

## 9.6 The changing healthcare landscape

The implementation of the diabetes specialist nurse (DSN) in shared care was one of the first examples in the Netherlands of the handover of tasks from medical professionals to nurses. In recent years, a number of functions within the nursing profession have been developed to advance that policy. In particular, practice nurses (PNs) [50, 51] and nurse practitioners (ANPs) [52, 53] have been introduced in the care for chronically ill people. PNs are either nurses with a bachelor's degree or practice assistants who work for family physicians. Their tasks in primary diabetes care are to carry out the three-monthly follow-ups and yearly health checks, assess patients who have not been seen by the physician, prescribe and/or change the insulin dosage, regulate the glucose and cholesterol levels as well as blood pressure, and cooperate with the DSN [50]. ANPs have a master's degree in advanced nursing practice and work in primary and hospital settings [53], with an expanded scope of duties that include diagnosing, prescribing medications and treating medical conditions within specific settings [54]. Because there is substantial overlap of tasks between the DSN, PN and ANP, our model is especially useful for the three professions in supporting patient autonomy. In addition, PNs and ANPs are employed in the family physician context, which enables them to develop long-term relationships with chronically ill patients and understand patients' social context, which in turn is important in supporting patient autonomy.

Another aspect of a changing healthcare landscape is that people with chronic conditions increasingly use the internet for health purposes [55]. In the Netherlands several sites have been launched for chronically ill people in general and people with diabetes in particular. The Diagnostics Association of the Netherlands [56], for example, focuses on tests for the prevention, diagnosis, prognosis and treatment of all kinds of conditions. It offers a special diabetes mellitus subsection with information on self-monitoring of glucose parameters. Another website is the Diabetes Interactive Education Programme [57], whose key goal is to provide diabetes education to increase self-management. Features of its educational material are background information as well as information on hyper- and hypoglycaemia, lifestyle, treatment, management and self-monitoring, and useful addresses and links. Many aspects are

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supported by spoken fragments from fellow patients. Clearly, e-health services are becoming increasingly available to supplement patient autonomy in general and self-management in particular.

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## 9.7 Theory testing and development

Today, more and more nursing scientists are developing theories within the qualitative paradigm. Polit and Beck [58] propose the following steps for theory testing: Researchers use a particular theory as guiding framework. They deduce propositions and develop research hypotheses, which are predictions about how certain variables would be interrelated if the theory were correct. The hypotheses are subjected to empirical testing, which involves comparing observed outcomes and those predicted by the hypothesis. If studies repeatedly fail to disconfirm the theory, it gains support and acceptance [58]. In nursing, it is customary to associate theory testing with quantitative methods [22, 23, 59, 60], though qualitative methods may also be suitable, [61, 62]. The goal is not primarily to test the theory for measureable outcomes or for generalisation to a wide population, but to systematically evaluate the theory [63] and develop it further [7]. Strauss and Corbin [7] state that “If one is interested in extending an already existing theory, then one might begin with the existing theory and attempt to uncover how it applies to new and varied situations, as differentiated from those situations to which it was originally applied” (p. 51). In line with this, researchers who want to develop our theory further might apply the general framework of competency in shaping one’s life to various situations and contexts. These might be illness specific, such as diabetes mellitus type 1, chronic heart and lung problems, chronic neurological and functional difficulties, etc. Alternatively, they might be contexts where patients interact with healthcare professionals, such as DSN and specialist nurses in other settings, nurse practitioners, practice nurses, health visitors, nursing and medical professionals working inside and outside the hospital, and so on. Other situations might involve patient autonomy within family relationships or professional–patient–family relationships. Our theory then provides a set of sensitizing concepts and relationships [7] which researchers might verify against their own data. With the findings of subsequent studies, our theory can be amended, added to or modified to fit those particular situations [7]. It is imperative that these subsequent findings support *meaning-in-context* [63] in relation to the theoretical ideas of competency in shaping one’s life. However, we suggest that the research questions relating to this competency should determine the appropriate research design.

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## 9.8 Some thoughts on method

In Chapter 7 we discussed the use of literature as data in grounded theory. We now want to elaborate on the presentation of literature in grounded theory articles. This dissertation began with the literature overview, which at first glance may seem at odds with the principles of grounded theory. However, Strauss and Corbin [7] state that researchers doing grounded theory studies read and use published literature during all phases of the project. While the authors do not specify the structure and organisation of grounded theory manuscripts, they do provide a broad rhetorical structure and writing parameters, and their approach involves the literature being part of all sections of a manuscript (i.e. the introduction, findings and discussion). In recent grounded theory studies in various nursing journals, however, the literature is organized in the introduction. This may be because most journals only accept grounded theory manuscripts written according to the traditional structure. Most chapters in this dissertation were published in such journals. For this reason, and because we wanted the presentation of this dissertation to remain consistent, we therefore we opted for the traditional organization and structure. The sequence of chapters does not exactly mirror the process of the literature reviews, partly due to the publication lag and iterative nature of grounded theory analysis. We performed an initial but not exhaustive literature review to write the proposal and to meet the requirements for ethical approval. During and after the principal data collection and analysis, we turned to the literature again, reviewing the theoretical and empirical literature on patient autonomy (Chapter 3). Because this led us to perceive the need to elaborate on the literature in depth, we decided to write a separate publication (Chapter 2). Subsequently, we worked out the various dimensions and again turned to the literature, this time related to the processes of realizing autonomy in relation to each specific dimension (chapters 4–8). Finally, at the end of the study we used the literature to link existing theoretical and empirical findings to the model as a whole (Chapter 9). Although we organized the dissertation in the traditional style, therefore, we remained loyal to the use of the literature in grounded theory as advocated by Strauss and Corbin.

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