Family Relationships, Roles and the Meaning of Active Aging among Rural Northeastern Thai Elders

Walaiporn Nantsupawat, Peerasit Kamnuansilapa, Wanapa Sritanyarat, Supawatanakorn Wongthanawasu

Abstract : This ethnographic study sought to explore family relationships, roles and the meaning of active aging among rural Northeastern Thai elders. Study participants consisted of 58 elderly informants and 45 family members from 44 different family structures. Data were collected through participant observation and in-depth interviews, and analyzed via latent content analysis. Results revealed four types of family relationships (one-generation, two-generation, three-generation and four-generation living patterns) and two major roles (earning a living and instructing children/grandchildren). Active aging meant elders made contributions and achieved happiness by doing things beneficial for themselves, family and society. Within active aging, eight ways of life were noted (working; looking after grandchildren/great grandchildren; getting loans; participating in social life; visits from descendants; children's gratitude; health; and, pre-death preparations). Positive circumstances resulting from elders' active aging included: having economic stability; good health; and, having children who were grateful to them in times of independence, as well as dependence. One and two-generation family patterns were found not to promote active aging, resulting in elders not feeling secure that someone would care for them in the future. However, three and four-generation family patterns were found to promote active aging, resulting in elders feeling secure that someone would care for them now and in the future.

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Background and Significance

Over the past two decades the global population has been transformed via technological and social changes that have brought declines in birth and death rates around the world.[1, 2] Thus, the world is now undergoing a rapid process of population aging, a decline in the proportion of children and young people, and an increase in the number of people 60 years of age and older.[2]

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Thailand, like many other countries, currently is experiencing a rapid growth in its aged population. Projections are that the proportion of elders in Thailand will rise to 15 percent by 2020, at which time they will number more than 7 million.[3] The increased number of elderly, in Thailand, will have an impact on the country's socio-economic development. The most immediate concern is the increasing demand for, and strain on, health care services due to a rise in the incidences of age-related acute and chronic diseases.[4] In addition, there will be an escalation in the demand for health care and social security benefits, creating an unavoidable strain on national budget appropriations for other social services.

Old age, traditionally, has been associated with inactivity, disengagement through retirement and illness, and subsequent dependency.[2] Such negative images, however, reflect an old paradigm of population aging that highlights the need for increased resource allocations for the elderly. The new paradigm sees elders as a group of experienced individuals who have potential for contributing to society, and are independent or self-reliant. Viewing older persons as contributors to society, rather than as burdens, is part of the concept of "active aging."[2]

The World Health Organization (WHO) defines "active aging" as the process of optimizing opportunities for health, participation and security in order to enhance people's quality of life as they age.[2] Active aging is accepted as a global approach toward helping older individuals achieve healthy, productive, safe and fulfilling lifestyles, as well as independence,[5, 6] and requires action on three basic fronts: health, participation and security. Through active aging, functional capacity can be maintained in the elderly, with families and communities providing the necessary support.[2] Thailand has been well aware of the importance families play, as evidenced in its Social and Economic Development Plan-number 10 (2007-2011), which proposes advancement of the nation for survival, under globalization, by building family integrity and good relationships.[7]

From a sociological perspective, the family has long been viewed as the primary social unit. It is generally held that a person can encounter difficulties with appropriate development when a functional family is absent.[8] A family is viewed as a social system that carries out functions which serve individuals. Five essential basic functions have been identified for a family to survive as a healthy unit, including: affection, socialization and social placement, reproduction, economics and health-care.[9] In order to meet these basic functions, individual family members take on specific roles. Family roles refer to "the recurrent patterns of behavior by which individuals fulfill family functions and needs."[10 (p. 1)] Therefore, family roles play an important part in maintaining healthy family functioning. While active aging is the new paradigm for managing the elderly population, little is known, especially in rural areas where most Thai elders reside,[11,12] about how to put the concept into action as it relates to family structure and social policy development. Therefore, the purpose of this study was to explore family relationships, roles and the meaning of active aging among rural Northeastern Thai elders.

Method

Design and Setting: The study employed an ethnographic design and was conducted in a rural northeastern Thai village of the Khon Kaen province. For the purpose of this study, rural referred to an area outside a municipality. The village and province were purposively selected because they represented the general characteristics of rural areas throughout the northeastern section of Thailand.

Human Rights Protection: The study was approved by the Human Subjects Committee of

Khon Kaen University, Thailand, and the leader of the village where data were collected. The number of village households, as well as the names of village elders and their family members were obtained from the village leader. To facilitate the primary investigator's (PI) access to the village households, the village leader introduced her to the villagers by way of a local radio phone announcement. The PI then went door to door to meet and ask potential participants to voluntarily take part in the study. Each potential participant was informed about the: purpose and nature of the study; maintenance of confidentiality and anonymity; and, his/her right to withdraw from the study, at any time, without repercussions. Written or oral consent was received from each consenting participant. Oral consent was obtained when a potential participant was fearful about signing a consent form.

Participants: The sample consisted of 58 elders, who served as key informants, and 45 family members, who served as general informants. The key and general informants were from a total of 44 families, and spoke the Northeastern Thai dialect or Isan language. Inclusion criteria for key informants included being: 60 years of age or older; able to verbally communicate; and, willing to participate. Inclusion criteria for general informants included being: a family member of the elder who had consented to be in the study; able to verbally communicate; and, willing to participate.

The key informants (elders), included 32 women and 26 men who were 60 to 89 years of age (mean = 68.94 years). The vast majority (83% ; n = 48) were considered young-old (60-74 years), while 14 % (n = 8) were considered middle-old (75-84 years) and 3% (n = 2) were considered old-old (85 years and over). Thirty-two of them were female, and 26 were male. The general informants (family members) were 6 to 59 years of age (mean = 29.60 years), and included six wives, 20 children (14 females, 6 males),18 grandchildren (10 females, 8 males), and one male great-grandchild.

Procedure: The PI served as the sole data collector, since she: was born in Khon Kaen; had been living, since birth, in the Northeastern village used for data collection; was fluent in the Isan language; and, had ten years of experience in working with elders prior to data gathering. Data collection was organized into three phases: field preparation, data collection and exit from the village.

Field preparation involved the PI introducing herself to the: leader of the village, head temple monk, housewives' group and people of the village. To establish rapport among the villagers, the PI participated, as a member of the village, in activities such as making Bai Sri trays (banana leaves, decorated with fresh flowers) for the Bai Sri Su Kwan ceremony,[23] with the housewives' group, and making merit at the local temple.

Data collection involved participant observation and in-depth interviews with key and general informants. In order to gain a full and complete perspective of what was occurring during participant observation and the interview process,[13] a tape recorder, field notes, camera and a genogram,[14] a conceptual tool for drawing a family tree that records information about family members and portrays their relationships, were used to capture data. Participant observation of informants took place in temples, health centers, grocery stores, rice fields, festivals and funeral ceremonies. In-depth interviews of key and general informants took place in their respective homes, and ranged in length from 30 to 60 minutes per session. Key informants were interviewed between one and five times regarding active aging, their role within the family structure and relationships among family members. General informants were interviewed one to three times regarding the role of the elder within the family structure and relationships among family members. A researcher-constructed interview guide was used

in the interview process for both types of informants. Examples of interview questions, for both key and general informants, that focused on the family roles of elders and relationships among family members included: "How many people are there in your households, and who are they? "What does each family member do?" and, "What roles do elders play within the family structure?" Examples of interview questions, posed only to the elders that addressed active aging included: "What do you do in your daily life?" How do you feel about life?" "What does health mean to you?" and, "How do you make yourself health?"

Exit from the village took place when no new information emerged during data collection, and validity and trustworthiness of the data were verified with select informants. The PI then notified the leader of the village she had completed her research activities.

Rigor of the Study: Rigor, which is integral to qualitative inquiry, is composed of internal validity and external validity.[15] Internal validity, in this study, was supported by the data. To present external validity, thick descriptions of findings were written. Three members of the research team provided peer review with subsequent approval of the interpretation of the findings. The playback method from people in the village was used in order to evaluate the validity and trustworthiness of the data analysis results.[16]

Data Analysis: Latent content analysis was chosen as the method of analysis. Unlike manifest content analysis, which tallies and generates statistics on specific words or ideas expressed, latent content analysis uses qualitative inquiry, which is composed of the process of identifying, coding and categorizing primary patterns in data.[15] The meaning of the patterns then are determined within the context of the entire data set.

Results

Family Relationships: Genograms were used to describe the family relationships among participants. The findings revealed four types of living patterns (One, two, three and four generations) based on the number of generations residing within a single household.

One-generation living patterns: There were nine households of one-generation families, which consisted of three different types of living arrangements. The first arrangement involved an elderly male who lived alone, while the second consisted of an elder living with an older or younger brother or sister. The third arrangement involved an elderly husband and wife living together.

Two-generation living pattern: There were fifteen households of two-generation families that presented two types of living arrangements. The first type involved four families that consisted of adult children living with their elderly parents. The second type involved 11 families where paternal and maternal grandfathers/grandmothers lived with grandchildren and/or great-grandchildren. The children in these families were of varying ages, as reflected by their attendance at pre-school, kindergarten, primary school or secondary school. The elders, in these families, played the role of parent, as evidenced by the use of the term, "mother", when referring to a grandmother.

Three-generation living pattern: Seventeen households were made up of three-generation families. The three generation living pattern consisted of paternal and maternal grandparents, daughters and sons-in-law, and grandchildren. The elders, in each of these families, lived with their daughter. Traditionally, in Thailand, when a daughter marries, she and her husband live with or in close proximity to her parents. This arrangement requires the daughter to look after her parents. The youngest

daughter of a family usually is expected to assume the greatest amount of responsibility for parents, compared to the other daughters, except when the youngest daughter is unable to do so. In the three-generation living pattern, the elders did not shoulder the major responsibility of looking after grandchildren or working to earn a living. They simply provided supplemental assistance to their adult daughter and her husband.

Four-generation living pattern: Three households of four-generation families included elderly parents and their children, grand-children and great-grandchildren. The relationships and activities among the four generations living together were similar to those of the three-generation families.

Family Roles: The elder informants had two major roles: earning a living, and instructing children and grandchildren. Details about each category, with illustrative quotes to support their existence, are presented below.

Earning a living: Rice farming or wage laboring were the ways elders earned a living. Since they had no other means of support, earning a living was required in order for elders to survive. Since rice farming relies on occurrences in nature (sufficient rainfall), productivity was not always possible. Thus, when the farmer had an unproductive crop indebtedness often resulted. The informants' statements included:

> "Rice farming is not successful because of drought. Many children are in school. I discussed selling farmland with my husband, but he did not agree, saying that if I want to sell the farmland, let him die first. After that, he went to live somewhere else. He no longer stays with me. I mortgaged the paddy field and had money to pay for the children's schooling." (Female-60)

> "If somebody hires me to do any kind of job, I will go do it, no matter what it is, fence-making or house-building. My son asked me to stop. I told him, I can't stop. I am used to doing it." (Male-62)

Teaching children and grandchildren: Teaching was the process by which older family members informed younger family members about what to do and what to avoid. Discussions varied according to the family member's age and stage of development. The process by which teaching was conducted was diverse, and included such methods as assigning and demonstrating certain tasks, and providing examples about life activities. The focus of the teaching revolved around the topics of: learning to work; health practices; good study habits; and, good behavior. Examples of elder and family members' statements included:

Learning to work:

> "In the beginning, I let the children work on rice growing. After they came home from school, I let them look after cattle, taught them how to cook some things, such as sticky rice and some dishes. If they cannot do it, I would do it for them. I taught them one by one to wash clothes according to their age, until they could do it well." (Female-72)

> "I told grandchildren to be diligent, not lazy, so that they would have enough to eat." (Female-72)

Health practices:

> "My grandmother taught me "Don't go swimming at the weir and big pond because you will get sick and drown." (Male-6)

"I forbid my children to drink too much. If they drink too much they can't control themselves, and will quarrel and have fights with others. I am afraid that they will die, and that others will die. If somebody dies, it will cost money or lead to a jail sentence." (Male-70)

Good study habits:

"I tell grandchildren to study hard, don't be lazy. Effort is everything. Where there is effort, there is success. Reading for a long time will help one pass the exams. If you're lazy, you'll have to work on rice farms. I want my grandchildren to have happiness, to be able to sit and work indoors with ease and money." (Male-72)

"I taught my son not to get involved in drugs or alcohol. Stay away from them. If you get involved in drugs, you will not be able to finish your studies." (Female-63)

Good behavior:

"I teach grandchildren to look after their parents. The favor (bun khun) performed by parents is too great to ever be repaid in full. You see, if there are no parents, you cannot be born. Parents are the children's saints (arahants) so the children must compensate them." (Female-72)

"I teach my grandchildren not to behave inappropriately. Don't do what will cause trouble for your parents. Don't start quarrels or fights." (Male-76)

Meaning of Active Aging: Based upon field notes, participant observations, and interviews with elders, active aging was reflected in the presence of diverse ways of life. The ways of life, which addressed movement from self-reliance to dependence on others, were found to involve happiness and suffering, and to vary according to the specific elder's individual experiences, environment, thoughts, beliefs, economics and health. Ways of life could be placed into eight categories: working; looking after grandchildren and great-grandchildren; getting loans; participating in social life; visits by descendants; children's gratitude; health; and, pre-death preparations.

Ways of life reflected the meaning the elders held about active aging. It was noted the elders often depended on themselves for survival, and were considered a source of contribution for both the families and society at large. Such feelings were demonstrated in the following informants' comments, which reflected the eight categories of the elder's ways of life.

Working:

"I earn my own living; I don't expect to have to depend on children." (Female-69)

"I help my daughter work the farmland every year. My son-in-law has gone to work abroad. There is no one else to help, and I also can do it." (Male-80)

Looking after grandchildren and great-grandchildren:

"I help my daughter sell goods, take my grandchild to my son's house at the edge of village, and swing the cradle for my grandchild to take a nap in the daytime." (Female-72)

"Great-grandma said to me, 'Don't go swimming at the weir and big pond, if you do you will get sick and drown.' She did not allow me to play far away for fear that a stranger would cause me to hurt my eyes or lose a limb." (Male-6)

Getting a loan:

"I owe the BAAC (the Bank of Agriculture and Agricultural Cooperatives) 60,000 baht: 10,000 baht which was spent; 50,000 baht for buying cattle to sell, and for buying a motor cart for my daughter to be able to buy and sell recycled solid wastes." (Male-69)

"I owe the BAAC 40,000 baht, which I borrowed for my daughter to clear debts she had from sending her husband abroad. He went abroad for three months and died in his sleep."(Male-77)

Participating in social life:

"I go to the monastery every day. I have been observing the precepts since I was a little over 40. I bring the morning meal and the pre-noon meal to the monastery. I always have faith in going to the wat (temple). My mother told me not to fail to bring both for the morning and pre-noon meals. Going to the wat earns me a great reward (anisong)." (Female-72)

"I have been the Vaiyavacchakorn (abbot's lay assistant) from 1972 until present. I am proud and happy." (Male-70)

Visits from descendents:

"Today my children and grandchildren came to visit me to perform the rod nam (in Songkran Day). I tied the cotton thread around their wrists and gave blessings to everyone." (Female-89)

"The male elder is repairing the roof of the house for the children, while his wife is cooking khi lek curry, saying that her daughter bought young khi lek leaves for her. When she finished making the curry, she called the daughter and grandson, along with the researcher, to have lunch together." (Field Note).

Children's gratitude:

"In the past, I was very poor and had to work hard doing all kinds of wage labor, such as cutting sugar cane and rice farming, so I could get money to bring up my children. Now I am relaxed and happy. The children bring me money and presents, making me happy." (Female-73)

"I suffer from renal failure and knee pain. My children take me to see the doctor. Now I am happy because I don't need to do anything. My children provide me with everything I want to eat. All of them are good me. I can sleep when I want to." (Female-84)

Health:

"In the past 20 years I've never gotten sick. I take care of myself by drinking Lactasoy, Vitamilk, M 150 and by doing aerobic exercises, liking bicycling." (Male-80)

"Formerly, I drank alcohol with others when there was a festival. I have stopped totally for fear that it will cause leg pain and I am afraid it will be dangerous to my asthma" (Male-77)

Pre-death preparations:

"I have a jhapanakich (funeral) policy with BAAC, so that when I die my children will have money to invest. When I die, I only want to have monks invited to preach and to pay for good food to entertain friends and relatives. I do not want movies or a molamn (Isan folk dance), which I don't like because the youth become rowdy. In particular, the molam has to be paid a large sum of money, and the jhapanakich fund is not much." (Female-67)

It was noted that the elders, generally, were happy and proud of their life situations. The positive circumstances leading to their state of active aging included their good health and their children's gratitude, as demonstrated in the following comments:

"This life is happy, there is nothing to worry about, no debt. I'm able to eat whatever I want. I have good health, no leg pain. I'm able to walk ten kilometers without fatigue or hunger, and I sleep well." (Male-80)

"I suffer from renal failure and knee pain. My children take me to see the doctor. Now I'm happy because my children provide me with everything I want to eat. All of them are good men." (Female-84)

The state of active aging for elders was found to involve a sense of usefulness to self, family and society. In addition, this process brought them happiness.

The elders' active aging process resulted from their success in playing the roles of earning a living and teaching their children/grandchildren. This was found to be particularly true of elders from three- and four-generation family living patterns. The elders from these family living patterns indicated a sense of security that someone would take care of them in the future. As the elderly informants indicated:

"I am happy because of my good deeds, teaching and looking after my children. In return, they come to look after me" (Female-72).

"Formerly, I was engaged in cattle trading. I told myself to accumulate cattle and land for my children and taught them how to earn a living. When they were grown up and able to stand on their own feet, I hope to rely on my children. Now, I am happy because I feel relaxed; there is no need to work hard. My children work. I guide them when they need it." (Male-80)

However, one-generation and two-generation families did not promote the same level of active aging. In these situations the elders, despite their ability to make contributions, felt burdened and unhappy because they did not have the security of knowing that someone would take care of them in the future. Often they solely were responsible for raising their grand or great-grandchildren, providing financial support for their adult children, or simply having to survive on their own, without the help of family members. These circumstances are reflected in the following comments:

"The two (husband and wife) of us live together. We try to stay healthy since nobody will look after us when we are sick. All our children live far away" (Male-62).

"When my grandchildren are all grown up, I will be happy, physically and mentally. I don't think it is fun to look after my grandchildren. Truly, it is very stressful. My children work far away." (Female-67)

Discussion

Family Relationships: The findings suggest that elders living in one-and two-generation family patterns did not, to a great extent, have support for active aging. Since some of them had to depend sole upon themselves, they had to earn a living, except for those who had health problems (whom the children looked after). The elders, who had to take on the role of parent, felt dissatisfied because raising young children created a burden for them.

The three-and four-generation family patterns, by contrast, appeared to be supportive of active aging. When the elders were unable to make a sufficient living, due to health problems or a decline in energy, they were looked after by their children. As a result, they had a strong sense of security. These findings are similar to those of Hornboonherm and colleagues,[20] who demonstrated an association between close family relationships, in the three-generation families, and elders' sense of well-being.

Roles: The elders, in this study, were found to have two major roles: earning a living, and teaching children and grandchildren. Earning a living was necessary in order for the elders to survive. In some cases, it was difficult to earn a living when the source of income was rice farming, since the results of farming can be unpredictable because of the forces of nature (i.e. rainfall). When income was inadequate, it caused stress for the elders.

The focus of some of the elders' teachings revolved around the topics: learning to work; health practices; good study habits; and, good behavior. These findings are similar to the work of Nanthamongkolchai, Nieamsup, and Chaumpluk,[21] who found parents expect their children to be good people, obey the rules, be serious about their education and do good deeds. In addition, the content of some of the elders' teachings (good behavior and the gratitude expressed by some of the children toward their parents) were similar to Kespichayawattana's[22] research findings on the expressed gratitude of children involving the care of aged parents. According to Buddhist teachings, children are suppose to look after their parents when they are aged.[23] Practicing *katanyu katawethi* (gratitude) is considered an important aspect of the Thai Buddhist culture.[24]

Meaning of Active Aging: The meaning of active aging, described by the elders had similarities to the WHO's description of the process of active aging, but dissimilarities with the outcome. According to the WHO, the process of active aging involves optimizing opportunities for health, participation and security when one gets older.[2] In this study, the process of active aging involved elders' making contributions (i.e. getting loans, participating in social life, maintaining their health and planning pre-death preparations), which affected not only them, but their families and society in general. However, unlike WHO's description of the outcome of active aging (ability to control, cope with and make decisions about life, and have independence to perform functions for daily living),[2] in this study, outcome was the support, security (i.e. financial and

care) and expressed gratitude elders received from their children. Prior findings have been similar to those found in this study, wherein elders: made contributions;[17] believed it what was important to maintain health and be able to work;[18] and, viewed aging as having bio-psychosocial aspects. In addition, as also noted in Rattakorn's[19] study regarding "successful aging," elders involved in active aging made contributions to others and society, and had a vested interest in the success of their children/grandchildren.

Limitations and Recommendations for Future Research

Like all studies, this study has limitations. It was conducted only on elders in a rural village located in one province in northeastern Thailand. Thus, the findings are applicable only to the elder members of the village used in the study. In addition, because the data were obtained via interview, one has to assume the information provided by respondents was truthful and comprehensive. One also has to be concerned that the participants may have been telling the PI what they thought she wanted to hear, since she was from the rural village used in the study.

It would be important for future research to conduct studies that: utilize multiple rural geographic areas throughout Thailand; identify the process and outcome of active aging from early life until old age; promote active aging, by way of action research, through the various identified elder roles; and, address family relationships, roles and the meaning of active aging of elders living in urban areas.

Conclusions

The findings of this study provide new information on family relationships, roles and the meaning of active aging among elders who resided in a rural village located in one province in northeastern Thailand. The findings could prove helpful, to health care providers and regional policy makers, regarding the: burdens elderly face when living in one and two-generation family structures; importance of effective elder role implementation; and, meaning of the process and outcome of active aging to rural northeastern elderly Thais.

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ความสัมพันธ์ของครอบครัว บทบาทและความหมายของพฤฒพลังในผู้สูงอายุไทยชนบทภาคตะวันออกเฉียงเหนือ

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บทคัดย่อ: การวิจัยเชิงคุณภาพแบบชาติพันธุ์วรรณนานี้ มีวัตถุประสงค์เพื่อ ค้นหาความสัมพันธ์ของครอบครัว บทบาท และความหมายของพฤฒพลังในผู้สูงอายุไทยชนบทภาคตะวันออกเฉียงเหนือ ผู้เข้าร่วมวิจัยประกอบด้วยผู้ให้ข้อมูล ได้แก่ผู้สูงอายุ 58 คน และสมาชิกของครอบครัว 45 คน จาก 44 ครอบครัว เก็บรวบรวมข้อมูล โดยการสังเกตแบบมีส่วนร่วม และการสัมภาษณ์เชิงลึก วิเคราะห์ข้อมูลเชิงคุณภาพ โดยการวิเคราะห์เชิงเนื้อหา ผลการศึกษาพบความสัมพันธ์ของครอบครัวมี 4 แบบ ได้แก่ ครอบครัวอยู่ร่วมกันแบบหนึ่งรุ่นวัย แบบสองรุ่นวัย แบบสามรุ่นวัย และแบบสี่รุ่นวัย **และฉากชีวิต**ของผู้สูงอายุ มี 8 ด้าน คือ เฮ็ดเวียกเฮ็ดงาน เลี้ยงหลานเลี้ยงเหลน กู้หนี้ยืมสิน เข้าสังคม ลูกหลานมาเยี่ยมมายาม ลูกกตัญญู สุขภาพ และเตรียมตัวก่อนตาย **ด้านบทบาทของผู้สูงอายุ** พบว่า มีบทบาทหลักในการทำมาหาเลี้ยงชีพ และการอบรมสั่งสอนลูกหลาน **พฤฒพลังของผู้สูงอายุ** หมายถึง การยังประโยชน์ของผู้สูงอายุอย่างเป็นสุข โดยผู้สูงอายุมีการกระทำที่สามารถเกิดประโยชน์ ต่อตนเอง ครอบครัว และต่อสังคม เงื่อนไขทางบวก ที่ก่อให้เกิดพฤฒพลังของผู้สูงอายุ ได้แก่ ผู้สูงอายุมีฐานะทางเศรษฐกิจที่มั่นคง สุขภาพดี มีลูกที่ดีและกตัญญูต่อผู้สูงอายุ แม้ในระยะที่ผู้สูงอายุสามารถทำงานพึ่งตนเองได้ หรือแม้ในระยะพึ่งพา ครอบครัวแบบหนึ่งและสองรุ่นวัย ไม่ส่งเสริมให้เกิดพฤฒพลัง เนื่องจากผู้สูงอายุรู้สึกขาดหลักประกันด้านผู้ดูแลในอนาคต ส่วนครอบครัวแบบสามและสี่รุ่นวัย พบว่าส่งเสริมให้เกิดพฤฒพลังได้ เพราะผู้สูงอายุรู้สึกมีหลักประกันด้านผู้ดูแลในอนาคต

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Role Development of Advanced Practice Nurses in Thailand

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Abstract: Advanced practice nurse (APN), a relatively new form of certification for nurses in Thailand, was approved, in 2003, by the Thailand Nursing and Midwifery Council (TNMC). Since inception of the APN role, in Thailand, study of its development has not been undertaken. The purpose of this study, therefore, was to explore, through use of a two-phase sequential mixed method design, role development of APNs in Thailand. The first phase employed a quantitative method, using self-reported questionnaires, to survey 154 APNs who had been certified, between 2003 and 2005, by the TNMC. The second phase utilized a qualitative method to seek information from 13 participants through use of in-depth interviews, non-participant observation, field notes and document review. Data were analyzed via descriptive statistics and content analysis.

Findings from the first phase revealed APN performance was high within the roles of direct clinical care, educator, consultant, administrator and researcher, while performance within the role of ethicist/legalist was moderate. Results from the second phase revealed APN role development was comprised of three stages: advanced beginner, competent practitioner and expert. The major facilitating factors of APN role development were found to be: a) organizational (healthcare system and organizational policies); b) human (quality nurse administrators and well-functioning multidisciplinary teams) and c) resources (financial assistance). The greatest barriers in role development were the: a) organizational factor of poor administrative functioning (lack of a clearly delineated organizational structure and unclear organizational policies); b) human factor of poor administrative support for advanced practice nursing (work assignments not reflective of advanced practice nursing and uncooperative behavior by members of multidisciplinary teams); and, c) resource factor of a nursing shortage (work assignments in non-advanced practice situations).

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Introduction

Advanced practice nurse (APN), a relatively new form of certification for nurses in Thailand, was approved, in 2003, by the Thailand Nursing and Midwifery Council (TNMC). The certification process for APNs has taken place yearly, with approximately 10 percent of Thai nurses designated as being engaged in advanced practice.[1] The approach used for development

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of Thai APNs has been based upon the American model[2] and initially evolved within five specialty areas: maternal/newborn, pediatrics, medical/surgical, mental health/psychiatric and community health. Gerontology was added to the list of APN specialties in 2005.

The main concepts which differentiate advanced nursing practice from general nursing practice are specialization, expansion and advancement.[2,3,4] Specialization involves in-depth knowledge and skills in a specific area of advanced practice nursing (i.e. clinical nurse specialist, nurse practitioner, nurse midwife or nurse anesthetist), while expansion refers to a commitment to life-long learning, and the acquisition of new knowledge, skills and competencies. Advancement addresses both specialization and expansion, and results in the integration of theory, new skills and competencies in order to respond to the needs of patients/families and the evolving healthcare system.

Because of the level of care provided, APNs are expected to respond to the holistic health care needs ascribed by the Thailand Health System Reform Policy, which mandates, at all levels of health care, emphasis be placed upon health promotion, cost-effectiveness and quality of services.[5] Thus, APNs must work to expand their knowledge and skills, so as to be able to meet the mandates of the Reform Policy.

Review of the Literature

Based upon certification guidelines, APNs are required to perform professional activities within six role areas: direct clinical care, educator, consultant, administrator, researcher and ethicist/legalist.[6] The direct clinical care role consists of providing healthcare within a specific specialty area, while the educator role involves delivering new knowledge to patients, families, nurses and other healthcare providers. The consultant role entails advising and consulting with patients, families, nurses and other members of the health care team, while the administrator role encompasses providing leadership, serving as a role model or mentor to other nurses, developing programs and organizing new care processes. The role of researcher addresses the development and implementation of scientific studies for the purpose of generating new knowledge, while the ethicist/legalist role consists of gathering morally relevant information for the purpose of making ethical and/or lawful decisions.

Role development, or role socialization, refers to the continuous and cumulative process of learning specific skills in preparation for performance of specialized work.[7] This may occur more through "tacit knowledge" assimilated through work experience than through formal training.[8] The stages of role development for APNs have been identified as: a) initial role socialization, which occurs during graduate nursing education, and further role socialization, which takes place within the actual practice setting, and involves integration of theory, research and knowledge gained after graduation;[9] b) identification, transition and confirmation;[10] c) the four phases of the nursing process;[11] and, d) baseline assessment, role identity through direct patient care functions, role change agent and role of consultant.[12] Regardless how one describes the stages of APN role development, it is a dynamic and complex process involving multiple components, including: a) aspects of adult development; b) development of clinical expertise; c) modification of self-identity through initial socialization in school; d) development and integration of professional role components; and, e) subsequent re-socialization in the work setting.[13]

Prior studies, regarding various aspects of role development of APNs, have been conducted solely in the United States of America (USA).[14,15] While Canada,[16] England[17] and Australia[18] have conducted studies on APNs, they have not focused on role development, but rather on role acceptance and implementation, and formal education programs. As a result of research, conducted in the USA, differing opinions exist regarding the process of role development,

in terms of stages, time intervals, functions and personal experiences.[13,19,20,21] Role development is a highly changeable and complex process that depends upon many factors, i.e. personal characteristics, mentoring, networking, health care environments, available support systems, role characteristics, aspects of role transition, personal and professional values, and family and life transitions. These influencing factors can be categorized as organizational, human or resource.[10, 19, 22]

Since inception of the APN role, in Thailand, study of its development has not been undertaken. Therefore, APN role development in Thailand remains unclear and ill-defined. Because of different cultures and contexts, existing Western studies on role development may not represent role development of APNs in Thailand. Therefore, this study aimed to answer:

(1) What is the role performance of APNs in Thailand?

(2) What is the role development process of APNs in Thailand?

(3) What are the factors influencing role development of APNs in Thailand?

Method

Research Design: A two-phase mixed method design[23, 24] was used. In Phase 1, a quantitative research questionnaire was utilized to assess role performance of APNs. Data collected in Phase 1was used as input for Phase 2. In Phase 2, a qualitative research approach was enacted using interviews, non-participant observation, field notes and documents to explore the role development process of APNs, and probe into their role performance.

Participants: The population for Phase 1 consisted of all APNs (n = 206) certified by the TNMC in 2003 (n = 49), 2004 (n = 95) and 2005 (n = 62). Inclusion criteria included APNs: a) working in a clinical setting of an institute/hospital in Thailand; b) functioning within one of the six specialty areas designated by the TNMC (maternal/newborn, pediatrics, medical/surgical, mental health/psychiatric, community health and gerontology); and c) willing to participate in the study. In Phase 1, 199 APNs met the selection criteria, with 154 (77.4%) returning usable questionnaires.

Subjects ranged in age from 31 to 56 years, with a mean age of 41.63. The majority: were female (n = 152; 98.7%) and single (n = 79; 51.3%); held a master's degree in nursing (n = 149; 96.8%); worked on an inpatient department within their respective institution/hospital (n = 102; 66.2%); worked in a regional hospital (n = 46; 29.9%); worked full-time (n = 128; 83.1%); held a staff nurse position (n = 99; 64.3%); maintained the same nursing position after obtaining APN certification (n = 132; 85.7%); remained on the same clinical unit after obtaining APN certification (n = 113; 73.4%); occasionally functioned as an APN (n = 102; 66.2%); and, worked on a medical/surgical clinical unit (n = 90; 58.4%).

The sample for Phase 2 was selected from subjects who participated in Phase 1. Inclusion criteria consisted of APNs: a) working in a clinical setting of an institution/hospital; b) carrying out, on a full-time basis, activities specific to advanced practice in an area of specialty matching certification from the TNMC and, thus, not simply carrying the title of APN or occasionally serving in an advanced practice role; and c) willing to participate in the study.

Only 52 APNs met the inclusion criteria for Phase 2. Thirteen of the 52 APNs were purposively selected to take part in Phase 2 so that: all regions of Thailand were represented; 2 to 3 APNs were from each specialty area; and, there was a presence of different backgrounds, ages, marital statuses, positions and types of workplace.

Phase 2 subjects were female and ranged in age from 32 to 50 years, with a mean age of 41.54. Over one-half (n = 7; 53.8%) were single. The specialty areas of medical/surgical, mental health/psychiatric and community health were represented by three participants, while the specialty areas of maternal/

newborn and pediatrics were represented by two participants. No APNs in gerontology could be located. Their work environments included a: regional hospital (n=4, 30.77%); general hospital (n=4, 30.77%); university hospital (n =2, 15.38%); department of mental health (n = 2, 15.38%); and, military (Air Force) hospital (n = 1, 7.70%). Each region of Thailand was represented: Northeast (n=4); Central (n=3); South (n=3); North (n=2); and, East (n=1).

Procedure: Approval to conduct the study was granted by the Faculty of Nursing, Chiang Mai University. Names and addresses of potential subjects for Phase 1 were obtained from the TNMC. Each potential subject was mailed a packet containing a: letter inviting participation; questionnaire to complete and return; and, self-addressed stamped envelope in which to return the completed questionnaire. The letter explained: the purpose of the study; how to complete and return the enclosed questionnaire; maintenance of anonymity and confidentiality; voluntary participation; and, the need to complete and return the questionnaire within four weeks. Consent to participate was indicated by each subject's return of the completed questionnaire. A second copy of the questionnaire was mailed to those who did not return the initial questionnaire, in the event they had not received the first copy. After the completed questionnaires were received, they were labeled with a code number, and the envelope, in which the completed questionnaire was returned, was destroyed.

For Phase 2, potential participants were contacted by telephone and informed: about the purpose of Phase 2 and what involvement would entail; involvement was voluntary and they could withdraw at any time without negative repercussions; anonymity and confidentiality would be maintained; field notes would be taken; all interviews would be tape-recorded; and, all tape recordings, transcriptions of tape recordings, field notes and documents used would be destroyed upon completion of the study. Once a potential participant consented to participate, a time for the first interview was arranged. Prior to the start of the first interview, each participant was asked to sign a consent form. All interviews were conducted in a location of each informant's choosing. Eleven informants requested to be interviewed in a private room at their respective workplace, while two preferred to be interviewed in their respective home.

After transcription and interpretation of data obtained from the first interview was accomplished, informants were telephonically contacted to arrange a second interview. The second interview was conducted, in the same location as the first interview, and occurred approximately 1 to 5 months after completion of the first interview. This time interval was required due to the availability of participants, as well as to the time needed for the primary investigator (PI) to conduct the interviews. The second interview was conducted to validate information obtained during the first interview and to see if new information could be generated. Both interviews lasted an average of three hours.

Following each interview, field notes were written to supplement the audio-taped transcription. In addition, official and professional documents, containing information about the APNs, were reviewed and used to assist analysis of the APN role development process.

Questionnaire and Interview Guidelines: In Phase I, a PI developed questionnaire was used to assess role performance of each APN. The questionnaire content was derived from the literature and the TNMC's proposed concept of advanced practice, and was comprised of four parts. Part 1 consisted of ten questions that requested demographic information, including; 1) gender; 2) age; 3) marital status; 4) highest degree obtained; 5) type of workplace/clinical area; 6) unit/department of employment; 7) type of part-time employment, in addition to a regular full time job; 8) type of position held before obtaining certification; 9) type of position held after obtaining certification; and, 10) type of advanced practice work experience after obtaining certification.

Part 2 included 16 questions regarding role performance of APNs, i.e. activities specific to advanced practice in an area of specialty matching certification from the TNMC. Five questions were open-ended questions, while 11 had both closed and/or open-ended components. The 16 questions sought to determine performance related to the roles of direct clinical care provider (n = 8), educator (n = 1), consultant (n = 1),

administrator (n = 3), researcher (n = 2) and ethicist/legalist (n = 1). Examples of the open-ended questions included: "How do you manage the target population with the multidisciplinary team?" and, "How do you deal with members of the target population so they learn how to self-manage their illnesses?" Examples of questions with closed and/or open-ended components included: "In what capacity do you engage in the advanced practice role (full-time, occasionally or not at all)?" and, "If you engage in the advanced practice role only occasionally or not at all, why does this occur?"

Part 3 consisted of 3 major questions with 11 sub-sections. The major questions related to factors influencing APN role development, while three 3 sub-sections focused on facilitating factors, 4 addressed barrier factors, and 4 looked at requirements for role development of APNs. The questions, with their sub-sections included, were: "What specific factors (i.e. administrative, multidisciplinary team or other) facilitated your role performance as an APN?"; "What factors (i.e. administrative, multidisciplinary team, other nurses or other) were barriers to your role performance as an APN?" and, "What requirements (i.e. self-development as an APN role model, networking, attending academic conferences/workshops or other) do you need to foster your role development as an APN?" Finally, Part 4 of the questionnaire involved one open-ended request: "Please provide any comments or suggestions."

Content validity of the questionnaire was appraised by a panel of five experts (2 surgical nursing APN program faculty members; 2 faculty members knowledgeable about educational curricula for APNs; and, 1 experienced cardiovascular APN) regarding enactment of activities specific to advanced practice. Based upon the review, minor wording changes were made in the questions, which lead to the experts' approval of the instrument. Prior to use, the instrument was pilot-tested with 14 APNs who met the inclusion criteria for the study. These same 14 APNs also were included in the actual study in order to obtain data that reflected the largest possible proportion of APNs in Thailand. Based upon the pilot study findings, and feedback from the 14 participants, no revisions were required in the instrument.

In Phase 2, a PI developed interview guideline was used to explore role development of APNs in Thailand. The interview guideline was developed from the second and third research questions ("What is the role development process of APNs in Thailand?" and, "What are the factors influencing role development of APNs in Thailand?"). The opening statement in the interview requested the participant to: "Please tell me about your experiences in role development as an APN." Following this request, a more focused question ("Please tell me about your direct clinical care role, what you do and how you do it?") was asked. The interview guide content was assessed by three experts (two qualitative research faculty members and one APN curriculum expert.) who agreed it was appropriate and inclusive.

To establish trustworthiness of the data and interpretation of the findings, credibility, dependability, conformability and transferability were addressed.[25] Summarization of the interview content was provided to each participant at the end of each interview to validate whether the data were accurate. Data coding was checked throughout the research process. Furthermore, field notes, non-participant observations and documents were coded for data analysis. The analytic categories were verified by the informants to ensure all categories were similar to their experiences. In addition, interview transcripts and findings were checked for validation by APNs with similar qualifications to those of the participants.

Data Analysis: Demographic data, as well as data from the close-ended questions in the instrument used in Phase 1, were examined using descriptive statistics (frequencies, percentages, means and standard deviations). Data obtained via the open-ended questions, from the instrument used in Phase I, were examined using content analysis.

In Phase 2, interview transcriptions, field notes, and official and professional documents containing information about APNs were analyzed using Miles and

Huberman's[26] analysis process, including: data reduction, data display, conclusion and verification. The process began with multiple readings of each document, field notes and interview transcripts in search of information regarding aspects of the role development process. Line by-line coding then was conducted, with notation of patterns related to specific categories reflecting the APNs' role development process. Interpretations of data were shared with informants, during their second interview, so that misunderstandings could be addressed. Results of the quantitative and qualitative data, finally, were combined to reflect a total interpretation of the findings.

Results

Role Performance of APNs in Thailand: The first research question ("What is the role performance of APNs in Thailand?") was addressed using data obtained during Phase 1. Results revealed more than 90% of the subjects had engaged in some aspect of five of the six roles of an APN (direct clinical care, educator, consultant, administrator and researcher), while only 57% were involved in the role of ethicist/legalist (see **Table 1**).

Table 1 Types, Numbers and Percentages of the Various Roles Enacted by Subjects

Role components	Number (n=154)		Percentage (%)	
1. Direct clinical care role				
Nursing care strategies in an individual/group				
Care management	98		63.6	
Primary nursing care	17		11.0	
Other	32		20.8	
Functional care		10		31.2
Care management & primary nursing care		8		25.0
Patient care team		8		25.0
Participation		3		9.4
Self-health group		2		6.3
Disease management		1		3.1
Not specified	7		4.6	
2. Educator role				
Personnel knowledge development				
Role performance*	144		93.5	
Lecturer		126		87.5
Clinical teaching/conferences		112		77.8
Training course		98		68.1
Other		62		43.1
Not specified	10		6.5	
3. Consultant role				
Advised the targeted population				
Role performance*	149		96.8	
Patients/relatives		138		92.6
Nurses		134		89.9
Nursing students		107		71.8
Physicians		73		50.0
Other		30		20.1
Not specified	5		3.2	

Role components	Number (n=154)		Percentage (%)	
4. Administrator role				
Participation in nursing quality assurance				
Participation	140		90.9	
No participation	14		9.1	
Participation in Hospital Accreditation (HA)				
Participation	135		87.7	
No participation	19		12.3	
Participation in organization management				
Participation	96		62.3	
No participation	58		37.7	
5. Researcher role				
Knowledge management in nursing practice				
Role performance*	142		92.2	
Research utilization		105		73.9
Innovation development		90		63.4
Creating knowledge from practice		73		51.4
Clinical publication		48		33.8
Other		35		24.6
Not specified	12		7.8	
Conducting and/or collaborating research				
Conducting research	43		27.9	
Conducting and collaborating research	39		25.3	
No conducting research	39		25.3	
Collaborating research	33		21.4	
6. Ethicist/legalist role				
Participation in considering ethical issues				
Participation	88		57.1	
No participation	66		42.9	

*more than one item possible

The Role Development Process of APNs in Thailand: In Phase 2 of the study, the second research question ("What is the role development process of APNs in Thailand?") was addressed. The qualitative results revealed the role development process was comprised of three stages: advanced beginner, competent practitioner and expert. These stages were not found to be clearly demarcated since, at times, they manifested similar characteristics. However, throughout all three stages, the APNs relied on prior experiences as they progressed through the role development process. A detailed summarization of each stage's characteristics is shown in **Table 2.**

Table 2 Role Development Process of APNs in Thailand and Influencing Factors

Categories	Stage 1: Advanced Beginner	Stage 2 : Competent Practitioner	Stage 3: Expert
Characteristics			
- Position	- Academician/staff nurse/ assistant HN	- Staff nurse/assistant HN/HN	- Staff nurse/HN/ supervisor
- *Type of workplace*	- Primary/Secondary/ Tertiary levels	- Secondary/Tertiary levels	- Secondary/Tertiary levels - Specialty units
- *Specialty area*	- General units/OPD	- Specialty units/OPD	- Target population in unit/communities
- *Population*	- Sub-specialty/small group	- Target population in each unit	- Freedom working inside and outside organization
- *Work practices*	- Restricted working inside and outside unit	- Working inside and outside unit	
Role development process			
- *Self-development*	- Formal passive self-learning	- Formal active self-learning	- Informal active self-learning
	- Learning from physicians	- Learning from physicians and nurses	- Learning from patients, physicians, nurses & other professionals
- *Work development*	- Developing quality care service programs in units	- Developing quality care service programs in organizations	- Developing quality care service programs inside and outside organizations
	- Utilizing research	- Developing work activities from thesis findings	- Developing work activities from thesis findings
		- Conducting work routine based upon research findings	- Conducting research
		- Integrating most of the various roles of an APN	- Integrating all of the various roles of an APN
- *Care team development*	- Encouraging colleagues	- Organizing short course training	- Providing research knowledge
	- Seeking cooperation of colleagues	- Sharing knowledge	- Creating networking
			- Being a preceptor/role model
Influencing factors	- Rare administrative support from administrators and the multidisciplinary team	- Occasional administrative support from administrators and the multidisciplinary team	- Full administrative support from administrators and the multidisciplinary team

HN = Head Nurse
OPD = Outpatient Department
APN = Advanced Practice Nurse

Factors Influencing Role Development of APNs: The third research question ("What are the factors influencing role development of APNs in Thailand?) was addressed using data obtained during Phase I (questionnaire) and Phase 2 (interviews). Similar to prior findings,[10, 19, 22] results of this study suggest factors influencing role development of APNs could be categorized into the realms of organization, human or resources. The major facilitating factor within the realm of the organization was policy (health care system and organizational). Health care system policy, in Thailand, addresses the delivery of health care to the entire population, in addition to implementation of projects that focus on special populations. Organizational policy is focused on intra-organizational management that addresses management systems, the provision of universal health care coverage, organizing hospital accreditation and developing human resources.

The following statements reflect the APNs perceptions regarding the influence of health care system policies:

> As the health care system changes, so do many approaches to care. For example, more emphasis is now placed on health promotion. Care is focused on holistic care, family involvement and empowerment. That's the health system.....it makes the APN take on more roles.

> When implementing the 30-baht system (universal health care coverage), a proactive approach to care is stressed and the provision of care to an entire family unit is emphasized. The approach is good for us since it provides clear health care responsibilities. Any projects that were to be launched have also been expanded.

The statements supporting the influence of organizational policy were reflected by several APNs as follows:

> The head nurse embraced the organizational policy of having case managers. Each patient care team (PCT) was to have one case manager so I was assigned to the medical unit. We set up and applied guidelines and, thus, the role of a case manager was developed.

> My concept is that patient care must be continuing care according to the hospital accreditation (HA) concept. As I do that work, it allows me to learn...enabling me to learn about patient care that requires continuous development. I see that the Department of Medical Services supports me to pursue a master's degree. It provides support for master degree study. It won't occur without the department's support. The department must see the importance. It's favorable for the APN role.

The major organizational barrier in role development was found to be poor administrative functioning, which involved the lack of a clearly delineated organizational structure, as well as unclear organizational policies. This is indicated by the APNs statements:

> The organizational structure and line of authority are not clearly defined. Now we must play dual roles of doing management activities, as well as performing APN duties.

> The agency still lacks a clear position for an APN. APNs have to work in the ward under the supervision of a head nurse....they must work morning, afternoon and evening shifts. That deprives them of the freedom of working truly as an APN. This hinders continuous follow-up on the target population.

> The hospital's policies aren't favorable for functioning as an APN. When I function as an APN, sometimes I have to 'break' (go against) the organizational system. It often costs me a lot of time.

The primary facilitators in the human realm of the APN role development were the presence of a quality nurse administrator and a well-functioning multidisciplinary team. The quality nurse administrator was found to demonstrate understanding, support, trust, opportunity, advice and encouragement. This finding was supported by the comments:

> I can call to consult with the nurse administrator, which is one way I can share my [work related] difficulties. Being able to do this makes me relaxed. I've obtained suggestions for ways to solve problems. Sometimes the tips I receive help me deal with my difficulties.... I have learned to solve problems.

> I submitted my thesis to the physician administrator to show what I was doing and what I wanted to continue. The center director provided me with opportunities that led me to becoming an expert in this area. Then I proposed a research project and asked for financial support.

> A commander is important.....like the nurse supervisor or the head nurse. There was the nursing care service pilot project that was mandated to provide comprehensive health care service, which required the development of a functional multidisciplinary team. It's a provider combination that helps make health care delivery flexible.

> Physicians trust us [APNs]. Our decisions are accepted and based upon our abilities to think psychosocially, with a community focus, and to use evidence-based information. We talk like friends...each of us shares the features of our careers. When I suggest something, they listen.

A well functioning multidisciplinary team was described as one that provided acceptance, support, trust, team work, knowledge sharing and advice in the development of the APN role. Comments made by the APNs included:

> The multidisciplinary team acted as a stimulator or inspirer for me as I developed my competencies and learned how to perform my role effectively.

> Networking is useful for sharing experiences and having a good community of practice.

> There was a case with underlying diabetes mellitus....the internists gave me relevant information about the illness so I could apply knowledge to teach the patient.

> We work as a team.....like the antiretrovial case. The team looked into the details together and shared suggestions. We helped each other with the care of the patient.

The primary barrier in the human realm of APN role development was a lack of administrative support of advanced practice nursing. This was demonstrated by the type of work assignments that were not reflective of advanced practice nursing and the manifestation of uncooperative behavior by members of the multidisciplinary team. Several APNs remarked:

> Some head nurses and supervisors don't understand what an APN is or what an APN should be doing in the work setting. They always assign us irrelevant tasks and that makes us become a referee or advisor for almost all issues.

> At present, I still report to the head nurse so I must do whatever I am assigned, but some tasks are not related to the target population. That prevents me from acting effectively as an APN.

> The multidisciplinary team doesn't give support. Cooperation from some team members is quite difficult to obtain, especially physicians.

In the third realm, resources, the primary facilitator of role development was financial assistance. This was demonstrated by the provision of monies for: purchasing educational media, presenting research findings at conferences, and developing clinical and research projects. The APNs indicated:

> I created and distributed cartoon books to teach patients in a pediatric outpatient department. The pediatricians found these books useful, so they asked for a budget to reproduce these books.

> Last year, we had 3 research projects. We presented two of the projects to the Ministry and the Department of Medical Service. They were approved for funding. This year we have one project that has been submitted for funding by the department.

> We have set up a team of home care, which is working at full capacity. I will ask for monetary remuneration from the Disease Control Center to cover this project.

In contrast, the major barrier in the realm of resources was a shortage of nurses. Because administrators did not have a sufficient number of regular nurses to cover the various clinical units, most APNs from Phase I (n = 102; 66.2%) were functioning in advanced practice on an occasional basis. As a result, these APNs spent most of their work time in non-advanced practice situations:

> I'm still unable to manage my work time to cover all the professional things I need to do.... because the ward still lacks staff. Thus, I always have to prepare academic activities, such as research projects and power point presentations for teaching nurses, at home.

> My responsibilities mainly involve patient care, reporting to physicians and being a charge nurse. I hardly have time to do other things. To be a nurse in charge, I must be responsible for all patient assignments and be supervised by a head nurse. Therefore, my work is more or less like a general nurse.

Discussion

Role Performance of APNs in Thailand: The findings reveal performance of APNs in Thailand was at a high level in five (direct clinical care, educator, consultant, administrator and researcher) of the six roles, and at a moderate level in the sixth role (ethicist/legalist). Since all of the roles facilitate delivery of quality health care services, they are perceived as valuable and recognized as important in advanced practice.[27] These findings are consistent with prior research,[22] which found CNSs tend to rank role performance according to the amount of time spent in each role. The fact the ethicist/legalist role was enacted at a moderate level may have been due to

the facts that: a) the participants were not involved in institutional/hospital committees related to ethics or the law, and b) although they were immersed in direct patient care, their involvement never required decision-making in the realm of ethics or the law.

Role Development Process of APNs in Thailand: The role development process of APNs in Thailand was found to be comprised of three stages: (1) advanced beginner, (2) competent practitioner and (3) expert. This finding, however, is incongruent with previous findings[19, 20] that indicate advanced practice role development (i.e. CNS) was a highly variable, complex and emotional process. In this study, the APN role development process involved transition from the role of experienced registered nurse to the role of an advanced practice nurse.

In the advanced beginner stage, APNs tended to learn primarily from physicians and by way of a formal passive learning style. Evolution of their work experiences involved learning a new role, i.e. developing quality care services and utilizing research findings. They tended to use their work experiences to encourage colleagues and to seek their colleagues' cooperation in developing the work activities of the clinical unit. These findings are consistent with previous studies,[28, 29] which found advanced beginners learn from clinical situations, focus on what is to be done for patients, and organize work according to the demands and requirements of the patient care situation. Although the advanced beginner APNs were starting to develop new skills and roles that were strengthening their abilities as advanced practice nurses,[30] they needed more experience to recognize all the nuances of a specific clinical situation. Unfortunately, APNs who were advanced beginners rarely obtained support from administration and members of the multidisciplinary team as they forged ahead in learning their roles in the advanced practice arena.

In the competent practitioner stage, APNs developed themselves by learning through formal active self-learning mechanisms, and by obtaining information and skills from physicians and other nurses. They also used past experiences to create quality health care service; developed work activities from their respective thesis findings; conducted their work routine based on existing research findings; and, were beginning to actualize most of the various roles of an APN. These findings are consistent with previous work, which indicated competent nurses focus on managing and organizing patients' conditions based upon the particular patient situations;[28] develop goals and plans to structure their work so as to 'make a difference' and to demonstrate their achievements;[29] perform their work effectively and with confidence, and integrate most of the APN roles.[30] Unlike the APN who was an advanced beginner, administrative and multidisciplinary team member support for the advanced practice role increased so that it was present on an occasional basis.

In the expert stage, APNs learned by way of an informal active learning style by obtaining information from multiple sources. They continued to develop their practice abilities by strengthening and integrating each of the individual APN roles into their daily clinical practice. Because of work positions and assigned responsibilities, expert APNs had freedom to continue to develop their competencies. The APNs used their expertise to: develop quality health care service programs inside and outside of their organizations; develop work activities from their respective thesis findings; and, conduct original research with colleagues. As experts, they were recognized by others for their knowledge and skills and, as a result, served as preceptors or role models, and received organizational awards for work they had done. These findings are consistent with prior studies,[28, 29] wherein expert nurses were found to have: more background and experience; a deeper understanding of what constitutes an appropriate health care action; and, a good intuitive grasp of each patient care situation. The expert APN (i.e. CNS) has been described as having integrated all advanced practice components into one role with increasing

confidence.[30] Expert nurses, according to Brykczynski,[13] act comfortably as role models for other nurses. Thus, one could conclude expert APNs are more fully developed than APNs at the advanced beginner and competent practitioner stages, and succeed in developing their area of specialty at an advanced practice level. By the time APNs, in this study, reached the stage of expert, they were receiving full administrative and multidisciplinary team member support for their roles as advanced practitioners.

Factors Influencing Role Development of APNs: Similar to prior studies, findings of this study reveal factors influencing role development could be categorized into the realms of organization, human and resources.[19,22] In the realm of organization the major facilitator of role development was found to be policy (health care system and organizational). The presence of health care system policy provided the APNs an opportunity to create various quality health care delivery projects focusing on their specific target population, while organizational policy allowed the APNs to continually develop themselves at an advanced practice level. This finding is consistent with prior research[22] wherein health care system changes, affecting advanced practice (i.e. CNSs), have been found to increase the delivery of high-tech patient care.

On the other hand, most of the informants mentioned the greatest organizational barrier affecting role development of APNs was poor administrative functioning, which consisted of the lack of a clearly delineated organizational structure and unclear organizational policies. This was particularly problematic when the organizational structure and policies failed to indicate positions for APNs. This finding is consistent with prior research,[31] wherein the major barriers, to the CNS role, have been shown to be lack of public recognition and absence of legal recognition for APNs in nurse practice acts. In addition, failure of the CNS role has been found to occur when CNSs are placed in a staff nurse position rather than an APN position.[34] Thus, for successful enactment of the APN role, organizations need to be structured in such a way so as to allow APNs to actualize role potential which provides for autonomy and accountability.[8] Effectiveness of the APN role is enhanced when commonality exists between the goals and expectations of the individual and the organization.[10] Brykczynski[13] suggests that administrative structures should consider unit-based, population-focused practice positions that match the skills and knowledge of the respective APN. In addition, the organizational structure needs to have enough flexibility to change its APN positions in the event the size, complexity and distribution of a specific patient population changes.

The primary human factors facilitating role development of APNs were the presence of quality nurse administrators and well-functioning multidisciplinary teams. These findings are consistent with previous research,[19,22] which has noted the majority of CNSs need administrative support, including: having a nursing administration system that shares knowledge; recognizing CNSs' accomplishments and providing guidance; allowing freedom and flexibility in development of the CNS role; and, providing CNS authority in the clinical setting. Regarding well-functioning multidisciplinary teams, prior research[19,22,32,33] indicates that peer support from others (i.e. other advanced practice nurses, nurse instructors, physicians and other members of the health care team) fosters successful enactment of the CNS role.

In contrast, the primary human barriers to APN role development was found to be a lack of administrative support of advanced practice nursing, which was demonstrated by work assignments not reflective of advanced practice, as well as uncooperative behavior on the part of multidisciplinary team members. These findings are consistent with prior findings,[19,31,34] wherein the lack of administrative and peer support have been found to be the major human barriers to role development of CNSs. This lack of support has been played out by misuse and devaluing of the CNS

role, as well as lack of recognition of CNSs.[19] Davies and Eng[16] suggest frustration and satisfaction experienced by a CNS is related to administrative support and decision-making authority of the CNSs within the healthcare setting.

The primary resource facilitator of APN role development was found to be financial assistance, which involved provision of monies for: teaching media, presenting research findings at conferences, and developing clinical and research projects. This finding is consistent with a prior study[22] that showed APNs (i.e. CNSs) indicated the presence of support when continuing education, library resources and access to professional organizations were made available.

Finally, the major barrier in the realm of resources, in this study, was the shortage of nurses, resulting in the majority of APNs occasionally functioning in an advanced practice capacity. Instead, APNs were expected to serve in non-advanced practice positions so that the shortage of regular staff nurses could be met. This finding is consistent with prior research[19, 35,36] wherein time management has been found to be one of the primary barriers to role development for APNs.

Conclusions

Results of this study provide information about the role performance of APNs in Thailand. The APNs indicated they functioned, to some degree, within six APN roles. However, the vast majority only occasionally served in an advanced practice capacity due to various organizational, human and resource issues. In addition, the informants progressed in their role development from advanced beginner to competent practitioner and, finally, to expert. However, with many of them not being able to consistently function within the realm of advanced practice, they were hindered in role development progression. This appears problematic regarding the future development of the APN role in Thailand, and needs to be addressed at an institutional, regional and national level.

Limitations

The sample included five of the six recognized specialty areas in advanced practice nursing. However, none of the participants were from the gerontological nursing specialty. Thus, application of the study's findings to this group must be used with caution. In addition, the sample size (n = 2 to 3) from each of the specialty areas used in Phase 2 was small, thereby, limiting generalizability of the findings. Future research needs to include APNs from all six specialty areas, as well as address the need for an increase in the size of the sample representing each APN specialty area.

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การพัฒนาบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูงในประเทศไทย

สุพร วงค์ประทุม, วิจิตร ศรีสุพรรณ, วิลาวัณย์ เสนารัตน์, พิกุล นันทชัยพันธ์, วรรณภา ศรีธัญรัตน์

บทคัดย่อ: ผู้ปฏิบัติการพยาบาลขั้นสูงเป็นเรื่องใหม่ของการได้รับรองวุฒิบัตรสำหรับพยาบาลในประเทศไทยโดยสภาการพยาบาลเมื่อ พ.ศ. 2546 ตั้งแต่มีบทบาทผู้ปฏิบัติการพยาบาลขั้นสูงในประเทศไทย ยังไม่พบการศึกษาวิจัยเกี่ยวกับการพัฒนาบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูง ดังนั้นวัตถุประสงค์ของการวิจัยครั้งนี้ เพื่อศึกษาการพัฒนาบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูงในประเทศไทย โดยใช้ระเบียบวิธีวิจัยแบบผสมผสาน 2 ระยะ ระยะแรกใช้วิธีการศึกษาเชิงปริมาณโดยใช้แบบสอบถามเพื่อสำรวจผู้ปฏิบัติการพยาบาลขั้นสูงที่ได้รับวุฒิบัตรจากสภาการพยาบาล ตั้งแต่ พ.ศ. 2546 – 2548 จำนวน 154 คน ระยะที่สองใช้วิธีการศึกษาเชิงคุณภาพเพื่อศึกษาข้อมูลจากผู้ให้ข้อมูลจำนวน 13 คน โดยใช้วิธีการสัมภาษณ์เชิงลึก การสังเกตอย่างไม่มีส่วนร่วม การบันทึกภาคสนาม และการทบทวนเอกสาร วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนาและวิเคราะห์เชิงเนื้อหา

ผลการศึกษาระยะแรกพบว่า การปฏิบัติบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูงมีมาก คือ บทบาทของผู้ปฏิบัติการพยาบาล ผู้ให้ความรู้ ผู้ให้คำปรึกษา ผู้จัดการ และผู้วิจัย ในขณะที่การปฏิบัติบทบาทด้านจริยธรรมและกฎหมายมีปานกลาง ผลการศึกษาระยะที่สองพบว่า กระบวนการพัฒนาบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูงประกอบด้วย 3 ขั้น ได้แก่ ผู้เริ่มต้น ผู้มีความสามารถ และผู้เชี่ยวชาญ ปัจจัยสนับสนุนที่สำคัญของการพัฒนาบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูง คือ ก) ปัจจัยด้านองค์กร (ระบบบริการสุขภาพและนโยบายองค์กร) ข) ปัจจัยด้านบุคคล (คุณลักษณะของผู้บริหารการพยาบาล และการปฏิบัติงานที่ดีของทีมสหสาขาวิชาชีพ) และ ค) ปัจจัยแหล่งสนับสนุน (การได้รับทุน) ปัจจัยอุปสรรคที่สำคัญที่สุดในการพัฒนาบทบาทของผู้ปฏิบัติการพยาบาลขั้นสูง คือ ก) ปัจจัยด้านองค์กรเกี่ยวกับการบริหารงานที่ไม่ดี (ขาดคำอธิบายโครงสร้างองค์กรที่ชัดเจน และนโยบายขององค์กรไม่ชัดเจน) ข) ปัจจัยด้านบุคคลเกี่ยวกับการสนับสนุนจากผู้บริหารด้านการปฏิบัติการพยาบาลขั้นสูงน้อย (การมอบหมายงานที่ไม่สะท้อนการปฏิบัติการพยาบาลขั้นสูง และพฤติกรรมไม่ให้ความร่วมมือของสมาชิกในทีมสหสาขาวิชาชีพ และ ค) ปัจจัยแหล่งสนับสนุนเกี่ยวกับการขาดอัตรากำลังพยาบาล (การมอบหมายงานที่ไม่ใช่การปฏิบัติการพยาบาลขั้นสูง)

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คำสำคัญ: การวิจัยแบบผสมผสาน การปฏิบัติและการพัฒนาบทบาท ผู้ปฏิบัติการพยาบาลขั้นสูง ประเทศไทย

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