The Transition of Nurse Practitioners to Changes in Prescriptive Authority

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Purpose: *To understand nurse practitioners' (NPs) decisions about whether to obtain prescriptive authority for controlled substances, to describe NPs' experiences with providing or prescribing controlled substances, and to describe the relationship between perceived autonomy and prescriptive authority for controlled substances.*

Design and Methods: *Twelve focus groups were conducted with approximately 100 NPs who attended continuing education conferences. Discussions were audiotaped and transcribed verbatim. Grounded theory approaches were used for data collection and analysis.*

Findings: *A core category of Letting go and taking hold characterized Washington State NPs' experience of the transition to prescribing schedule II–IV medications. Three dimensions of the NPs' transition were Resisting change, Ambivalent about change, and Embracing change.*

Conclusions: *The core category, Letting go and taking hold, indicated how transition to a new scope of practice extended beyond successful passage of legislation, the importance of examining the nature of professional transition that accompanies successful legislative change, and role development as an ongoing process throughout one's career in response to changes in scope of practice. NPs need preparation for a new scope of practice long before legislation actually passes. Revealing and examining this process can facilitate the goal of achieving fully autonomous NP practice.*

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Transition to a new scope of practice goes beyond successful passage of legislation. Before 2001, Washington State nurse practitioners (NPs) had independent practice, including prescriptive authority for legend drugs and schedule V controlled substances. In 2001 Washington State implemented a law allowing NPs to prescribe schedule II-IV controlled substances if they had a joint practice agreement (JPA) with a physician. Examples of schedule II-IV controlled substances include narcotics such as oxycodone, hydrocodone, and codeine; benzodiazepines such as lorazepam and diazepam, and testosterone. This was the first time Washington State NPs were required to have any physician involvement in practice. Two years after the law was in effect, approximately half of NPs had obtained schedule II-IV prescriptive authority, but the other half had not. This difference surprised NP leaders who had worked hard for over a decade to gain passage of the law and anticipated it would be enthusiastically embraced.

The slow adoption of prescriptive authority for controlled substances by Washington State NPs illustrates a transition process that followed the change in scope of practice (Kaplan, Brown, Andrilla, & Hart, 2006). To date, no research was found on how NPs who, limited by law, adapt their practice to specific constraints and then make the transition to a new scope of practice when the law changes. This study was done to provide such information.

Background

Bridges' (2001) theory of transitions was the conceptual foundation of the current study. Bridges defined transitions as a three-stage process of (a) ending; (b) neutral zone; and (c) beginning again. Although transition and change are

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often used synonymously, change represents a situational shift, for example, starting a new job. In contrast transition is "The process of letting go of the way things used to be and then taking hold of the way they subsequently become" (p. 2), such as beginning a new professional role. "Transition is the way we come to terms with change" (p. 3).

Stage 1, the ending, is focused on loss of old values, self-image, perspectives, and realities. For some, a significant aspect of this stage can be the challenge of acknowledging the reality that things are no longer as they were. Stage 2, the neutral zone, is a time of limbo when things are neither the old nor the new. This in-between time can be confusing and unsettling, but it also offers new possibilities. Stage 3, new beginning, is embracing the new reality, outlook, or self-image. Bridges' theory of transition provides a framework for analysis of the process through which NPs integrate a change in scope of practice as well as the influence of that change on their professional identity.

The transition to full autonomy for NPs also involves a paradigm shift similar to Kuhn's explication of the process of adopting of a significant new scientific perspective. In *The Structure of Scientific Revolutions* (1970), he described the basis of scientific changes that lead a profession to a new set of commitments and a new basis for the practice of science. The decision to accept a new paradigm is concurrent with the decision to leave another paradigm behind. Kuhn noted that:

> During the transition period there will be a large but never complete overlap between the problems that can be solved by the old and by the new paradigm. But there will also be a decisive difference in the modes of solution. When the transition is complete the profession will have changed its view of the field, its methods, and its goals. (p. 85)

Much like a scientific revolution, a new scope of practice creates a period of disequilibrium with competing perspectives about change. For Washington NPs, more than 20 years elapsed between the passage of initial prescriptive authority and the implementation of schedule II-IV prescribing. During that period, prescribing limitations became normalized and accepted as the foundation for practice, analogous to what Kuhn refers to as "normal science." The period of disequilibrium has challenged NPs to reflect on whether "normal practice" should be continued or replaced with a new professional paradigm. The transition process central to adoption of a new scope of practice is generally invisible. Clarifying this phenomenon can lead to new knowledge to develop consensus and a unified approach to eliminate external and internal threats to actualizing full autonomy.

The current study, conducted 3 years after implementation of the II-IV prescriptive authority law, builds on our prior research of prescribing barriers of NPs in Washington State. The initial study to identify prescribing barriers was conducted in 2001 before implementation of the law. The second study, conducted in 2003, was focused on determining whether the law eliminated prescribing barriers. The purposes of this study, conducted in 2004, were (a) to understand NPs' decisions about whether to obtain schedule II-IV prescriptive authority; (b) to describe NPs' experiences with providing or prescribing controlled substances; and (c) to describe the relationship between perceived autonomy and prescriptive authority for controlled substances. This longitudinal approach in our program of research provides the opportunity to analyze the transition process as it evolves.

Methods

Washington State uses the title of advanced registered nurse practitioners (ARNPs) for advanced practice nurses, including NPs, certified nurse midwives (CNMs), psychiatric clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). This study did not include CRNAs who mainly provide anesthesia care under a set of rules separate from the prescribing law. Use of the term NP includes NPs, CNMs, and Psychiatric CNSs. To prescribe medications in Washington State, all ARNPs must submit an additional application and document appropriate pharmacology coursework.

Procedures

The coinvestigators selected the use of focus group sessions to stimulate interchange among study participants to elicit a broad range of contextualized responses. One strength of this approach is that group dynamics can help participants analyze and clarify their views and enhance authenticity of the information (Burns & Grove, 2005).

Approval from the coinvestigators' institutional review boards was obtained. A purposive sample was recruited using flyers distributed to attendees at NP continuing education conferences inviting them to participate in focus groups. Flyers were also distributed to recruit NPs willing to participate in an individual interview at a later time. Conference registrants were from various geographic areas within Washington State. Inclusion criteria were current NP practice in Washington State and prescriptive authority. Immediately before each focus group and interview, informed consent was obtained.

A total of 12 focus groups involving 88 NPs were conducted by the coinvestigators at the conferences in a private room. The groups were organized according to whether the participants had II-IV authority. Sessions lasted 30 to 60 minutes. The focus groups provided sufficient data for saturation, so only two individual interviews were conducted. These interviews occurred at a location of the participant's choice and lasted 30 to 90 minutes. Focus groups and interviews were audiotaped, transcribed verbatim, and analyzed. Each study participant received a USD5 coffee gift card.

Discussion was facilitated using open-ended questions about the experiences of the NPs related to issues such as why they had or had not chosen to obtain II-IV prescriptive authority; the effect of their choice on their experience of autonomy; their process of assessing a patient's need for a controlled substance; and how they handled perceived

drug-seeking behaviors in their patients. Debriefing and discussion between the investigators at the end of each focus group led to further refinement of the questions and directions for subsequent focus groups.

Data Analysis

Data analysis was guided by grounded theory approaches as developed by Glaser and Strauss (1967). The process of data collection and analysis included constant comparative analysis. The iterative processes of grounded theory enabled further exploration of concepts and key issues that arose during the group discussions. Identification of initial conceptual categories was followed by more focused data collection to expand and verify themes, identification of the core variable, and concept modification and integration.

Rigor was achieved by systematically addressing the criteria of truth value, applicability, consistency, and neutrality (Charmaz, 2000; Strauss & Corbin, 1998). Strategies included reflexive investigator debriefing, prolonged engagement with the data, and feedback on scholarly presentations. Randomly selected transcripts were exposed to an independent audit trail to confirm categories and verify that sufficient data existed to support the study themes. Poster and podium presentations of preliminary data were made to practicing NPs and NP faculty who then critiqued the validity of the theoretical process and categories. Finalization of the categories and concepts included incorporating feedback from the presentations and developing consensus between the researchers following in-depth dialectical interchange.

Results

Letting go and taking hold, a process discussed by Bridges, was identified as the core category to describe Washington State NPs' experience of the transition to prescribing schedule II-IV controlled drugs. This transition consisted of a complex set of responses to the new law. Some NPs grappled with whether to obtain prescriptive authority for controlled substances and with the meaning of autonomy and self-determination. Others eagerly adopted the new responsibilities. Embedded in the complexity of this nonlinear professional evolution were three dimensions: Resisting change, Ambivalence about change, and Embracing change (see **Figure**). Over time, some NPs experienced two or three of these dimensions, while others were firmly fixed in one. Moreover, whether NPs had schedule II-IV prescriptive authority and in which dimension they were situated did not determine the extent to which they perceived themselves as autonomous.

Resisting Change

NPs who resisted change were a diverse group. Some simply did not want to prescribe controlled substances, while others were comfortable with their current approaches to providing II-IV drugs to patients. In juxtaposition with this group was a cadre of NPs philosophically opposed to mandated physician involvement in their practice and who elected to wait for full autonomy. Five themes were identified that describe this dimension: (a) Why change? The status quo works; (b) Having a scapegoat; (c) Creating a practice without; (d) Passing the buck; and (e) Holding out for full autonomy. Often the study participants' experiences were characterized by multiple themes simultaneously.

Why change? The status quo works describes NPs who were the quintessential embodiment "new law, old ways." As one study participant noted, "I really have not found it [not having prescriptive authority for controlled substances] inconvenient." They identified numerous strategies to continue to provide rather than prescribe controlled substances for their patients. These strategies involved assistance from colleagues with full prescriptive rights.

Having a scapegoat indicates that some NPs used the lack of II-IV authority to avoid the responsibility of prescribing controlled substances by telling patients they were not legally authorized to prescribe these medications. These NPs essentially blamed "the law," making it the scapegoat. This strategy was useful for NPs who did not want to prescribe controlled substances, especially when patients explicitly asked for them. One NP commented, "In my former practice about 75% of the patients were drug seekers and it was a nice 'out' to be able to say 'I'm sorry I can't prescribe that.'" The strategy also saved time and eliminated the need to negotiate with patients and acquire the necessary prescribing competencies. As one NP described, "I can say to clients: 'I can't prescribe, I don't have the license to prescribe these particular type of meds that are potentially addictive. You'll have to work that out someplace else.'"

Creating a practice without schedule II-IV drugs reflects an adaptation to the constraints of the prior law that some NPs chose to continue. For example, some pediatric NPs designed their practice to exclude certain patients with problems such as attention deficit hyperactivity disorder (ADHD). "I haven't had a need for it [prescriptive authority for controlled substances] in the clinic where I do have physicians working because generally the pediatricians do the ADHD evaluations and pain medications." A psychiatric/mental health NP who owned her own practice hired physicians to manage patients who required controlled substances. She continued to employ physicians rather than develop a joint practice agreement to prescribe controlled substances herself: "It's not that important to me to prescribe these meds, so I'd rather not ask [for a JPA]."

Some NPs without II-IV authority resisted change by Passing the buck. NPs in specialty practices, such as cardiology, believed that the primary care provider should write prescriptions for controlled substances to assure continuity and coordination of care. However, without II-IV authority, these NPs were unable to prescribe a controlled substance for a short-term need such as postprocedure or surgery. Also noted in this category was the interest of some NPs who

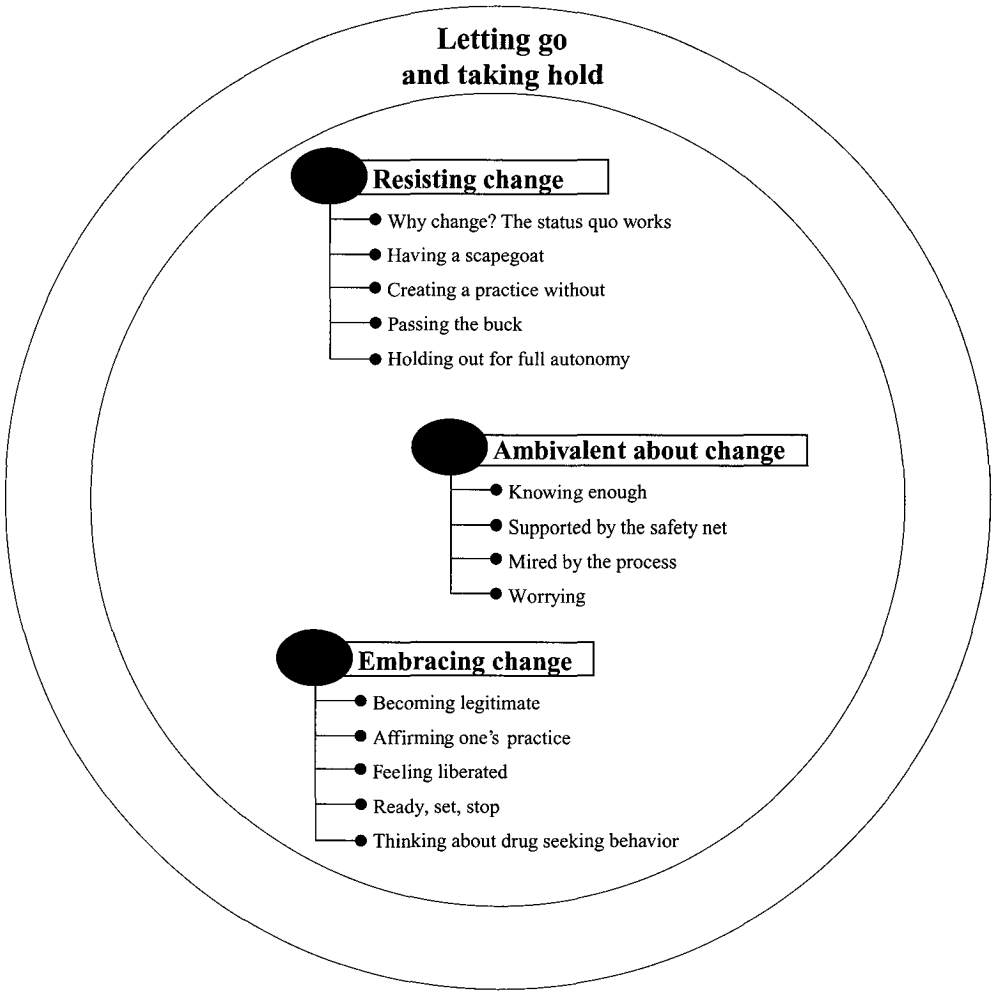

Figure. Responses to new law on prescriptive authority of nurse practitioners.

referred patients to another provider or a pain management clinic to address the patient's request.

One group of NPs distinguished themselves from others who resisted change by "Holding out for full autonomy." These NPs, philosophically opposed to any mandated physician involvement in their practice, were willing to wait for fully autonomous prescriptive authority. One described mandated physician involvement as "relinquishing independence." Yet another explicitly said, "I feel like I'm losing my autonomy." The fear of physician control served as a barrier for some NPs who wanted to avoid a "doctor coming in and trying to take over ... My practice is separate and his practice is separate and I want to keep it completely that way. I don't want to blur the idea in his mind of who's who." Another NP suggested that the terminology "joint practice agreement" was a misnomer: "It's not really a joint practice agreement because the other side isn't asking for anything joint."

Ambivalent about Change

Some NPs, both with and without schedule II-IV authority, expressed ambivalence about prescribing controlled substances. NPs without II-IV authority more closely resembled NPs who resisted change; however, they were contemplating the possibility of prescribing controlled substances. Those with II-IV authority more closely resembled NPs who embraced change; however, they still expressed concerns about possible consequences of prescribing controlled substances. Both external and internal barriers to prescribing were apparent in this group. Four themes characterized this dimension: (a) Knowing enough; (b) Supported by the safety net; (c) Mired by the process; and (d) Worrying.

Knowing enough about II-IV medications to prescribe them was one concern noted. Some NPs had provided II-IV drugs before the law changed with adaptive strategies such as presigned prescription pads, but others had created a practice that excluded controlled substances. Overall they wanted additional education about controlled substances to feel more competent with prescribing these medications. As one NP said, "I think I'm planning on getting II-IV authority. Initially I was thinking, 'Do I know enough?'" This concern about knowledge represents an internal barrier to prescribing II-IV medications.

Being supported by the safety net allowed some NPs to delay obtaining II-IV authority even though they were aware of potential gains. They were able to stay with the status quo because of supportive colleagues. However, many were well aware of the "hassle factor" of requesting cosignatures on prescriptions. One NP commented, "It's something I've been wanting to do but I've been procrastinating. . . . There's always someone around I can ask (for a II-IV prescription for my patients) . . . so that makes it easier to procrastinate."

In contrast to NPs who delayed, other NPs attempted to obtain a JPA but failed to be able to secure a physician with whom to collaborate. Problems with navigating the process to obtain a JPA, knowing how to write one, and what paperwork the state required were common experiences. These NPs were Mired by the process that created external barriers, diminished the importance of obtaining II-IV authority, and created a sense of ambivalence. As one frustrated NP said, "I've been turned down three times by different psychiatrists. There's a doctor you can talk to and he'll contract for $150 and I'd be on my way. But that really irritates me.. . . So I've just decided I'm going to wait."

Worrying about the potential for disciplinary action by regulatory bodies also diminished some NPs' interest in prescribing controlled substances. This concern was common to NPs both with and without II-IV authority. One NP had not obtained II-IV authority even though she knew it would facilitate her practice: "I could take care of people more efficiently if I could prescribe a controlled substance, but my nurse practitioner colleagues and I are a little bit leery because we are concerned about our license."

A major source of ambivalence was worrying about working with patients perceived to have drug-seeking behaviors. Many said it was a "difficult issue" and they could be "taken advantage of" by patients asking for a medically unnecessary narcotic pain medication. A psychiatric NP without II-IV authority made the following distinction: "With alcohol you're not in a position where they are coming and try bamboozle alcohol out of you . . . but [with controlled substances] they are trying to get something out of you . . . give me the pills, give me the pills." Another NP's ambivalence was founded on prior experience: "I was fearful at times when I worked at a clinic that had a high percentage of drug seekers. I was truly afraid when I left late at night that someone would be waiting outside with a gun and shoot me." Nonetheless, she decided to obtain II-IV authority.

Embracing Change

NPs who embraced change were generally those with II-IV authority, but a few NPs, despite their enthusiasm, were unable to obtain a JPA. These NPs expressed positive sentiments about obtaining II-IV prescriptive authority. Themes included, (a) becoming legitimate; (b) affirming one's practice; (c) feeling liberated; (d) ready, set, stop; and (e) thinking about drug-seeking behavior.

Obtaining II-IV prescriptive authority provided NPs with the experience of becoming legitimate. These NPs had made decisions about and provided patients with these drugs before the new law, as noted by one NP, "We were always recommending these drugs and providing them, it was just through other people and now it's us . . . It's a matter of the law catching up with the practice."

A closely aligned theme was "Affirming one's practice." NPs who had been providing II-IV medications understood the distinction between providing and prescribing the medications. "Before I had responsibility without the authority . . . Now we have both the responsibility and the authority for the patient." Moreover, some NPs believed that prescribing controlled substances affirmed their knowledge and skills, enhanced their ability to practice, and more efficiently meet patients' needs: "People depend on you to be able to help them with their pain and without the availability of narcotics . . . they see you as not being able to help them."

Feeling liberated was the sentiment of many NPs who obtained II-IV authority. They were no longer burdened by the need to ask for a cosignature on a prescription, which some also found demeaning. One enthusiastic NP exclaimed, "I find it liberating . . . I no longer have to go and beg for something that I know is necessary for a particular patient."

While the law itself was liberating, some NPs confronted external barriers that prevented them from obtaining the II-IV authority they desired. Ready, set, stop describes the NPs who were unable to find a collaborating physician. As one disappointed NP said, "The reason why I do not have it . . . is that the chair of the department believes that we don't need it . . . so what we've done now is (seek support from) . . . the medical director." Other NPs faced institutional barriers such as a pharmacology test, requesting special privileges, mandatory chart reviews, and maintenance of drug logs. These external barriers prevented some NPs from obtaining II-IV authority, and for others it caused a substantial delay by creating a more burdensome process.

Despite embracing change, some NPs continued Thinking about drug-seeking behavior. This theme indicates the importance of thoughtful prescribing of scheduled drugs and ways to address the NPs' concerns about decision making. They cultivated specific skills that enabled them to identify patients with a legitimate need for specific medications. NPs expressed commitment to alleviating pain, reducing psychological distress, and other appropriate and necessary uses of controlled substances. They also enhanced their awareness of recognizing patients who have behaviors perceived to be related to drug seeking. One NP said, "You need to be able to set limits with patients. If you're not able to you could get a patient who could 'twist your arm' and then you're in trouble." NPs who developed this expertise and undertook the process of complex decision making despite their initial reluctance generally felt positively about their decision. One NP commented, "I did not want to have that Pandora's box opened for people knowing that I could prescribe [II-IV drugs]. I finally went ahead and did it and I'm really glad I did."

Autonomy and Prescribing II-IV Drugs

Study findings showed that practical issues were paramount to most NPs' decisions about obtaining II-IV prescriptive authority rather than the need for professional autonomy and legitimization. NPs wanted to provide comprehensive patient care and reduce the time and hassles related to providing II-IV drugs.

Whether NPs had II-IV authority did not determine the extent to which they viewed themselves as autonomous. Some NPs found the requirement to collaborate with a physician to form a JPA to prescribe II-IV drugs as an incremental step forward. "I feel very much autonomous with the JPA. I don't like to have to go to somebody and keep explaining why I want something." Other NPs expressed ambivalence about the law and its relationship to autonomy. "(The JPA) is a hoop you jump through that gets you to a more autonomous function in your day-to-day work, and yet it is sort of an admission that we are being monitored; it is sort of one step forward, one step backward feeling." For some NPs the JPA created a sense of loss of autonomy. "It makes me feel less autonomous because if I had chosen not to prescribe these medicines I wouldn't have to consult with a doctor at all." As noted earlier, however, some NPs without II-IV authority were holding out for full autonomy because they currently believed they were independent practitioners. "I am a professional who has been practicing for 28 years. I do not need a law to tell me what I can control."

Discussion

The paradigm of autonomous practice has not been fully embraced by all NPs. Because practice laws have varied widely across the US, this variation reflects an intraprofessional dilemma originating from decades of fighting for legitimacy. In the old paradigm many NPs feared the backlash of pushing for full autonomy.

The core category identified in this research, Letting go and taking hold indicates how transition to a new scope of practice extends beyond successful passage of legislation. Study findings showed that NP practice did not necessarily change with the introduction of the new law. A much smaller percentage of NPs applied for schedule II-IV prescriptive authority following implementation of the law than Washington State NP leaders had expected. Twenty-one percent of NPs had II-IV authority after 1 year, 47% after 2 years, 55% after 3 years, and only 60% after 4 years (Washington State Nursing Care Quality Assurance Commission member, personal communications, June 2002 to July 2005). Letting go and taking hold symbolizes a dissonance among NPs regarding the significance of incremental change toward full autonomy.

Role transitions are dynamic processes of change that occur over time (Brykczynski, 2005). Prior research has shown that NP role development extended at least through the 1st year of NP practice (Brown & Olshansky, 1998). Our data showed evidence of role development as an ongoing process throughout one's career in response to changes in NP scope of practice. This process can be linked to the transition process as described by Bridges' three stages of letting go, neutral zone, and new beginning. Our research formulates a new perspective to understand the transition process involved in scope of practice changes. The three dimensions of Resisting change, Ambivalence about change, and Embracing change mirror Bridges' three stages of transition.

Transitions

Bridges transition theory begins with Stage 1, letting go, which describes the ending and loss of old values, self-image, perspectives, and realities. NPs identified as being situated in the dimension of Resisting change were generally comfortable in the way they practiced. For many NPs, their professional identity had developed with the limitation of being unable to prescribe II-IV drugs. Consequently, prescribing controlled substances would have challenged this identity. Some perceived advantages to the adaptation strategies, or "old ways," that allowed them to avoid the responsibility of prescribing controlled substances. Other NPs who exemplified the theme of Holding out for full autonomy had developed a type of independent practice without physician involvement. They were unwilling to enter into a joint practice agreement that they perceived as the loss of their fundamental value of independence.

In Stage 2 of Bridges transition theory, the neutral zone refers to a time of flux and instability when things are neither the old nor the new. The second dimension, Ambivalence about change, included NPs contemplating applying for II-IV authority as well as some who had obtained this authority for practical reasons but who still had reservations about prescribing controlled substances. These NPs often faced external barriers, such as institutional requirements, and internal barriers, such as concerns about adequate knowledge. Over time NPs redefined their professional identity by using an internal process to come to terms with change.

Stage 3, the final component of Bridges transition theory, is the new beginning as accepting the new reality, outlook, or self-image. NPs who embodied Embracing change were typically "early adopters" who tended to be enthusiastic about the benefits of having II-IV authority to them and their patients. For the most part, these NPs were psychologically prepared for the law to change and easily assumed a new identity when the law was implemented.

Autonomy

Autonomy is considered the basis of a profession. Davis (1966) defined autonomy as "socially granted and legally defined freedom to make practice decisions without technical evaluation from sources outside the profession." Since 1973, NP practice in Washington State had not required any physician involvement in practice or prescribing legend and Schedule V drugs. However, NP leaders did not perceive NP practice as fully autonomous, because NPs lacked the

freedom to make practice decisions regarding controlled substances. NP leaders envisioned the compromise of a joint practice agreement for II-IV prescribing as an incremental step toward full autonomy. Some Washington NPs shared this vision but others did not.

Of particular note was the NPs' internal experience of autonomy. Whether NPs had II-IV authority did not affect the extent to which they viewed themselves as autonomous. This phenomenon may be explained by the normalization process that occurred over the many years that NPs had to adapt their practice and used creative strategies, such as the ones noted earlier for providing their patients with controlled substances. This normalization process also contributed to the use of old ways despite a new law.

Implications

This study indicated the importance of examining the nature of professional transition that accompanies successful legislative change. New laws are typically celebrated as a beginning. In Bridge's transition theory, however, the legislative change was an "ending" that allowed for letting go of old ways. By letting go, NPs might be better prepared for the previously invisible process of transition embedded in the adoption of new scope of practice laws. The transition process underlies the paradigm shift (Kuhn, 1970) necessary for NP autonomy, which in turn involves a new set of commitments. "It is not just in action but in thought that we create our autonomy" (Kaplan & Brown, 2006, p. 37).

Most of the current literature on legislative change is focused on the course of action necessary for the passage of new laws. This study contributes to a new area of research on the invisible nature of the transition process triggered by efforts to adopt new scope of practice laws. Furthermore, this research introduces a new perspective about the importance of understanding the effect of legislative change at the individual level. Study findings have three important implications for policy makers and NP leaders across the country working at the state and national level: (a) NPs need preparation for a new scope of practice long before legislation actually passes; (b) Policy makers need to recognize that patients benefit when NPs are legally authorized to utilize their expertise; and (c) NP faculty should socialize students to value full autonomy.

Another Legislative Change

After this study was completed, Washington state passed legislation that eliminated the requirement for a JPA with a physician and granted II-IV authority to all NPs rather than requiring a special application. The law, implemented on July 24, 2005, created fully autonomous practice for Washington State NPs. Ironically, the transition to fully autonomous practice continues. At the time that the law went into effect, 40% of Washington NPs did not have II-IV prescriptive authority (Washington State Nursing Care Quality Assurance Commission member, personal communication, July 6, 2005). One year later, approximately 58% of Washington NPs had DEA numbers with endorsements to prescribe schedule II-V controlled substances, indicating that 42% had not assumed responsibility to prescribe all controlled substances (Drug Enforcement Administration member, personal communication, July 26, 2006).The next step in our program of research includes a survey of NPs who did not have II-IV prescriptive authority when the law changed in 2005 to better understand the nature of their transition.

Conclusions

The phenomenon of transition is a complex, iterative process that is usually invisible. NP role development in response to a new state law on prescriptive authority extended beyond the 1st year of practice and, like the transition process, was complex, iterative, and usually invisible. Revealing and examining this process can facilitate the goal of achieving fully autonomous practice nationwide.

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