry K. Kaczmarek
Senior Director
American Burn Association