A specialist nurse: an identified professional role or a personal agenda?

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A specialist nurse: an identified professional role or a personal agenda?
Specialist nurses have existed for many years. Initially denoting a nurse with extensive clinical experience, implicit within nursing's professional agenda for attaining 'specialist' status since the 1960s has been the requirement to achieve a high degree of 'specialist' knowledge through post-basic education. Despite the professional agenda, much confusion surrounding definitions of specialist nurses prevails. In recent years this confusion has been compounded in the United Kingdom by the introduction of advanced nurse practitioners alongside existing clinical nurse specialists. This paper suggests that health care professionals' perceptions of a 'specialist' are subjective, grounded in their own experiences. Drawing on a study which examined relationships between paediatric oncology outreach nurse specialists and other health care professionals, two types of personal agenda from which perceived 'specialist' status evolves are described: (1) 'needs-driven agendas', and (2) 'peer-driven agendas'. When 'specialist' status is accorded to paediatric oncology outreach nurse specialists, 'specialist' knowledge is derived from: formal qualifications, hands-on technical skills, previous 'specialist' work experience, in-depth medical knowledge and/or insight into families' dynamics. The relative contribution each of these makes towards constructing a 'specialist' depends on the experiences of individual health care professionals and the varying work locations and professional backgrounds of paediatric oncology outreach nurse specialists.

Keywords: paediatric oncology specialist nurses, knowledge, status, professional agendas, personal agendas, clinical nurse specialist

INTRODUCTION

For the first half of the 20th century the term 'specialist' denoted a nurse with extensive experience in a particular area of nursing and in North America nurses have been deemed 'specialist' since 1910 (Hamric 1989). However, 'specialist' nurses such as 'Sister Dora', who became famous during the 1870s for her specialized nursing treatment of machinery accident victims in Walsall (Manton 1971), have existed within the United Kingdom (UK) since the Nightingale era. Castledine (1994) argues that the creation of specialist nursing practice began during this period with both the establishment of the Florence Nightingale School of Nursing and with the publication of her second version of *Notes on Nursing*. These two initiatives, he suggests, identify and link nursing as a profession with that of a specialty in which two classes of nurse are described: the amateur and the professionally prepared hospital nurse.

In the history of nursing, however, it is more generally considered that the clinical nurse specialist (CNS) first emerged in North America, reaching the UK during the

early 1970s. Storr (1988) suggested that 'specialists' in clinical nursing evolved when the term 'nurse clinician' was first adopted in 1943. Others have considered that the CNS title dates back to 1938 (Peplau 1965). Elsewhere some confusion reigns as to the origins of the title (Hamric 1989). It is agreed nonetheless that the title's beginnings arose in North America, during the late 1930s or early 1940s. More commonly, the label CNS began to appear in the 1960s when, in North America, much of the early literature focused on the justification for master's level education for advanced clinical practice (Storr 1988, Hamric & Spross 1989, Fenton 1992).

The rise in specialist nurses within the UK occurred in response to an increase in public demand for services, an expansion of knowledge and skills, both in medicine and in nursing and particularly in technological interventions, and a desire on the part of nurses for a more varied career structure (Castledine 1982, 1983, 1994). Early CNSs within the UK sometimes took on tasks previously undertaken by doctors, whilst others developed new skills to cope with new patient problems (Castledine 1994). More recently similar theories have been assigned to the emergence of the advanced nurse practitioner (United Kingdom Central Council for nursing, midwifery and health visiting, UKCC 1994, Cassidy 1996, Chan 1996, Dowling *et al.* 1996, Caballero 1998).

In his earliest study of CNSs, Castledine (1982, 1983) identified 11 key aspects of the role of the CNS which no single CNS fully encompassed. These comprised: direct involvement in care, responsibility and accountability for nursing actions, to be highly educated, a researcher, an educator, a co-ordinator of care, an expert in both clinical assessment of patients and in her field, to be autonomous, to be a writer and to form a liaison between the community and the hospital. This multiplicity of roles is reflected in a later survey conducted by the Daphne Heald Research Unit of the Royal College of Nursing (RCN) in which it was reported that 1016 CNSs nationally held 82 differing job titles (Wade & Moyer 1989). Debating this confusion Steele and Fenton (1988 p. 45) wrote:

> Even though the role of the clinical nurse specialist (CNS) has been described in educational criteria, standards and the literature, some confusion still exists about the essential clinical practice skills needed for this advanced role. This situation may be due to the wide diversity of roles that CNSs assume in health care settings. In one institution a clinical nurse specialist may be involved primarily as an educator, in another as a consultant, and in another as an administrator or researcher or some combination of these roles.

More recently, the emergence of the advanced nurse practitioner has compounded the continuing confusion regarding the CNS role and delineation between the two roles is indistinct (e.g. Hamric 1992, Castledine 1996, Castledine *et al.* 1996, Coyne 1996, McGee *et al.* 1996, Mills 1996). However, a recent British review of the literature, reflecting an earlier study by Storr (1988), suggested six major components to CNS roles to which many health care professionals currently subscribe. These comprise: clinical expert, resource consultant, educator, change agent, researcher and advocate (Miller 1995).

Although it has been recognized in the UK since the last decade that nurse specialists: 'are prepared beyond the level of registration' (RCN 1988 p. 6), in contrast to North America, distinctive criteria regarding educational attainments of CNSs remain unspecified. Moreover, educational accomplishments of CNSs have varied and jobs have frequently been developed around the experiences of individuals (Smith 1990). Whilst the UKCC has recommended that nurses entering a specialty (as distinct from becoming a specialist, i.e. 'expert') be appropriately trained (UKCC 1996), there remain limited stipulations for attaining 'specialist' status.

Implicit within examinations of specialist nurses over the years is an assumption that a high degree of 'specialist' knowledge is acquired. Despite continuing confusion surrounding CNSs and advanced nurse practitioners, including both a lack of a clear definition of their roles and explicit educational criteria in the UK, for the last 30 to 40 years 'specialist' knowledge pertaining to CNSs, and more recently advanced nurse practitioners, has been grounded in 'specialist', post-basic education. It is, however, also embedded within extensive clinical experience (Castledine 1982, 1983, Benner 1984, RCN 1988, Hamric 1992, Lipman & Deatrick 1994, MacLeod 1996).

This paper draws on data from a study which examined the relationships between hospital- and community-based health care professionals and a group of specialist nurses collectively known as paediatric oncology outreach nurse specialists (POONSs). It suggests that, despite nursing's continuing attempts to establish a professional agenda concerning the 'specialist' knowledge status of CNSs, health care professionals working with POONSs commonly disregard professional agendas and confer 'specialist' status on POONSs according to their own personal agendas and experiences. The paper therefore offers some new insights into defining 'specialist' practice. Firstly, it provides multidisciplinary rather than nursing-specific definitions of 'specialist', through the perceived value of POONSs. Secondly, it proffers informal as opposed to formal definitions of 'specialist' which are not wholly enshrined in measurable criteria which have to be met, such as qualifications. Thirdly, it tenders insight into the influence of work settings on the definition of 'specialist' practice.

THE NURSING SPECIALITY OF POONSs

POONSs emerged as a nursing specialty during the mid-1980s as a result of perceived gaps in services both by

families caring for children with malignant disease and by health care professionals in regional paediatric oncology units. They arose predominantly to support both families and carers through a child's terminal illness, at home. The successes of early posts led to a nationwide expansion of services, incorporating care through all stages of a child's illness and enhancing the philosophy of 'shared care' (Bacon 1989, Orton 1994, Bennett *et al.* 1994, Hooker & Williams 1996, Patel *et al.* 1997, Gibson & Williams 1997, Hunt 1998a, Greener 1998). POONSs acts as main contact persons to families in their own homes during periods of treatment and post-treatment, enabling them to feel more secure (Bignold *et al.* 1994). In so doing they provide links between primary, secondary and tertiary care, offering local services information and support.

The degree to which POONSs fulfil the role of a CNS, as identified within the literature, is varied and is influenced by the different organizations associated with funding their work (Hunt 1996, 1998a). In addition, the funding arrangements of POONSs have historically influenced their work location (Hunt 1994, 1995, 1996, 1998a) and POONSs may either be located within children's departments at district general hospital trusts or within specialist paediatric oncology units at tertiary referral centres. The funding arrangements and work location of POONSs in turn influence service structure and POONSs may either work alone or in teams (Hunt 1994, 1996, 1998a). The impact that differing work locations have on health care professionals' perceptions of a 'specialist' are highlighted in this paper.

THE STUDY

This paper draws on qualitative interview data from the second stage of a large two-part study which explored the impact of funding arrangements on the professional relationships between POONSs and other health care professionals (Hunt 1996, 1998a). The first stage was designed to understand better the structure, organization and working practices of POONSs. Interviews were conducted with all POONSs in post in the UK and the Republic of Ireland during 1993, using a semi-structured interview schedule ($n = 43$). Findings from the first stage of the study have been reported elsewhere (Hunt 1994, 1995, 1996, 1998a).

The second stage was designed to examine the perceptions and experiences of health care professionals working with POONSs. It comprised case studies at three locations in England (two regional, Southern Regional Hospital and Northern City Children's Hospital, and one district, Westlands District Hospital), consisting of focused, in-depth interviews with a broad cross-section of community and hospital-based health care professionals. These included: senior and junior medical and nursing staff, specialist social workers, general practitioners (GPs), health visitors (HVs) and district nurses (DNs). Sixty-five interviews took place between October 1994 and April 1995. The participants are summarized in Table 1.

The interviewees of both stages of the research were consenting health care professionals, negating any requirement for ethical committee approval. Ethical

Table 1 Interviews conducted at case study sites

Interviewees	Southern Regional Hospital	Westlands District Hospital	Northern City Children's Hospital
Hospital-based staff			
Senior medical staff (consultants/associate fellows)	2 (I)	2 (I)	3 (I)
Junior doctors (SHO/registrar)	1 (G)	1 (I)	1 (I)
Ward sister/OPD sister	1 (G)	1 (I)	3 (I)
Junior staff nurses	1 (G)	1 (G)	1 (G)
Social workers	1 (I)	1 (I)	1 (G)
Community-based staff			
GP (newly diagnosed patients)	5 (I)	4* (I)	4 (I)
GP (terminal care)	4 (I)	3* (I)	4 (I)
HV (depending on age of child)	4 (1G, 3I)	3 (2I, 1G)	1 (I)
DN (depending on disease status of child)	6 (2G, 4I)	3 (I)	6 (I)
Total No. of interviews	25 (19I, 6G)	17* (14I, 2G)	24 (22I, 2G)

* One GP included twice since interviewed both in connection with a newly diagnosed child and a terminally ill child.
I = individual interviews.
G = group interviews (2–4 interviewees).

considerations, however, mean that hospitals and individual participants have been allotted pseudonyms to maintain their anonymity.

Analysis

Issues with analysing qualitative data are not concerned with generalizability or 'sample to population' representativeness but with establishing theoretical links within each case and developing new theories (Brannen 1992, Miles & Huberman 1994). In this study, analysis of the interviews with health care professionals was conducted through the development of a conceptual framework which was generated using a data reduction, display and verification model (Miles & Huberman 1994). Four major themes emerged from within the conceptual framework. These included: teamwork, relationships between POONSs and other nurses, relationships between POONSs and doctors, and specialist knowledge. Only data pertaining to the theme of 'specialist knowledge' are drawn upon in this paper.

CONFERRING SPECIALIST STATUS ON POONSs

Disregarding nursing's professional agenda to ensure that specialist nurses be highly educated and experienced in their field, this study indicates that in general health care professionals confer 'specialist' status to POONSs according to their own experiences and agendas. Perceptions of 'specialist' knowledge appear to be contingent upon the level of experience health care professionals have themselves gained in the speciality in question, the hospital location and the professional background of the POONS/s they work with. When 'specialist' status is conferred to POONSs, 'specialist' knowledge is seen to be derived from a combination of: formal qualifications, hands-on technical skills, previous 'specialist' work experience, in-depth 'medical' knowledge and/or insight into families' dynamics. The relative contribution each of these makes towards constructing a 'specialist', primarily depends upon the regional or district location of POONSs (Figure 1). Different emphasis is placed on each conferred component of specialist knowledge, depending on the agendas of individual health care professionals working with POONSs. Here, examples of two personal agendas are described: (1) 'needs-driven agendas' and (2) 'peer-driven' agendas.

Needs-driven agendas

Some health care professionals who work with POONSs have professional needs, either concerning caring for children with malignant disease, or helping them to pursue their own careers. This has led to the identification of four personal 'needs-driven agendas' which contribute to health care professionals conferring 'specialist' knowledge and status on POONSs: (1) a knowledge gap, (2) resolving anxieties, (3) pursuing 'specialist' nursing careers, and (4) knowing families.

A knowledge gap

Primary health care professionals' experiences of working with children with malignancy, although different, are extremely limited (Halliday 1990, Pinkerton 1993, Hunt 1996, 1998a, 1998b). These limited experiences are epitomized by one GP from this study who said:

> this particular patient was the first one… in general practice. I've not had anyone that's had a terminal illness. Yes, yes, I've not had anyone else.
>
> (GP5, Northern City Children's area)

The personal 'needs-driven agendas' of primary health care professionals relate to these limited experiences — primary health care professionals need to understand how to care for sick children and their families before comprehending the more 'specialist' problems associated with paediatric oncology. In this scenario emphasis is placed on two components of conferred 'specialist' knowledge: hands-on technical skills and 'specialist' work experience (Figure 1). The definition of 'specialist' work experience depends not only on the past experiences of individual primary health care professionals, but also on where the

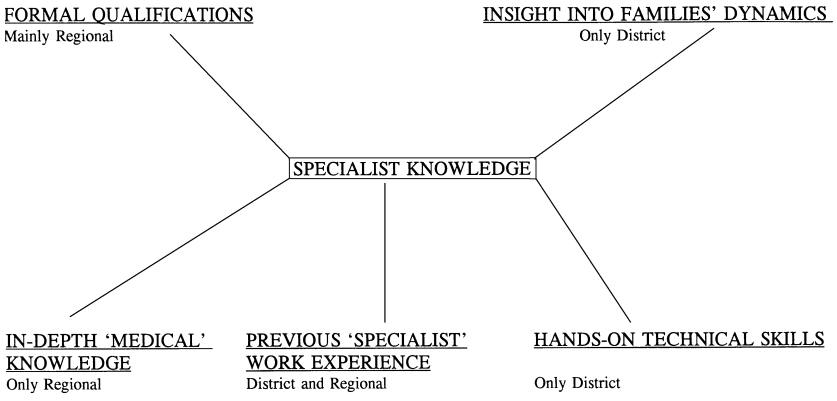

Figure 1 Components of 'specialist' knowledge conferred on POONSs by other health care professionals.

POONS with whom they work is located. At one level, all POONSs achieve 'specialist' status since all have 'specialist' paediatric experience relative to primary health care professionals' needs. As one distinct nurse (DN) suggested: '[POONSs are] used to actually dealing with children' (DN9, Southern Regional area). Hence nursing sick children, irrespective of the disease: 'needs somebody who's got experience of looking after children' (DN2, Northern City area).

At a second level, however, work experience takes on a more 'specialist' perspective. Whilst a basic cognizance of paediatrics was seen as essential by all primary health care professionals, in contrast to those working with a POONS at a district general hospital trust, many primary health care professionals working with regional POONSs considered 'specialist' work practice to be derived specifically from paediatric oncology nursing experience. As one DN involved in the care of a newly diagnosed child commented: 'she's a specialist and I can't possibly keep up with the [cytotoxic] drugs, you know, the current ones' (DN15, Southern Regional area).

Resolving anxieties

A second 'needs-driven agenda' whereby 'specialist' knowledge is conferred on POONSs, concerns resolving anxieties. District nurses, unused to nursing sick children, experience a great deal of anxiety when faced with caring for a child with malignant disease (Hunt 1998a, 1998b). In this situation, anxieties may be resolved through the availability of 'specialists' with hands-on technical skills and previous work experience (Figure 1), which they lack.

For junior staff nurses (SNs) on a general paediatric ward, used to nursing sick children but less familiar with malignant disease, anxiety also arises when caring for children with cancer or leukaemia and their families. The perceived 'specialist' status of POONSs, arising from SNs' anxieties, similarly draws on 'specialist' work experience and hands-on technical skills. It may also draw on formal training. 'Specialist' knowledge as identified by SNs is epitomized thus:

> I wouldn't be able to cope with the bereavement side of things — I just feel very inadequate and I'd need a lot of training in that direction I think, with parents, with knowing what to say and then saying it.
>
> (SN8, Westlands District Hospital)

Hence 'specialist' status is granted to POONSs through the 'needs-driven agendas' of both DNs and SNs at district hospitals, to resolve their anxieties. However, the stresses endured by these two groups of nurses, both inexperienced in paediatric oncology, arise from different baseline perspectives. Whilst DNs and SNs at district general hospitals confer 'specialist' status on POONSs because of their 'specialist' work experience and hands-on nursing skills, their definitions differ. For DNs, these skills pertain to paediatric nursing, whilst the hands-on skills and work experiences demanded by junior SNs at Westlands are specific to the needs of children with malignant disease.

Pursuing 'specialist' nursing careers

A third 'needs-driven agenda' in which 'specialist' status is accorded to POONSs concerns SNs pursuing careers — becoming a POONS is one option which is open to them. Contemplating future career pathways affects all junior SNs similarly, regardless of the environment in which they work; work experience and further formal qualifications assist SNs up the ladder of seniority and to attaining 'specialist' status. 'Specialist' status is conferred upon POONSs according to the perceived deficits in SNs' own knowledge which they would have to rectify before undertaking the work of a POONS (thereby becoming a 'specialist') themselves. It is this perceived need of SNs to rectify shortfalls in their own knowledge before attaining 'specialist' status, which contributes to this 'needs-driven agenda'. However, 'specialist' knowledge is constructed differently according to the environments in which SNs work, the formal training and experiences of the POONS/s they work with and, for those at regional centres, current professional agendas concerning the professional and academic qualifications of CNSs. Furthermore, formal qualifications demanded by SNs to achieve the 'specialist' status of POONSs differ between regional centres and Westlands District Hospital.

Staff nurses at the district hospital overlooked professional agendas which attempt to dictate the formal post-registration training be undertaken to attain 'specialist' status. Instead, reflecting the background of the POONS they worked with and their own working environment, they generally beheld 'specialists' as having extensive work experience and hands-on technical skills. In contrast, in addition to 'specialist' work experience, SNs at regional centres, mindful of the professional demands nursing places upon itself to achieve 'specialist' status, also emphasized the importance of formal post-basic qualifications.

Junior SNs at the district hospital considered that 'specialist knowledge' is gained through extensive work experience following the attainment of the Registered Sick Children's Nurse/Registered Nurse (Part 15 UKCC registration, Child). It comprises 'specialist' hands-on nursing tasks (Figure 1) such as handling central venous access devices and administering intravenous drugs. It may, for a limited number of SNs, comprise formal post-basic training attained through a National Board Certificate in paediatric oncology nursing. One SN commented:

> You've got to have an overall paediatric knowledge… learning and knowing about oncology problems, of treatments…
>
> (SN7 Westlands District Hospital)

In contrast, SNs at regional centres envisaged that 'specialist' knowledge of POONSs comprised both formal

post-basic community nurse training and 'specialist' experience in this field. Taking the premise that formal training and lengthy experience in both paediatrics and oncology is accomplished by all senior nurses working within the field of paediatric oncology, it was the community nursing experience and formal training in this area of work which was seen to separate POONSs from other senior nursing staff:

> You have to have a community qualification to be in the community, I mean that's a criterion to be a community nurse, you can't otherwise do it.
>
> (SN11, Southern Regional Hospital)

Knowing families

POONSs are seen to develop especially close relationships with families (Hunt 1998a, Bignold *et al*. 1994, 1995a, 1995b, Hunt 1998a). This arises through POONSs' abilities to 'boundary hop' between the hospital and the community. However, unique to the paediatric consultants at the district hospital, the in-depth knowledge of families' dynamics brought about through 'befriending' (Bignold *et al*. 1995b) families, is seen as a skill of POONSs to be drawn upon (Figure 1). This gives rise to a fourth 'needs-driven' agenda in which consultants depend upon this knowledge to assist them in making treatment-related decisions about patients. The reasons consultants at Westlands District Hospital depend on this knowledge are unclear, but may lie in consultants' frequent provision of hands-on care to children, both in hospital and at home (Hunt 1998a). In this situation, consultants are reliant on POONSs to teach them specialist technical 'nursing' skills such as accessing central venous access devices. To undertake such tasks requires 'befriending' the child with malignant disease and his/her family in order to gain their trust. Consequently, in this 'needs-driven' agenda, consultants not only confer 'specialist' knowledge on POONSs through POONSs' relationships with families, they also draw upon their 'specialist' hands-on skills.

In summary, in this study 'needs-driven agendas' were derived from four perspectives: knowledge gaps of primary health care professionals, anxieties of some groups of nurses, career pathways of SNs and POONSs' knowledge of families. 'Needs-driven agendas' which drive health care professionals to confer 'specialist' status on POONSs are not only influenced by individuals' experiences and agendas. They differ predominantly according to the hospital location and the background of the POONS/s they work with.

Peer-driven agendas

A second type of personal agenda exists where 'specialist' knowledge is conferred by health care professionals who do not 'need' to draw on POONSs' knowledge. These personal agendas are referred to as 'peer-driven agendas', and two types are discussed here: (1) distinguishing between specialists, and (2) the professional status of POONSs. In the main, these exist for senior, hospital-based health care professionals at regional centres, who, in the absence of POONSs, could (and previously did) provide a skeleton outreach service to children being cared for locally. In this scenario, 'specialist' is denoted by the attributes which distinguish one 'specialist' from another. However, 'peer-driven agendas' also exist for senior medical staff, regardless of their work location, whose concerns include the professional status of POONSs.

Distinguishing between 'specialists'

A major characteristic of 'peer-driven agendas' concerns distinguishing between 'specialists'. This arises from two perspectives: firstly it occurs when senior hospital-based health care professionals at regional centres distinguish the 'specialist' nature of POONSs' work from either their own, or that of other senior hospital staff. Secondly, it transpires when health care professionals across both community and acute hospital settings distinguish the 'specialist' nature of POONSs' knowledge from that of children's community nurses.

Senior health care professionals at regional paediatric oncology centres achieve their own 'specialist' status such that both consultants and sisters develop their own 'specialist' areas of practice, including bone marrow transplantation, long-term follow-up, adolescence and disease-specific areas. In this situation 'specialist' knowledge is constructed amongst peers of POONSs as that which distinguishes the nature of POONSs' work from their own, or that of other senior staff. In the main, 'specialist' knowledge is construed around the backgrounds of both the POONSs they work with and, for some, POONSs at other regional centres (through the professional bodies the Paediatric Oncology Nurses Forum of the RCN and the United kingdom Children's Cancer Study Group, several senior staff at regional centres possess global insight into POONSs' backgrounds); it is reflected in post-basic qualifications and 'specialist' work experience (Figure 1). One sister indicated this by saying:

> The people I've worked with are people who've had a community background and paediatric training plus oncology… to me it appears to work well so therefore I feel that is what they need
>
> (Sister 4, Southern Regional Hospital)

In this 'peer-driven agenda' there is an axiom amongst sisters and consultants that all senior nursing staff have attained previous work experience and formal training in paediatrics and oncology. The formal training and work experience which distinguishes POONSs' 'specialist' knowledge from that of their nursing peers, as suggested above, concerns community nursing work:

I think there is a dimension to care in the community which we who work in hospital don't understand.

(Consultant 5, Northern City Hospital)

Not only is great emphasis placed upon formal training and 'specialist' work experience in community nursing, but this type of agenda uniquely recognizes the importance of POONSs' in-depth, 'specialist', 'medical' knowledge. It is this in-depth 'medical' knowledge which distinguishes the 'specialist' knowledge of POONSs from that of consultants. Here, consultants and sisters alike, overtly recognize that POONSs' 'specialist', 'medical' knowledge lies in symptom management during terminal care which exceeds the knowledge of consultants. One commented:

Nearly always they [POONSs] know more about pain control than the doctors do, they have a much better feel for it… beyond sort of straightforward anti-emetics, you know, they're usually very good on second and third line anti-emetics

(Consultant 7, Southern Regional Hospital)

A second feature of this 'peer-driven agenda' which separated POONSs from other 'specialists', distinguishes between POONSs and children's community nurses. This arises when health care professionals across community and acute hospital sectors have experience working with both groups of outreach nurses (although nationally there is limited availability of childrens' community nursing services (Whiting 1995), the Southern Regional Hospital is located in a region which is particularly well served by children's community nursing teams). Whilst it is formal training and experience in community nursing which stands POONSs apart from hospital-based health care professionals at regional centres, it is community nursing which links POONSs with children's community nurses. However, there are components of conferred 'specialist' knowledge which distinguish POONSs from children's community nurses. The different experiences of primary health care professionals and acute hospital staff mean that professionals across the two health care sectors draw on different components of conferred 'specialist' knowledge to determine the specialist nature of POONSs.

Primary health care professionals predominantly distinguish the 'specialist' nature of POONSs' work from children's community nurses through hands-on technical skills. Whilst they acknowledge that both possess 'specialist' technical skills relative to their own fields, the skills of POONSs are perceived to be more 'specialist' than those of childrens' community nurses. Hospital-based health care professionals on the other hand, distinguish POONSs from children's community nurses because of their formal qualifications, previous 'specialist' work experience and in-depth 'medical' knowledge. One hospital doctor said: '[POONSs] are likely to have had to have done more, longer, specialist training (than children's community nurses)' (SHO 3, Southern Regional Hospital), whilst a consultant commented: 'I don't know how they [children's community nurses] get trained but I assume as part of their training they wouldn't have a lot of emphasis put on how you manage a child dying of cancer at home' (Consultant 6, Southern Regional Hospital). The differences in formal training, specialist work experience and hands-on tasks are confirmed by a children's community nurse interviewed during the course of this study who said:

Nurses in that specialty usually have gone through courses for blood-letting and, you know, the practical things.

(CCN2, Southern Regional area)

The professional status of POONSs

A second 'peer-driven agenda' concerns the professional status of POONSs. This feature of conferred 'specialist' knowledge is predominantly associated with senior hospital doctors who assume a level of responsibility for the professional welfare of POONSs. The reasons why these perceived responsibilities arise are unclear. However, they are particularly developed in consultants who have procured charitable funds to establish POONS services (Hunt 1998a). In this instance, consultants appear to maintain a vested interest in the well-being of POONSs to ensure the success of the service. The concerns for the professional status of POONSs, which steer this 'peer-driven agenda', arise firstly from the perceived 'specialist' knowledge required to establish successful relationships with local communities. Secondly, they exist for district-based consultants concerned that POONSs maintain professional credibility through sustaining 'specialist' knowledge.

Regional consultants, concerned for the professional status of POONSs, are troubled by relationships between POONSs and local communities. In this scenario, professional status is assumed by consultants to be gained through credibility with community nurses. This is achieved through POONSs accomplishing community nursing qualifications. Here, it is anticipated that POONSs require a community nursing qualification to make them: 'more acceptable to the local people' (Consultant 6, Southern Regional Hospital) and 'to the local paediatric teams' (Consultant 7, Southern Regional Hospital). Credibility as a 'specialist' is then established when, it is perceived, the post-basic qualifications of POONSs both match and exceed those of community nurses. In this agenda great value is placed on post-basic formal qualifications (Figure 1).

Concerns for the professional status of a district hospital-based POONS, by consultants, take a different form. Here, sustaining and up-dating knowledge is required in order to establish credibility amongst hospital-based health care professionals, thereby maintaining a 'specialist' status. In the main, this concerns keeping up-to-date with hands-on technical skills. When it is perceived that hands-on skills are kept up-to-date, professional

credibility, 'specialist' and consequently professional status is maintained. As one consultant commented: 'she's very good at going off and going into all the sessions and so forth' (Consultant 2, Westlands District Hospital).

CONCLUSION

Reflecting on the continuing confusion surrounding 'specialist' nurses, this paper has argued that health care professionals' perceptions of 'specialists' are subjective, being grounded in their personal experiences of, in this instance, childhood malignancy and the hospital locations and individual backgrounds of the POONS/s they work with. Disregarding nursing's professional agenda in which 'specialist' nurses are expected to attain a high degree of post-basic education, health care professionals generally confer specialist status on anyone they perceive as more experienced or 'specialized' than themselves. These perceptions and experiences have given rise to two personal agendas which have been termed 'needs-driven agendas' and 'peer-driven agendas'. 'Needs-driven agendas' comprise: POONSs' abilities to fill a knowledge gap, resolving anxieties, pursuing 'specialist' nursing careers and knowing families. 'Peer-driven agendas' are drawn from the distinctions regional senior hospital staff make between POONSs and other oncology 'specialists' and from differentiations between POONSs and childrens' community nurses. Secondly, they are derived from senior hospital doctors' concerns about the professional status of POONSs.

Both 'needs-driven' and 'peer-driven' agendas have drawn upon formal qualifications, hands-on technical skills, 'specialist' work experience, in-depth medical knowledge and/or insight into families' dynamics (Figure 1). The relative contribution which each of these 'knowledge' components makes to conferring specialist status on POONSs is primarily dependent upon the regional or district work location of POONSs. In the main these concern distinctions between 'specialist' paediatric experience and education, and 'specialist' paediatric oncology and community nursing experience and education. These factors contribute to the adoption and adoption of George Orwell's (1945 p. 114) slogan that: 'All nurse specialists are specialists, some nurse specialists are more specialist than others'.

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