

A Study Of Nurses' implementation of assessing, diagnosing and prescribing of patient treatment in different health care settings in Bamenda, Cameroon : Philosophical and Methodological underpinnings.

Winnifred Groves
Faculty of Business and Law
Kingston, University,
Kingston Hill
Kingston upon-Thames
Surrey
United Kingdom
KT2 7LB

Tel:(00 44) 7711 846 799
E-mail: winniegroves@yahoo.com

Supervisors:
Professor Christine Edwards : c.edwards@kingston.ac.uk
Professor, Paul Wainwright : pwainwri@hscs.sgul.ac.uk

18th EDAMBA Summer Academy Soreze, France July 2009

ABSTRACT

The purpose of this paper is to review the philosophical and methodological aspects of my doctoral thesis. Whilst the main philosophical tradition employed in this study is Social Constructionism, it does also use realism which shares some aspects of social constructionism as well as positivism. Mainly an inductive research approach will be used to understand the way in which individuals interpret their social world (Saunders et al, 2003) A deductive approach is used by way of data collection thereby adding a positivistic perspective. The research strategy is exploratory. The purpose is to examine and understand issues affecting assessing, diagnosing and prescribing of patient treatment by nurses in the course of providing health care. The research strategies make use of case studies, phenomenology, grounded theory to a certain extent.

Using the four frames outlined in *Reframing Organizations*: Structural, human resources, symbolic and political (Bolman and Deal, 1997) together with some adaptations to the model to include, economic, cultural, micro and macro factors, the author will examine issues around assessing, diagnosing and prescribing to patients by nurses. Concepts such as the changing role of the nurse: nurses' role in patient treatment impetus for change, power sharing between doctors and nurses, nurse-patient relationship, facilitating / factors acting as a hindrance to nurses prescriptive authority, advantages and disadvantages of assessing of diagnosing and prescribing patient treatment and finally the experiences and feelings of the different stakeholders' about the extended role of the nurse will be addressed.

Key Words: Social constructionism, interpretivism, four-frame model, extended role of nurse, assessing, diagnosing and prescribing, stakeholder experiences.

INTRODUCTION

The aim of my research is;

- To explore the range and nature of diagnosing and prescribing by nurses in Cameroon through obtaining patients/ stakeholder accounts of treatment interactions with nurses and to ask other stakeholders, their perceptions of the role of the nurse in diagnosing patient illness and prescribing treatment.
- To describe and to explore power relations between nurses-doctors and nurses and patients as a result of nurses ability to assess, diagnose and prescribe. The purpose of the research is to increase and enlighten the reader's understanding of nurses' prescriptive authority as a microcosm of the role of the nurse within the health care system in Cameroon.

Objectives:

- To investigate the current role of the nurses in assessing, diagnosing and prescribing for patients.
- To identify and describe factors affecting nurse prescribing in Cameroon
- To explore the strengths and weaknesses of nurse prescribing in Cameroon
- To compare and relate findings to existing knowledge of nurse prescribing in the UK, USA, Canada, Australia, New Zealand, Sweden.
- To identify and describe the different categories of nurse prescribing in Cameroon
- To evaluate different stakeholder perspectives and experiences of prescriptive authority by nurses.

What does it mean to a) assess, b) diagnose, and c) prescribe?

a) In the context of this study, assessing refers to when the nurse observes physically/uses laboratory tests to examine a patient in order to identify the patients health needs.

b) To diagnose is to discover a disease by examination of symptoms and c) prescribing is the act of indicating what medication or treatment a patient should receive following on diagnosis. In can take a verbal or written form as in the case with most Western style medicine.

RESEARCH QUESTIONS:

- 1) To what extent are nurses involved in assessing, diagnosing and prescribing of patient treatment in Cameroon?
- 2) What are the drivers/push factors of assessing, diagnosing and prescribing by nurses in Cameroon?
- 3) What are the facilitating / barriers of assessing, diagnosing and prescribing by nurses?
- 4) What are the advantages and disadvantages of diagnosing and prescribing to the different stakeholders?
- 5) What are nurses, patients, doctors, nurse managers, the state's expectations /perceptions and experiences of assessing, diagnosing and prescribing by nurses?

CONTEXT /SIGNIFICANCE.

Nurses in Cameroon have always been involved in assessing, diagnosing of patients' diseases and prescribing of treatment to a far greater extent than is traditional in Western Europe and other developed countries. This is because of a) few medical practitioners, b) the culture of accepting and seeking treatment from nurses by patients. So this study will be very important in the context of Cameroon. Additionally, since nurse prescribing has become an important issue in the UK, USA, Sweden, Australia, Canada, New Zealand, my research can draw on existing studies as regards conceptual and methods ideas and also contribute to theory and practice in those areas by providing a study of a contrasting situation.

Theoretical framework

In order to examine how assessing, diagnosing and prescribing by nurses came about in Cameroon, I needed to identify a theoretical framework which would help me to organize data collection and framing research questions.

The theoretical framework that seems to fit albeit broadly with this current study is the four frame model by Bolman and Deal (1997) outlined in *Reframing Organizations*. It will be used with some modifications to fit the topic under investigation and to allow for contextual factors. Bolman and Deal write about the Structural frame, the human resource frame, the political frame, and the symbolic frame. Within these I will be examining political, economic, socio-cultural aspects related to the topic of my research. The structural frame draws from sociology and management science, the human resource frame draws from psychology, the political frame is rooted in political sciences and the symbolic frame draws from social and anthropological studies. The structural frame emphasizes goals. Nurses and Drs share a common goal of improving patients' health. This is done through division of labour with every one having a role to play. Roles can be negotiated and interaction takes place within organizations which have structures. Some of these structures are hierarchical in nature and often there are conflicts which need to be resolved. With roles come responsibilities. There are policies and procedures which need to be followed. Effective management is needed to align policies with organizational goals and failure to do so will lead to problems.

The human resource frame sees the organization as an extended family. A family is made up of individuals with needs, feelings, prejudices, skills, and limitations. Nurses are not a homogeneous group. There are different specialties, different grades. Different levels of experiences, training, attitudes, beliefs etc. This frame suggests that that in order for nurses to do the job well, managers have to find a way to make nurses feel good about what it is they are doing and promote their capacity to learn.

The political frame stipulate that within organizations there are different interests competing for power, resources etc. Power can take different forms from overt to covert. As a result there must be some level of, bargaining and negotiation. Problems arise when power is in the wrong places.

The symbolic frame sees organizations as tribes. Within these tribes, there are cultures, rituals, ceremonies, stories. Actors play the role while audiences form impressions. Problems occur when actors play their role badly, when symbols lose their meaning and potency (Bolman and Deal, 1997).

Nursing care is not practiced in a vacuum. The environment/setting within which nursing care takes place varies. There are managers who manage resources and most important the state which is in charge of legislation and regulation of nursing practice.

Nurses work along side doctors in providing health care to patients. The working relationship between nurses and doctors is crucial in providing good quality care to patients, (Salvage, 2000, Davies, 2000). The professional relationship between nurses, doctors and patients is centered around roles. Where there is a structure there is hierarchy and roles .

A hospital consists of a variety of health service and other ancillary workers, Strauss et al,(1985), Friedson (1963) The division of labour in hospital has been a subject of great interest to Strauss. these roles come with a certain degree of power. From a historical perspective, hospitals have long posed a hierarchical organizational structure. Ever since nurses as a professional group entered care work in the 1800s, their relations with doctors have been characterized by this hierarchical order. Nurses' subordination to medicine is well documented (Stein et al, 1990, Davies et al1999, Salvage & Smith, 2000,Davies,2000) Strauss in Dingwall and McIntosh 1978 noted, this relationship as been deeply rooted in , among other things, society's status differentiation, women's position in society and the biomedical representation of care itself (Porter, 1991;1992; Strauss, 1978 Navarro, 1977 in Keddy et al, 1986). Gender is closely linked with power particularly so in the case with Cameroon where it is predominantly a patriarchal society, coupled with the fact that nursing is predominantly female profession. There is constant negotiation of roles. Espoused by Strauss, (1979), a negotiated order approach is fundamental to the understanding of social organizations. It stresses the point that one of the principal ways by which goals get accomplished in organizations is through people negotiating with one another (Svensson, 1996) The over riding goal of the nurse and the Doctor is to always work in the best interest of the patient. It is therefore appropriate to find out from these patients whether assessing, diagnosing and prescribing of treatment works in the best interest of the patients and if not what can be done to improve nursing care?

PHILOSOPHICAL PERSPECTIVES OF THE STUDY.

An epistemology of interpretivism is used in this current study which is a contrasting epistemology of positivism. According to interpretivism, the study of social phenomena requires an understanding of the social world that people have constructed and which they reproduce through their continuing activities..... Natural scientists have to find concepts to interpret what they study, but since people think about social activities, social worlds are already interpreted before social scientists arrive" (Blaikie, 2007, p124) and so the job of social scientists (as interpretivists) is to produce a description of these social worlds. Walshaw, (1995) notes that Interpretive methods of research adopt the position that our knowledge of reality is a social construction by human actors. As a result, value-free data cannot be obtained because the enquirer uses his /her preconceptions in order to guide the process of enquiry, changing the position of both parties. It is predicted upon the view that respects the differences between people and the objects of the natural sciences " (Bryman & Bell, 2003, p16). The philosophy of interpretivism is appropriate in the case of business and management and Health studies research. This is because human beings are unique and complex creatures. Interpretivist studies focus on how the people being studied, make sense of and how they talk about, their world.

Critiques have argued the lack of generalizability of interpretivism. However, interpretivists argue that generalisability is not of crucial importance. Although the aim of my study is not to generalize, implicitly it would be useful to be able to predict future behaviour on the basis of the findings. Also it is argued that organisations are constantly changing and evolving and so therefore some of the value of generalisation is lost during these changes (Saunders et al, 2003).

Realism as an epistemology of social constructionism is based on the belief that a reality exists which is independent of human thoughts and beliefs (Burrell & Morgan, 1979). Critiques would argue how the two approaches can be combined, given that realism is directly opposed to interpretivism. I would argue that we need to understand those external forces which affect the nurse – patient relationship in order to grasp the meanings behind people’s behaviours. What this means is that there are large- scale social forces and processes that affect people without people being aware of the existence of such forces, their influence and interpretations and behaviours. In this respect, realism shares some philosophical aspects of positivism in that it acknowledges, external, objective nature of some macro aspects of society and their impact on how we as individuals perceive the world. Whilst the purpose of the positivists is to seek explanation of human behaviour, the social sciences seek to understand human behaviour. The latter has it’s roots in Sociology echoing, Max Webber (1864-1920) of a *Verstehen* approach.

One of the main intellectual traditions associated with interpretivism is phenomenology. This refers to how individuals make sense of the world around them and how, in particular, the philosopher should bracket out his /her own preconceptions in his/her understanding of that world. Qualitative research is interpretative in form and follows a naturalistic paradigm. (Bryman and Bell, 2003, Bowling &Ebrahim, 2005, Holliday, 2007, Morse, 1994, LoBiondo-Wood & Haber, 2006). This view has been contrasted by Blakie, (2007) claiming that interpretivism is anti-naturalism. The fundamental difference between the natural scientists and the social scientists is that with the former, the observer must be objective, explanations must demonstrate causality, use statistical analysis to generalize findings, randomly select large numbers for sampling. The purpose of Quantitative research’s is to generalise to a population, demonstrating causality and making predictions. The latter is part of what is being observed, researchers aims to increase general understanding of the situation, collects rich data from which ideas are induced, should incorporate stakeholder perspectives, use theoretical abstraction and selects small numbers of cases purposefully for specific reasons. (Easterby-Smith et al, 2002 Saunders et al, 2003,).

This paradigm developed by philosophers during the last half century “ is largely in reaction to the application of positivism to the social sciences, stems from the view that “reality” is not objective and exterior, but is socially constructed and given meaning by people. The idea of social constructionism as developed by Berger and Luckman (1966), Watzlawich (1984) and Shotter (1993) cited in Easterby-Smith, 2002 p29, focus on the way that people make sense of the world especially through sharing their experiences with others via the medium of language. Social constructionism is an interpretative method. With this research method, the idea of “reality” is determined by people rather than by objective and external factors. The

aim of the research is partly to gather facts and to ascertain how often assessing, diagnosing and prescribing by nurses occurs, and also to explore the different constructions and meanings that individuals place upon their experiences with nurses who have prescriptive authority.

The use of mixed methodologies positivist as evident in some of the my research questions 1-4 is evident in the sense that whilst I am using nurses, patients, nursing managers, government representatives as observers of that I could not observe due to practical reasons and collecting their facts as to what is going on, I am also concerned with explaining nurses' social worlds rather than just describing what they do.

Bowling & Ebrahim (2005) state that qualitative research is any form of data collection that generates narrative or non-numeric information. However, most qualitative research will seek to adopt an emic perspective at a slightly deeper level in the sense that the research attempts to gain access to the insider's view of his or her own social world without, at the stage when data is being collected, making any value judgements. The research focuses on the experiences and meanings of individuals in order to analyse how and why people form associations with other people, things and with their immediate environment.

Comparisons between quantitative and qualitative research approaches tend to emphasize often exaggerating differences between the two approaches rather than acknowledge the similarities between the two. Traditionally, qualitative research has been described as a soft science and artistic rather than empirical process as is the case with quantitative studies (Norwood, 2000). This rather weak perception of qualitative research together with nurses quests for professionalism and laying claim to being scientists has resulted in nurses pursuing quantitative strategies for addressing research questions. However, in recent years there has been a growing recognition of the contribution of qualitative studies adding to our knowledge of health studies making qualitative research approaches more acceptable.

Quantitative research is based on positivistic paradigm which maintains that truth is absolute and consist of a single reality that can be measured objectively and can be compared to predefined norms. Quantitative researchers believe that a phenomenon is best understood by examining their component parts and the relationship between these parts, resulting in a "reductionist" perspective. In quantitative research the researcher pre-selects variables of interest which will be measured and then analysis the data using statistical methods. It uses mainly structured designs of data collection, Such as surveys, structured interviews, structured observations and relatively large samples. Objectivity is an aspect of quantitative studies while subjectivity is viewed as a source of bias.

Qualitative methods of investigating nurse prescribing win out over quantitative methods in order to cover depth avoiding superficial findings. Morse, (1992) identifies three features that distinguish qualitative research from a Quantitative approach.

- 1) An emic perspective-eliciting meaning, experience or perspectives from the participant's point of view rather than that of the researcher.
- 2) A holistic perspective-considering and including underlying values and context as part of a phenomenon.

- 3) An inductive and interactive process of inquiry-the researcher determines the analytic process as he/she gains comprehension and insight into the phenomenon being studied.

The premise of qualitative research thus is that there is no single reality, rather reality fluid, varies from person to person, and has meaning only within a given situation or context.

Research Methodology

Qualitative Vs Quantitative methodologies

The ontological basis for the design of this study is primarily based on symbolic interactionism, which asserts that reality, rather than being a fixed entity, is continually being recreated by the meaningful actions and interactions of social actors.

This study uses mixed methodology, using a combination of techniques to enquire about the nurses' role in assessing, diagnosing and prescribing for patients. It employs both qualitative and quantitative methods of data collection and analysis. However, it is mainly a qualitative study using social constructionism/interpretivism. But it also uses self – completion questionnaire, which is also a method used in collecting data with a positivistic epistemology. And social constructionism through the use of in-depth interviews, secondary data as a data collection method with the aim of increasing general understanding of issues around nurse diagnosing and prescribing. These methods help to generate insights into how respondents see their world. In doing so the concepts include different stakeholders' perspectives and generalisations are made from the findings since the sample is representative of what is happening in practice across different hospitals and amongst different stakeholders.

The social constructionist is interested in understanding the subjective meanings of social actions ; the study will focus on how nurses diagnose and prescribe, to what extent this practice is carried out by nurses, why nurses are diagnosing and prescribing, how this impacts on their other nursing duties, exploring the what the facilitating factors and barriers of nurse prescribing are and how this impacts on patient care. Issues of clinical governance such as how managers monitor the work done by nurses in order that nurses provide patients with a high standard of care, looking at issues of training and development for nurses how their job is facilitated. Asking patients what they think and feel about their experiences with nurse diagnosing and prescribing, what makes diagnosing and prescribing work well? what makes it fail?, How can it be improved?. Asking doctors about their working relations with nurses and how they feel about the role of nurses in diagnosing and prescribing etc. The Dr-nurse-patient relationship has always been at the heart of effective health care. 19th century were often advised to understand these three relationships as a household. (Davies et al, 1999).

The researcher will use mainly a qualitative approach to examine and to explore this aspect of health care delivery by nurses as a means of answering the research questions. This style of research is inductive, rather than deductive which seeks to confirm or disconfirm a hypotheses. The study adopts a flexible research strategy. However, Qualitative research is particularly well suited to study the human experience of health and health (, Norwood, 2000; LoBiondo-Wood & Haber, 2006) and health care delivery.

An observation study would be equally beneficial but due to practical limitations such as time constraints, given that the researcher is resident in the UK, cost implications, etc. As a result, the methodology involved the use of semi-structured interviews, which meant that as far as possible, the same questions based on particular themes were asked in each of the interviews but questions varied between the different stakeholders.

Information was collected by using a variety of sources, hence triangulation. The use of one-to-one in-depth interviews and informal interviews, questionnaire, researchers own note / diary, journals, other publications. This multiple sources of data collection add credibility to the findings than if data collection came from a single source (Maxwell, 2005).

The data obtained from this study is to be used to increase our insight into aspects of nurse diagnosing and prescribing rather than assume representativeness. The aim of this qualitative method is to explore and understand a complex phenomena and to generate hypotheses, rather than to apply the findings to a wider population.

Use of questionnaire

The use of questionnaire was employed to obtain factual information. Both open and closed questions were used in the questionnaire. The purpose of the questionnaire was to use this information to construct a picture of the respondent and contextualize their later responses. Also, it serves as a prelude to the interviewer since the questions are easy to answer and then the interview will build up on the questionnaire as a natural progression. Also, it served to reduce the number of questions asked during one-to-one interviews as participants can get tired by so many questions which will in turn affect the quality of information they provide. The use of a questionnaire to gather factual information is appropriate and useful in understanding how contextual, different variables such as age, sex, longevity in service, educational background etc impact on the ability of nurses in diagnosing and prescribing.

Prior to administering the self-completion questionnaire, a trial run was carried out on two research participants. The pilot study gave me the opportunity to discuss the questionnaire with other more learned and experienced colleagues, ensuring it addressed the research questions. Also to verify whether it had face validity, identifying typing errors and ensuring that the layout was user friendly. Feedback from pilot study led to a few changes such as the use of terminology, using language which is culturally acceptable, and easily understood to achieve cultural equivalence. The researcher hand delivered self-completion questionnaires together with a letter of consent / confidentiality which also explained the purpose of the research and when participants will next be contacted by the researcher to arrange interviews. Participants were informed that they could withdraw at any stage of the research if they so wished. Permission for tape recording the interviews was also obtained from participants at this initial stage.

Study Sample

ACCESS TO RESEARCH PARTICIPANTS AND ORGANIZATIONS

Access to participants was straight forward and unproblematic. Access was made through networking with friends and family members in Cameroon, explaining what this research entailed. Friends put me in touch with organisations. I made initial contact by telephone, followed by email correspondents prior to my field visits.

The study sample include small numbers of organisations and individuals selected for different reasons. The different methods of sampling employed in this study are convenience sampling, purposive sampling and snowballing, stratified sampling. The study sample has a mix of different age groups, gender, and longevity of service, geographical area, different health care settings. By so doing, the different groups in the study population (strata) are correctly represented in the sample. The unit of analysis is organisations and individuals.

The different Organisations studied include;

- "A" Integrated **Health Care Centre** (extremely rural) **Peripheral Level**
- "M" Integrated **Health Care Centre** (rural) **Peripheral Level**
- "S.T" Catholic **Medical Centre** rural /semi urban) **Peripheral level**
- "M" **District Hospital** (Rural area) **Peripheral level**
- Provincial **General Hospital** (urban area) **Intermediary Level**. A large modern metropolitan hospital.
- "S L" Clinic **Private** (urban area) **Intermediary Level**

The involvement of different health care settings in this study adds to external validity of any conclusions drawn as it attempts to represent the different types of health care settings in Cameroon. The individuals included nurses, patients, doctors, nursing managers and medical doctors, because the study seeks to understand their experiences of diagnosing and prescribing in their own words. The study focuses a smaller number of organisations and individuals and attempts to investigate them intensively.

Case Study Approach

By adopting this case study approach, the researcher seeks to gain an understanding of how assessing, diagnosing and prescribing takes place in different health care settings, why it does and what might become important to look at in future research. A case study research investigates a phenomenon within its real life context. In this study it is based on multiple case studies and include both qualitative and quantitative evidence. It relies on multiple sources of data collection and makes use of prior theoretical framework, Bolman & Deal, (1997) to evaluate effects of diagnosing and prescribing by nurses. An advantage of using a case study approach is that it can enable one to challenge an existing theory and also provide a source of new hypothesis (Saunders, 2003, Yin, 1994). Also, A case study will capture all the details of a phenomenon giving a greater coverage of participants experiences more than a questionnaire survey alone.

In order to assess the feasibility of this research, a pilot study was carried out between December and January 2007. Contact was made through friends and relatives pointing the researcher to some nurses, doctors, nursing managers, government representatives, patients. As a result of informal and formal discussions with the different stakeholders in different health settings, preliminary findings highlighted some problems with nurse diagnosing and prescribing which needed further investigation. Having established the suitability of the research as an important role of the nurse which warrants greater discussion, the researcher set out to obtain ethical approval.

Face-to-face Interviews / semi-structured interviews

Face-to-face interviews were conducted on a one-to-one basis. All interviews were taped recorded.

Breakdown of research participants;

- 14 Nurses, 5 of whom are also managers
- 21 patients
- 1 Nursing teacher
- 5 medical doctors of whom 3 represent the state as they are also administrators.

The interviews were carried out with a view to collecting information, stories from stakeholders about how nurses perform their role of diagnosing and prescribing vis-à-vis patients. My focus is on what nurses do, how they do it and how they feel about it and how different stakeholders feel about their experiences.

An In-depth interview is a structured encounter between the researcher and the research participant with the aim of eliciting information. Interviews offer a practical, flexible and relatively economical way of gathering data. An interview is described as a conversation with a purpose, which should produce interesting and prolific stories, data that are abundant in detail and examples and narratives that reveal people's complex feelings, perceptions and viewpoints (Hoskins & Mariano, 2004). The interviews focused on various themes identified from literature (allowing fluidity) and included mostly open-ended questions allowing the participant to express their feelings, emotions, attitudes, and opinions freely Interviews have the advantage of allowing the researcher to directly intervene in the research process, it allows the researcher to guide the participants to talk about specific issues (Bowling and Ebrahim, 2005). However, interviews give the researcher a description of what the interviewee said, and not a direct understanding of his or her perspective. Generating an interpretation of someone's perspective is inherently a matter of inference from descriptions of that person's behaviour (Maxwell, 1992 cited in Maxwell, 2005). While interviews are a valid way of gaining someone's perspective on a particular phenomenon, observations can enable one to draw inferences about a phenomenon that cannot be obtained by relying on just what the interviewee says. Observations are a useful way of gaining tacit understanding as well as gaining knowledge of some of the participant's behaviours which they would not otherwise state in an interview (Maxwell, 2005).

Although the interviewer used a pre-planned script, quite often, supplementary questions and analytical themes were generated through the interview session. In which case, subsequent questions were revised. The researcher took a more receptive role in listening and probing for more detail. The different methods of data collection was used in order to identify and represent as accurately as possible the phenomena under investigation as suggested by (Easterby-Smith et al, 2004).

Interview Procedure

Before each interview I provided a brief preamble as to the purpose of the interview and obtained permission for the participants to audio-tape the session. All interviews were pre-arranged to suit both parties particularly the interviewees. Participants chose when and where they liked to be interviewed. Some interviews took place in participant's homes, some in the Health centres out of working hours. Some during working hours especially those with hospital managers. All interviews took place in a quiet room to avoid interruptions.

A list of open ended questions was prepared before hand for the different stakeholders (nurses, patients, doctors, nursing managers, the state) prior to interviews. Interview questions were modified as interview progressed as responses from participants pointed towards some more questions. Questions were asked to all participants but tailored to each individual stakeholder requirements. This is in order to allow for the ease of analysing data. The interview guides were subsequently revised (following first few initial interviews) in order to reflect developing themes. This process is in keeping with grounded study approach. Grounded theory proved to be a useful methodology as the concept evolved from the real live experiences of the respondents and was explored through these perceptions of their experiences

The advantages of face-to-face interviews include; It provides an opportunity for the interviewee to identify verbal clues, interviewee body language for example facial expression, inflection of voice. These clues can be used to further develop secondary questions, hence gaining more meaningful data than initially setting out to obtain. The main reason for conducting in-depth interviews is to understand how individuals construct the real situation formed from personal beliefs and values. These help to explain and predict events in the world.

Face-to-face interviews provide rich and quotable material that enriches research findings. The fact that interviews were taped recorded means the data is available in its original form, word verbatim. Tape recording saves time as the researcher does not have to hurriedly scribble notes during the interview. The advantage of using an audio tape recorder as observed by Silverman (2003) is that "we can not depend on our recollection of conversations or speeches and depending on our memories, we generally tend to summarise what people have said. Silverman also notes that the advantage of audio tapes over other means of recording e.g field notes, is that what one presumes is not interesting in writing only field notes may turn out to be more interesting when listening to the recorded material later since we are able to focus on "actual details".

Also, the fact that I used a digital tape recorder meant I did not lose time in changing tapes compared to if I had used an ordinary tape recorder, also, the sound quality on digital

recorder is better than on an ordinary tape. The digital recorder was also useful in that I could store the data electronically in different files therefore giving me peace of mind about not losing my tapes / recordings. The researchers' concentration is increased as they focus on asking the questions and actively listening in order to pick up clues or information that had not been included in the research questions but that the respondent has identified and which is useful for the study.

Despite the above mentioned benefits of face-to-face interviews and its claim of being "the best" method of collecting qualitative data, its complexity can sometimes be underestimated. It is expensive and time consuming. Expensive in the sense that several appointments had to be made with research participants, on some occasions, appointments had to be cancelled and rescheduled for a variety of reasons. Several journeys had to be made to same institutions for one to one interviews. This cost money in terms of transport /petrol cost and time. Another limitation is interviewer bias, both when and how the questions are asked and when the answers are interpreted. To minimise error / misunderstanding and increase validity to the research findings, the interviewer used exploratory and silent probes to clarify interviewees' responses and mirroring, reflecting and expressing in the interviewee words, what the respondent has just said.

ANALYSIS.

Content analysis / thematic analysis will be used with the help of Computer package, Qualrus. The data analysis was part of the research design. The researcher had to decide on the methods that the data will be analysed from the inception of the research process. The data was being analysed and notes jotted in the diary as the interview process began. On completion of the interviews. The interviews were listened to with further note jotting prior to transcribing. The process of analysing continued through out the transcribing phase with notes/memos written in parentheses or in dairy etc. The researcher mainly wrote down what was heard and observed (body language during interviews) notes on the developing categories and relationships. Taking note of reoccurring categories and differences. These notes included words, phrases used by participants and an etic perspective, the researchers' own concepts gained form prior reading/ existing literature. The intention is to use these in developing conclusions. The researcher compared each section of the data with every other through out the study looking for similarities, differences and relationships. All the data will be coded and categorized and from this process major concepts and constructs will be formed. The search for major themes will follow in order to create a story line of assessing, diagnosing and prescribing by nurses.

Trust

Trust is an important factor contributing towards the effectiveness of social interaction between researcher and the research participants in qualitative research methods, especially with in-depth face-to-face interviews on individual basis. Prior to travelling to Cameroon for the field study, I phoned the prospective research participants met during the pilot phase of the study and informed them of my impending visit for the purpose of primary data collection. Being a Cameroonian and a nurse by profession seem to work in my favour as I have some inside knowledge of the Country and nursing practice. In some way, research participants felt less threatened and more trusting as compared to if the researcher was an

outsider. It is thought that this could promote participation, cooperation and commitment to the research process.

TRANSCRIBING.

As a novice researcher, transcribing is an extremely tedious and laborious process, but at the same time it allows me the opportunity to immerse myself in the data identifying significant categories within the data which are the early stages of Analysis. Some the interviews are transcribed verbatim whilst those interviews that were carried out in pidgin English and in the Vernacular and translated into English prior to typing. The number of participants saying similar things also differing perspectives and experiences are also noted.

LIMITATIONS.

How was I going to secure trust and co-operation from participants. I had to remember to wear appropriate clothing. Worries about cultural issues. Issues around eye contact, crossing of legs etc

A potential limitation of this study

Limited sample. Not representative of the entire nursing population with prescriptive authority in Bamenda, the town where the study is taking place

Some interviews in local language (Interviews in vernacular) making translation difficult. Risk of misinterpretation or losing valuable knowledge/ findings through transcribing.

CONCLUSION.

My claim is that interpretive approach is a valuable method in studying assessing, diagnosing and prescribing by patients better than positivism in this study. The intent is to increase understanding of nurse diagnosing and prescribing in a specific cultural and contextual setting (Cameroon) and the examination of this element of the role of the nurse from the perspective of research participants.

REFERENCES & BIBLIOGRAPHY

- 1) Blaikie, N (2007) *Approaches to Social Enquiry*. London : Polity Press.
- 2) Bowling, A & Ebrahim, S (eds.) (2005) *Handbook of Health Research Methods: Investigation, Measurement And Analysis*. Maidenhead, England: Open University Press.
- 3) Burrell,G & Morgan, G (1979) *Sociological Paradigms and Organizational Analysis*. London: Heineman.
- 4) Davies, C (2000) Getting health professionals to work together. *British Medical Journal*, Vol. 320, p 1021-1022.
- 5) Davies, C; Salvage, J & Smith, R (1999) Doctors and nurses: changing family values? *British Medical Journal*, Vol. 319, Aug, p463-464.
- 6) Easterby-Smith,M; Thorpe, R; & Lowe,A (2002) *Mangement Research: An Introduction*, Second edition, London: Sage Publications.
- 7) Friedson, E (ed) (1963) *The Hospital in Modern Society*. London: The free press of Glencoe: Collier MacMillan Limited.
- 8) Holliday, A (2007) *Doing and Writing Qualitative Research*. Second Edition, London: Sage Publications.
- 9) Holloway, I & Wheeler, S (2002) *Qualitative Research in Nursing*. Second Edition. Oxford: Blackwell Science.
- 10) Hoskins, C.L & Mariano, C (2004). *Research In Nursing And Health : Understanding and using Quantitative And Qualitative Methods*. Second Edition. New York: Springer, Series on the Teaching of Nursing, Springer publishing Company.
- 11) Keddy, B; Gillies, Mj; Jacobs, P; Burton, H; Rogers, M (1986). The doctor-nurse relationship : A historical perspective. *Journal of Advanced Nursing*, 11, p745-753.
- 12) LoBiondo-Wood, G & Haber, J (2006) *Nursing Research : Methods and Critical Appraisal for Evidence-Based Practice*. Sixth Edition, St Louis, Missouri: MOSBY Elsevier.

- 13) Maxwell, J.A (2005) *Qualitative Research Design : An Interactive Approach*. Second Edition, Applied Social Research Methods Series, Vol. 41. Thousand Oaks, London Sage publications.
- 14) Morse, J M (ed) *Critical Issues in Qualitative Research Methods*. Thousand Oaks: Sage publications.
- 15) Norwood, S.L (2000) *Research Strategies for Advanced Practice Nurses*.
- 16) Porter, S (1992). Women in a women's job:the gendered experience of nurses. *Sociology of Health & Illness*, Issue14, No.4, p510-527.
- 17) Porter, S (1991). A participant observation between nurses and doctors in a general hospital, *Journal of Advanced Nursing*, 16, p728-735.
- 18) Salvage, J & Smith, R (2000), *Doctors And nurses: doing it differently*. *British Medical Journal*, April, 1019-1020.
- 19) Saunders, M; Lewis, P & Thornhill, A (2003) *Research Methods for Business Students*. Third edition. Harlow, England: Prentice Hall, Financial Times.
- 20) Silverman, D (2005) *Doing Qualitative Research*. London: Sage.
- 21) Stein, (1967) The doctor- nurse game, *Archives Of General Psychiatry*, Vol. 16, 699-703.
- 22) Stein, L (1978) The nurse-doctor game In *Readings in the Sociology of Nursing* Dingwall , R & McIntosh, J (eds) Edingburgh: Churchill Livingston. P108-117.
- 23) Strauss, A, Fagerhaugh, S, Suczec, B & Weiner, C (1985) *The Social Organisation of Medical Work*. Chicago: University of Chicago Press.
- 24) Svensson, R (1996) The interplay between doctors and nurses – a negotiated order perspective. *sociology of Health & Illness*, Vol.18 No. 3, pp379-398.
- 25) Walsham, G (1995) The Emergence of Interpretivism in IS Research. *Institute for Operations Research and the Management Sciences, Information Systems Research*, 6:4; pp376-394.

26) Yin, R.K (1994) Case Study Research: Designs and Methods. Second Edition, Beverly-Hills, CA: Sage.

<http://coe.winthrop.edu/blackburn/EDCI%20636/Bolmananddealfourframe.ppt>