

Le cheminement évolutif des infirmières praticiennes en soins actifs

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L'étude fait appel à la phénoménologie herméneutique selon l'approche de van Manen pour explorer la nature des expériences vécues par les infirmières praticiennes (IP) en soins actifs au sein des hôpitaux universitaires du Canada. Les auteures ont mené des entrevues auprès de 26 IP. L'analyse révèle que les IP suivent un cheminement évolutif caractérisé par *un désir de dépassement*; ce sentiment est au cœur du rôle de *pionnières* qu'elles sont appelées à assumer. Cinq thèmes se dégagent des entrevues : *le désir de se surpasser* (se rapprocher des patients, être autonome, affirmer ses compétences et son rôle et surmonter des défis); *une impression de désorientation* (se sentir déroutée, incertaine, perdue, tout en aspirant à surmonter les difficultés); *l'affirmation de son identité comme IP* (se sentir compétente, confiante, à sa place, engagée et satisfaite); *les exigences liées à de nouvelles responsabilités* (porter deux chapeaux à la fois); *le dépassement de soi* (devenir une infirmière spécialisée). Le cheminement de l'infirmière praticienne en soins actifs se dessine comme une expérience complexe, mais méconnue dans la plupart des cas.

Mots clés : soins actifs, infirmière praticienne

The Transformational Journey of Nurse Practitioners in Acute-Care Settings

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This study explored the nature of the lived experience of being nurse practitioners (NPs) in acute-care settings in Canadian teaching hospitals using hermeneutic phenomenological inquiry guided by van Manen's approach. A total of 26 NPs were interviewed. Data analysis revealed that NPs experienced a transformational journey as they searched for *being more*, the overarching phenomenon that best characterizes their overall experience, which occurred in the context of *being pioneers*. Five themes emerged: *being called to be more* — being more connected, in control, visible, challenged, and able to make more of a difference; *being adrift* — being disconnected, uncertain, lost, and staying afloat; *being an acute-care NP* — being competent, confident, comfortable, committed, connected, and content; *being pulled to be more* — being a wearer of two hats; and *being more* — being an advanced practitioner. The NP journey reveals the complex, largely invisible experience of being an acute-care NP.

Keywords: acute care, advanced nursing practice and education, liminality, nurse practitioner, nurse relationships/professional issues, nursing roles, phenomenology, transformational process, transition

Although the nurse practitioner (NP) role in primary health care has been well documented, less is known about its role in acute care. The number of studies examining this NP specialty has grown as the role has been implemented worldwide to meet the needs of acutely ill patients (Chang, Mu, & Tsay, 2006; Kaan & Dunne, 2001; Norris & Melby, 2006). The NP role has been researched in terms of role classification, responsibilities, and functions (Kleinpell, 2005; Kleinpell, Hravnak, Werner, & Guzman, 2006); demographics, educational preparation, geographic region of practice, and type of employment setting (Hurlock-Chorostecki, van Soeren, & Goodwin, 2008; Sidani et al., 2000); quality of care provided, as compared to that provided by physicians (Carter & Chochinov, 2007; Russell, VorderBruegge, & Burns, 2002; Sidani et al., 2006a); and patient satisfaction (Fanta et al., 2006; Sidani et al., 2006b). Multiple studies in a variety of acute-care settings have examined how the role has been operationalized and legitimized (Reay, Golden-Biddle, & Germann, 2006), barriers to effective NP utilization (Irvine et al., 2000; van Soeren & Micevski, 2001), and its associated economic impact (Hoffman, Tasota, Zullo, Scharfenberg, & Donahoe, 2005; Meyer & Miers, 2005).

There is a paucity of studies exploring the ontological nature of the NP role, most of which have been undertaken with primary health care NPs (Brown & Draye, 2003; Brykczynski & Lewis, 1997), although one study explored the neonatal NP role as perceived by parents (Beal & Quinn, 2002). The experience of acute-care NPs in Taiwan during their first year of role transition has also been examined (Chang et al., 2006).

Given the lack of research on the experience of being an NP, the purpose of this study was to explore the following question: *What is the nature of the lived experience of being and becoming an NP in acute care?* For the purposes of the study, acute care refers to the level of health services that can be provided only in a secondary- or tertiary-care hospital. In acute-care settings, medical conditions are usually characterized by a sudden onset of or a sharp rise in severe symptoms and a short course, and treatment is aimed at cure or prolongation of life and symptom management.

Method

A qualitative method based on hermeneutic phenomenological inquiry grounded in the philosophical writings of Heidegger (1927/62) and Gadamer (1960/89) was selected. The study was guided and operationalized by van Manen's (1997) interpretive framework; therefore, it was both descriptive and interpretive in nature.

Setting and Participants

The participants were chosen using purposive sampling. NPs who met the following criteria were recruited: (1) English-speaking, (2) graduated from a university-based nursing program with an NP focus, (3) practised in an acute-care NP role for at least 2 years, and (4) employed at least 20 hours weekly in an NP role. The last two criteria ensured that the participants had had time to accumulate experiences as an NP. NPs were recruited from four adult and pediatric teaching hospitals in the Canadian provinces of Alberta, Ontario, and Quebec. Ethical approval was obtained from the University Health Research Ethics Board and the research ethics board of each hospital. Names of NPs were accessed through the professional nursing association, the institution's human resources department, and/or nursing administrators. Letters describing the study were then distributed via intra-hospital mail, as per the hospital's directives.

Data Collection

Participants engaged in one face-to-face in-depth interview with the first author in a private, quiet setting of the participant's choosing. A flexible interview guide with open-ended questions was used. Interviews lasted an average of 2.5 to 3 hours and were audiorecorded. Prior to the inter-

view, formal consent was obtained. Each conversation generally began with the prompt *Share with me a day in your life as an NP* and proceeded gradually to what drew the participants to the NP role, their education and learning, seminal influences that shaped them in the role, key relationships, accounts of what they found satisfying and dissatisfying about their work in the course of a day, real-life clinical decision-making, and visions of their future. Participants were encouraged to enrich or clarify their comments by sharing specific stories about encounters in their work situation. Field notes complemented the data. Art work, scientific and literary readings, films, impromptu discussions with NPs at conferences, and chat-room conversations on an advanced nursing practice e-mail forum provided additional thoughts for reflection.

Data Analysis

Three principal approaches suggested by van Manen (1997) guided the uncovering of hidden meanings within the NPs' experiences and the structures of meaning or themes: (1) the sententious or holistic approach; (2) the selective or highlighting approach; and (3) the detailed, line-by-line approach (p. 92–93). This initial level of analysis was conducted for each transcribed interview and then the resulting aggregate of formulated meanings was organized into clusters of themes by the authors, working closely with a group of advisors expert in this research methodology and in the Canadian NP movement. Through the process of making comparisons and asking questions, connections between categories emerged. A subsequent interpretive analysis was undertaken and the themes were then reflectively transformed into “more phenomenological sensitive paragraphs” (van Manen, 1997, p. 95), using the technique of varying the examples to demonstrate the invariant aspects of the phenomenon as it came into view (p. 121).

Methodological Rigour

The criteria of credibility, fittingness, auditability, confirmability, and redundancy were used to support the study's rigour (Leininger, 1994). For example, for three participants a second interview was held 2 to 6 weeks after the first, to explore further reflections about their experiences that arose following the first conversation and to more deeply probe ideas raised. No new issues or themes were generated; rather, thoughts previously mentioned were reaffirmed through the sharing of additional stories, thereby lending support to the trustworthiness of the data. Data were collected until redundancies were observed in the concurrent data analysis. The preliminary analyses were shared with a few participants and with several NP groups working in similar settings; this served as an opportunity to evaluate the interpretive work.

Results

The sample comprised 26 NPs of both genders. The participants worked in neonatal, pediatric, and adult critical care; adult and pediatric neurology, neurosurgery, oncology, cardiology, and cardiovascular subspecialty services; and adult nephrology/dialysis, orthopedics, family medicine, gerontology, and infectious diseases. Six of the NPs had previously been clinical nurse specialists (CNSs). Table 1 provides a descriptive summary of the participants.

Table 1 Descriptive Summary of Participants	
Characteristics	<i>n</i>
Gender	
Female	4
Male	2
Age	
31–40	10
41–50	13
≥ 51	3
Number of Years as NP in Acute-Care Setting	
2–5	14
6–10	9
11–15	2
16–20	1
Number of Years of Nursing Experience	
11–15	7
16–20	3
≥ 21	16
Type of Specialty	
Adult	12
Pediatric	14
Subspecialty	
Adult Critical Care	1
Pediatric Critical Care	8
Medicine	12
Surgery	3
Medicine/Surgery	2

Analysis revealed that becoming an NP involved a journey from one mode of being to another, a transformative process embedded in a dialectical experience, which is the overarching phenomenon that best characterizes these participants' overall experience. The NPs' journey was directed both *outward* into the world and *inward* into the self. The journey was not linear or unidirectional; rather, its nature was intertwining, dynamic, and iterative as a result of learning, growing, doing, struggling, and accommodating, within relationships that were different from those previously known. Some transformations were dramatic, but most were insidious and cumulative in nature and resulted from many ordinary, day-to-day experiences. The journey, which occurred within a context of *being pioneers*, took longer or was more intense for some than for others. Five principal themes emerged within the transformational journey: *being called to be more*, *being adrift*, *being an acute-care NP*, *being pulled to be more*, and *being more*. Table 2 lists the themes and subthemes. Brief excerpts of data along with the participants' words or terms (in quotation marks) are presented to illustrate the journey.

The Context of the Transformational Journey

The participants considered themselves pioneers of the NP role in acute-care settings. As pioneers, they had left well-established communities of practice in order to build new ones. As a collective they had yet to develop their own rituals, artifacts, and histories binding them together across time and space such that there was a common sense of belonging and identity. Except for neonatal NPs, this was typically an endeavour they faced alone:

The thrust at that time was to phase out the CNS role, to have the NP role, which started here about 10 years ago. And the role started because there was a shortage of residents. And then eventually people saw that NPs, in an expert scope of practice with a specific and well-defined patient population, could take the burden off the physicians. I'm not sure that the role was ever really thought out as to what the benefits could be for the patients, but nursing then took that opportunity to try and articulate that . . . But nobody really knew what the NP role was going to look like. So I really led that process of creating a vision and developing a role . . . And I think that part of pioneering something new, that we had no idea of what was going to happen, was a definite challenge.

Being Called to Be More

The journey began with the recognition that what they were doing no longer fit with what they wanted to do and who they wanted to be as nurses. The participants were required to seize the opportunity or create

<p>Table 2 <i>Themes and Subthemes of the NPs' Transformational Journey</i></p>
<p><i>Being Called to Be More</i> Being more connected Being more in control Being more visible Being more challenged Being able to make more of a difference</p>
<p><i>Being Adrift</i> Being disconnected Being uncertain Being lost Staying afloat</p>
<p><i>Being an Acute-Care NP</i> Being competent Being confident Being comfortable Being committed Being connected Being content</p>
<p><i>Being Pulled to Be More</i> Being a wearer of two hats</p>
<p><i>Being More</i> Being an advanced practitioner</p>

one, with the NP role seen as possibly being “the perfect fit,” thus fulfilling the call to be more. This call concerned being able to “have the opportunity to work with patients, hands on, all the time,” which was an integral part of the perfect fit. Five dominant forces were revealed (and rarely was the call associated with only one of these): *being more connected*, *being more in control*, *being more visible*, *being more challenged*, and *being able to make more of a difference*.

Being more connected. “I was afraid that I had begun to move too far away from the patients . . . and I never wanted that feeling of being disconnected to happen again.” As noted by this NP, being more connected, physically and emotionally, to patients and families was a strong force. Likewise, others explained that being a clinical manager or clinical educator was “too far away from the patient.” The NP role opened up the

possibility of being able to combine teaching with leadership and research while still remaining close to the patient.

Being more in control. Some participants were strongly attracted to being able to have both increased responsibilities and the autonomy to act in their clinical practice, something that had eluded them as bedside nurses. One participant said, “It was a little bit of independence, which I think was probably the most important thing, and challenge, but mostly it’s the autonomy issue”:

A patient has a headache. As a nurse you’ve certainly got the knowledge and expertise to know they need Tylenol, but you can’t give them Tylenol until you call the physician to get an order. I found that kind of thing incredibly frustrating . . . the patient’s suffering while you’re jumping through these hoops to get something that the nurse should be able to do . . . So I thought I might jump ship and go into medicine, which didn’t really appeal to me because I love nursing. . . . At that time the NP role was being piloted at our hospital . . . and I decided that it might just be the perfect fit for me.

Being more visible. The search for a more collaborative practice and for the feeling of “really being valued” spoke to the NPs’ quest to be more visible. The NP role was seen as an opportunity to be affirmed and recognized for what they really knew and did, instead of having their actions attributed to the physician:

The doctor and residents and respiratory therapist go from bed to bed and the nurse gives report. And so many times they’re all like this [turned away, bored look] until the nurse is done talking and then the resident essentially says the exact same thing as the nurse. And it’s like brand new news to them because it isn’t the nurse talking any longer.

Being more challenged. The desire to be “stretched” or to “expand one’s wings,” the need to be challenged and to “feed [one’s] inquisitive nature” concerned being more challenged. For some, being a pioneer in this role was the challenge they were seeking: “I felt I was one of the first people that saw the nurse practitioner as a way to expand my wings.” All participants wanted to be more challenged clinically. One NP said, “I thought it would be the perfect fit for someone who wants to constantly strive for more knowledge and skills that can be used at the bedside, close to the patients and their families”:

A lot of the excitement is in the diagnosis, seeking information, putting the clues together . . . And maybe part of it is the inquisitiveness or the intuition that takes you to the next step: Have you thought of ____? Did you ____? Would this have made a difference? Why are we doing things

the way we're doing them? Have you ____? . . . And I felt I was fairly competent at the bedside and ready for another learning opportunity and role expansion.

Being able to make more of a difference. The participants wanted opportunities to better meet the holistic and multiple health-care needs of patients and families, especially in a more timely matter, and to use their creativity to bring about system-wide changes. They also envisaged being able to provide more consistency and continuity of care, instead of the “episodic” contacts that tend to occur within the medical model of care. The NP role was seen as an opportunity . . . know the patient’s clinical condition in more depth and to have a larger repertoire of interventional skills to better help the patient and family:

The driving force for me was that there was this role that was written in the literature, that neonatal NPs can do so much more for your families and patients . . . Here was an opportunity for nurses to provide continuity of care and consistency of the relationship with the families while writing orders.

Additionally, most participants, particularly those who had been CNSs, were drawn to making more of a difference to nurses and the nursing profession “by marrying teaching, research, and leadership with advanced nursing care at the bedside.”

Being Adrift

Being adrift, a time of transition lasting 2 years or more, was characterized by turbulence, primarily associated with the medical management of patients. Being adrift was a painful time, when the participants were required to let go of old ways of being and their old identity and learn new ways of thinking, acting, and relating to others. They experienced feelings of being disconnected, being uncertain, and being lost. Staying afloat was required if they were to survive. This transitional experience was affected by such factors as serving as the catalyst for change, the individual NP’s emotional and physical well-being and level of knowledge and skills, environmental resources and support, and the expectations of others, who were themselves in transition due to the introduction of this role.

Being disconnected. The focus of NPs’ learning was necessarily the medical agenda; therefore, they had “no time to be present with the patients and families” in the way they preferred, which left them feeling disconnected. The search for being more connected seemed even more elusive and the resulting turbulence they experienced left them questioning their choice and lamenting what they had left behind:

I just don't have enough time. I'm too busy doing stuff. I find I miss bedside nursing . . . When I walk in sometimes when I'm doing rounds, I get jealous . . . because they're communicating with the little girl and they're talking to the mom and teaching her how to give the Septra, and I'm ordering the pills and I'm doing the spinal tap . . . I want to be on the other side of the fence again and be that comforting person at the bedside and put the cloth on her forehead.

In the absence of NP mentors, pioneering NPs described “being the physician’s shadow” for months and even several years, adding to their sense of being disconnected from nursing. At the same time, there was a strong realization that they would never be accepted by medicine except at the outer edge of the experience. There was an emerging sense of not really being part of either group, of not really fitting in anywhere:

It's hard, because you should be, from a clinical perspective, on the physicians' team, but they've got their own little team too. And so there are many teams in which you take part but you're not always a part of; you're just a part of them when they think you should be a part. And so it's sort of like floating in your own little space.

Being uncertain. NPs provided medical care to patients with complex, acute, and often life-threatening conditions, sometimes making clinical judgements rapidly in tense situations. They felt “overwhelmed,” “vulnerable,” “inadequate,” “confused,” and “mentally exhausted” as they continued to learn “from the ground level up” how to “attack” patient care management while learning to master the required procedural skills. Some NPs described being uncertain as merely “unsettling”; however, most described feeling “terrified,” “scared,” and “frightened” — emotions that were present to some degree most if not all of the time and heightened when they performed something new:

It was very frightening at the beginning. For my first 2 years of working, every time I had a call to come see something the one thing I used to do when I got woken out of bed was say, Dear God, help me make it through the night; help me make the right decision.

NPs were preoccupied with “horrible thoughts” about poor clinical decision-making and a hyper-vigilance born out of worry for the safety of patients and staff because they “did not know” what to do or how to do it, what they should and should not know in order to clinically manage the patients, or how to think, speak, and write like a physician. They spent inordinate amounts of time day in and day out going through the events of the day, endlessly questioning themselves: “What have I ordered? Was there something better? Should I have done it differently?”

Some even returned to the hospital after going home because of the second guessing:

And it was such hard work to do this. When I had to order Lasix, it was like — should it be Q6, Q8, Q12H? I don't know. Once a day? You've got to think about this, this, this, and this. You need to look at a weight gain, and fluids, fluid balance, urine output. And it was just so tiring because there was so much to think about.

Being lost. The sense of loss of identity grew from being disconnected and being uncertain. The constant focus on writing orders, performing procedures, and being explicitly told to “stop thinking like a nurse” by their physician colleagues led them to wonder, “Is this what being an NP is all about?” “Am I just a resident?” “Is this what I really want?”

So where's the NP in what I do? That's the challenge. At the beginning, people referred to me as a resident. Nurses were calling me, “Are you my resident today?” “No, I'm not your resident today; I'm your NP today.” And I think that was because the training was fairly medical. So it was a struggle and a challenge getting away from the fairly medical training and bringing back the good that I got in nursing training and putting it together.

Feeling like an “impostor” contributed to the sense of being lost. One NP explained that it was 10 months before she “no longer minded coming to work” because she felt as if she was “living with a false identity.” An inability to articulate what it was she did and how she did it, rather than “this is where I can be found throughout the week,” contributed to her sense of homelessness and lack of a sense of self as an NP. Although this perception was augmented by the lack of a graduate degree and NP certificate, their acquisition did not diminish it:

I didn't belong here. This wasn't home, this wasn't welcoming, and I was an impostor in my role . . . Well, I've got the title but I still didn't have my master's yet, I still didn't have my NP certificate yet, and yet I'm in the role, and I'd been in the role for a couple of years before I finished all the schooling pieces, only to then realize that the schooling pieces and everything didn't shape how I functioned as much as just the experience on the floor.

Staying afloat. Not all was lost during this time. Despite the turbulence, staying afloat became a motivator in itself: “Well, we're going to be the first ones out of the gate, before everybody else.” The will to succeed was a matter of “pride,” while the struggles and tensions were perceived as the sacrifice necessary to attain the rewards. Positive affir-

mations, hours of studying, jumping into the fray, checking and rechecking orders, issuing medical directives or clinical guidelines, and using their worry to promote learning became strategies for coping with the worries associated with being uncertain. Maintaining close physical proximity to the physicians in their practices was also essential to staying afloat. This “lifeline” or “safety line” concerned the physicians’ availability as support for NPs in their need to become knowledgeable and skilful in the medical management of patients. Several participants were unable to develop or maintain this lifeline and were forced to leave the role, if only temporarily. Physician support was exemplified by physicians’ willingness to share information, demonstrate, teach, and coach:

When you’re first doing the role and carrying the responsibility, you need to have a system in place for support. You need to have physicians who don’t mind you popping in, maybe even several times a day, to say, “I just want to run this by you. What do you think about this? Is that right?” And they’ll confirm it or they’ll say, “Yeah, that’s right 90% of the time, except in this case.”

Being an Acute-Care Nurse Practitioner

The first time I felt like a real NP was my first night solo with a . . . critically ill infant and getting through all of the trials and tribulations . . . feeling confident . . . getting the airway efficiently, getting the lines in and pushing fluids, and getting the orders . . . and the sense of accomplishment with being able to do those skills . . . and being able to be there for the family as well . . . having everyone’s trust and their confidence . . . and this real sense of togetherness . . . and a real sense of success and making a difference in this family’s and baby’s life . . . knowing I was a key player in that team dynamic. It was an incredible feeling.

With time, experience, and reflective engagement, NPs gradually journeyed through being adrift to being an acute-care NP. Being an acute-care NP entailed a complex process of doing, talking, thinking, feeling, and belonging to a clinical practice team that recognized, acknowledged, and valued the performance by NPs of clinical components of practice traditionally performed by physicians. Gradually, a new energy surfaced and a feeling of inner security emerged from being competent, confident, and comfortable in performing the various elements of their clinical practice. This security opened the way for NPs to negotiate a means of being committed and connected to the patients, their families, and the health-care team in a way that was morally acceptable to them and that led to their being content.

Being competent. Being competent was demonstrated by NPs’ ability to independently diagnose health problems; understand their significance;

make multiple correlations in their mind in the form of running differentials; initiate, articulate, and defend the medical plan of care; and take responsibility for implementing the plan, all with a diminishing sense of angst. They even learned to live with the risk of initiating a medical treatment plan before all the definitive information was available.

NPs described how they had learned to (a) use the written language in an appropriate form in the physician's progress notes and discharge summaries; (b) speak in telegraphic sentences, for, as one NP noted, "without appropriate verbalization, how else would others know what you're thinking?"; (c) look the physician in the eye when defending their treatment choices, particularly during daily medical rounds; (d) wear a mask of certainty while learning to live respectfully with uncertainty; and (e) take calculated risks, all the while holding the lifeline more and more distant. Once the NPs knew that they could "think like a physician," they actively pursued the integration of this form of thinking with "thinking like a nurse," knowing that what they did as a nurse within the NP role made a difference that could not be realized medically:

A few physicians have said to me, "Oh, you're thinking like a nurse again," as if it's a bad thing . . . They're thinking more, what's this person's immediate health problem? . . . And they don't really take into account the rest of the patients' lives and what's going on with them . . . Whereas now I like to know more about the people and more of the social aspects than just the actual medical base . . . because I think it all plays in . . . Sometimes it's the other things in their lives that are going on that if you just sit there and talk to them, then I don't need to change anything medically because there's really nothing medically wrong.

Being confident. Gradually, self-doubt was replaced by self-assuredness. As NPs acquired more clinical knowledge and skill, they began to believe they could be trusted, by both themselves and others, to do the right thing for patients and families. One NP said, "It took me 2 years to get [the] confidence . . . to say, yes, I made the right decision; I'm satisfied that I'm doing it right; it's correct, and nothing bad is going to happen." After gaining confidence, NPs no longer double- and triple-checked their orders, nor did they need or want to verify every decision with a physician: "I'm confident enough now that for most diagnoses I know what it is; I communicate it [to] the parents and talk about the plan of care even before the physician comes into the room."

As a result of NPs' ability to differentiate between decisions that were easy due to their routine nature (despite their possible complexity), they were now confident in articulating, defending, and negotiating the boundaries of their scope of practice, as illustrated by the comment of one NP working in nephrology: "I don't do neuro and I've never put in

a chest tube and I never will.” Being clinically competent also created the possibility for advocacy and taking a stance for patient needs that at times was different from the stance of their medical partners.

Being comfortable. Being comfortable comprised feelings of pleasure, enjoyment, and even gladness — a sense of finally coming home. The feeling of turbulence was gradually replaced by one of calm, and there was a growing sense of being part of a community, albeit in a new way. The weight of the practice was no longer a burden but rather was a source of deep satisfaction. Clinical problems were now perceived as exciting opportunities to be “stretched.” For example, one NP, as a result of feeling confident in her own competence, was comfortable enough to found an autonomously managed neurosurgical assessment clinic for a particular subpopulation of patients, “seeing between 400 and 500 children a year.”

Being committed. Acting skilfully, being present in the moment with the patient and family, listening, providing information, reassuring, explaining, particularizing and personalizing care, and exploring with the patient and family the meaning of the illness event were revealed as integral to NP practice and to the participants’ sense of identity as NPs. For instance, an NP working in a pediatric oncology service discussed undertaking the performance of bone marrow aspirations. Her story reveals that being committed includes technological competence. Because the diagnostic procedure was performed perfectly, a repeat procedure was unnecessary, the findings were reliable, the patient experienced little post-procedure discomfort, and adverse effects were minimized. Also, embracing the procedure gave the NP an opportunity to consider the developmental needs of the children, along with pain and sedation management issues. A choice of pharmacological approaches, enhanced by hypnosis and play therapy, became part of the procedure.

Being connected. Part of being an acute-care NP was developing relationships with patients and families. Although there often were too few hours in the day for quality time with all patients and families, NPs worked hard to provide occasions for building connected relationships. Some NPs gave families their business cards and encouraged them to call; one NP used spare moments in her week to call four or five of her patients just to see how they were doing; others stayed behind during daily rounds to talk with families who seemed overwhelmed, instead of expecting them to wait until rounds were completed. NPs created opportunities for consistency and continuity and took pains to ensure that patients and families did not get lost in the system. For example, an NP practising in an infectious diseases subspecialty was concerned about patients who might be “falling through the cracks.” She built a “one stop care” practice to educate them about their illness, help them to negoti-

ate among multiple care providers, and bring health promotion into the picture. If patients were late for an appointment or “came on the wrong day,” she welcomed them regardless and met with them for as long as necessary.

Being content. NPs now experienced a feeling of satisfaction and even joy with what they were doing in their clinical practice, because they had finally found some or all of the “more” that they had been seeking. They had a sense of belonging. They rediscovered a sense of self by experiencing their practice in a fuller way. NPs now realized that being an NP did not mean abandoning a nursing framework of care. Although NPs acknowledged that medicine and nursing were still distinct, they no longer saw them as mutually exclusive. They discovered that they now lived in a new world, a space between medicine and nursing: “I guess I live in my own world . . . the NP takes all of the nursing and that extra bit of medical knowledge and comes together somewhere in the middle.” By living in this “in-between space” that they found very satisfying, NPs created new possibilities for caring:

I'm sort of stuck between . . . for example, physicians will say, “Turn off all the sedation and let the kid wake up.” But the nurses are the ones literally sitting on the kid and seeing this child cry and being uncomfortable. And sometimes they see me a bit as a traitor because I'm the one who actually writes the order — stop, d/c sedation . . . but the medical team see me a bit as a traitor too . . . “Stop being a nurse now” . . . But I can see that both parties need to be defended. So I go and say to the attending, “I don't think we should stop sedation because this kid's been on it for so many days,” and I try to negotiate . . . And there's times where it's “stop the sedation” and I can understand what the medical rationale is . . . so I try to explain to the bedside nurse, also saying, “Well, if we get into trouble, I'll be there and I'll try to find a solution for you.”

Being Pulled to Be More

“I think that at the 5-year point I began to feel there was . . . a routine nature to the role and I could do more.” The participants gradually emerged from being acute-care NPs — initially the “first and only priority” — to experience new tensions and struggles arising from the shift in externally or internally driven performance expectations in other dimensions of their role as advanced practice nurses. Consequently, this time in the journey was once again a time of polarization. Participants described *being a wearer of two hats*:

But am I wearing my CNS hat or am I wearing my NP hat now? What is it that I'm doing in all of this? Part of me feels it's more the CNS role. So if I get going with the survivors' program, work with them one-on-one,

is that the CNS role or the NP role? But in some ways I'm always doing the NP piece too . . . And I've struggled to really maintain and develop some skills in terms of research and some other aspects of the CNS role. So I've really tried to wear two hats basically at the same time . . . So how should this role look? . . . I'm just struggling with that right now, actually, at this point in my career.

Being a wearer of two hats. NPs now found themselves with two identities — wearing the “CNS hat” (education, leadership, research) and the “NP hat” (direct clinical practice). Their time was diverted from one role to another, the direct practice role sacrificed to the other domains of practice or, conversely, the other domains of practice sacrificed to direct practice. For some, this polarization resulted from a resistance to engage in all the various domains of advanced practice when the search for the “perfect fit” had been personally achieved in the direct clinical practice domain. NPs experienced this time as one of being “given” added responsibilities by management. *Being pulled to be more* was an irritant because these “extra” role functions interfered with the hands-on work they loved to do. “There’s always this struggle. My primary interest in this role is patient management, but it isn’t enough to give good patient care — nursing management wants to see more output than that.” For others, the polarization resulted from a lack of knowledge or skill in these domains and/or external barriers to taking on these challenges, such as physician resistance, time constraints, and organizational “can’t do philosophies,” while the call to find the “perfect fit, to experience “more,” remained only partially met.

Being More

With new opportunities for learning and an ongoing dialectic engagement, some NPs underwent another inner transformation, gradually unifying the direct practice, education, research, and leadership domains of advanced nursing practice such that increasing the level of participation in any one domain of practice did not dispense with any of the others, but, on the contrary, increased the requirements of the others. During this time of being more, as experienced in being an advanced practitioner, all domains of practice were viewed as inseparable and mutually constitutive, their complementarity giving the role its richness and dynamism. Ultimately, the unification became how some NPs identified themselves and how they were viewed by others.

Being an advanced practitioner. Having “wrestled” with the question of which hat to wear when, some NPs decided that they were “just going to have it all.” They generated questions from their clinical practice that they then took through the research process; engaged frontline

nurses in the research and project work, which included participating in presentations and preparing submissions for publications and the translation of findings into local practice; and developed multiple and varied partnerships. It was during this time that NPs found a greater sense of personal nursing fulfilment through their opportunities to make a more diverse and broader difference to patients and families and to their profession:

[Physicians'] usage of some of the medications that are less senior-friendly has been on Ortho. [Because of our teaching], when I screen the consults on Ortho now, I'm not sitting there taking [them] off Tylenol #3 and discontinuing Gravol. Those drugs are gone. And so I get to affect patient care in that way too. Now the Ortho nursing manager and I are going to work together to go through the computerized medication records and do a comparison, between our teaching periods, about uses of targeted drugs and then do a cost analysis of the changes. And then as a nurse practitioner when I'm doing consults, they'll ask me questions, whether it's the nurses on the team or the social workers or discharge planning. Next, I'm going to work with some nurses and maybe some students on a little research project about Foley catheters because of all the nosocomial infections in seniors.

Discussion

If NPs are to be accepted for more than responding to physician shortages and are to be supported in their own development, it is essential that we understand who NPs are in terms of their unique and significant contributions to patient care. This study uncovered the complex, largely invisible experience of being and becoming an acute-care NP. The participants were faced with tremendous turbulence during the initial years. Much of the distress during the first part of their transformational journey was related to the state of transition. Indeed, the transition resulted in an emotional journey during which the new NP had to leave behind old ways of being and the identity associated with them before redefinitions of self and the situation could develop.

The work of the cultural anthropologists Van Genneep (1909/60) and Turner (1969, 1974) helps us to find meaning in the NPs' experience of being adrift. In *The Rites of Passage*, Van Genneep distinguishes three stages of transition. During the first stage, one is separated from one's status in society. This separation results in a marginal and liminal state: the second stage. After initiation, the person is finally reintegrated into the social structure in the newly achieved role status: the third stage. During the state of being adrift, NPs had a sense of being disconnected or removed from the practice community with which they were most familiar.

Viewed from the perspective of Van Gennep's "rites de passage," this literal or symbolic removal from normal patterns set up the NPs' experience of liminality.

Liminality is etymologically connected to the word limbo. NPs found themselves living between two spaces, of being "betwixt and between" (Turner, 1969). They were passing from being in a nursing position with its traditional laws, customs, and conventions to being in a position with new and different laws, customs, and conventions. Their activities during that time tended to be perceived by others as extreme; they appeared strange and sometimes disturbing and dangerous. Since this liminal state was inter-structural, unclear, and contradictory, NPs were apt to be perceived as contaminated or impure, as aberrations, and even as a threat to the status quo (Turner, 1974). As a result, NPs did not always have the support of their communities as they changed from being one type of person to another. This accentuated the experience of being disconnected and uncertain.

NPs had feelings of insecurity, disequilibrium, disorientation, anxiety, apprehension, and disorganization, along with the numerous and varied feelings that accompanied the loss of relationships, confidence, and control. Transitions involved going through the no man's land between the old reality and a new, yet to be discovered reality (Turner, 1969). Yet NPs realized that, in order to establish a role that was their own, they had to distance themselves from both nurses and physicians. The experience of being lost was related not simply to what NPs were going to do but, more fundamentally, who they were going to be. This internal struggle forced them to question their loyalty to their profession and to their new career. Were they co-opting their nursing values for goals that were achievable only at the expense of those values?

Being lost was experienced as conflict between an either/or existence and feeling neither like a nurse nor like a physician. The NPs' past was severed and they had become two unconnected pieces. There were two *I*s, which were perceived as oppositional. There was the nursing *I* with whom the participants were familiar and connected. This was the *I* they enjoyed and wanted to promote and enhance at the outset of the journey. The other *I*, the one engaged in traditional medical acts, the visible one, was a stranger. They could not accept this *I* because it was not what they wanted, but they could not reject it because it was part of their new self. They needed the knowledge and skills they were acquiring in order to be more challenged, more visible, and more in control. Yet their old self clashed with their newly discovered self. Thinking like a physician was experienced as oppositional to thinking like a nurse.

Painful though it was, the experience of being adrift offered the NPs an opportunity to be creative, to develop into what they needed and

wanted to become, and to renew themselves. The struggle to stay afloat somehow made innovation and revitalization possible. This was a time of rapid and extensive learning and growth. The struggle to stay afloat provided NPs with moments of undeniable joy and satisfaction and a glimpse of how to find the perfect fit.

As a result of the NPs' passage through this turbulent time, new ways of being began to emerge and they found new energy. Being competent, confident, and comfortable as an NP, they were better able to be committed and to make a difference; that is, they discovered some or all of the fit for which they had been searching. As a result, they began to undergo an identity transformation and to become content in the role. After the transformation they began to see that what made them unique as nurses was the very fact that NPs were poised between two worlds. This was precisely what defined their identity. Amin Maalouf's (1996/2000) memoir, *In the Name of Identity*, challenges us to ask whether NPs are half nurse and half physician. The answer is no. The NP's identity cannot be compartmentalized. The findings of the present study show that being content is about resolving the tug-of-war between NPs' affiliation with the medical world and their allegiance and attachment to nursing. The acute-care NP experiences the in-between world in an entirely new way, one that is generative in building bridges and/or serves as a bridge.

Drawing upon Aoki's (1983) reflections on the meaning of the term bridge, being a bridge and bridging can be seen as NPs acting in ways that expedite service, helping patients to move from one place to another. However, looking at bridge/bridging only in this way keeps the NP role instrumental in nature. Aoki encourages us to view bridge/bridging as a dwelling place for NPs, a space between nurse and physician, one part of the health-care system and the other taking an active part on both sides and having an identity that is both and not-both. This illustrates why the unification of medicine and nursing is so significant and possibly why NPs should not be pressed to take sides or ordered to stay within their own discipline. And it is noteworthy in light of a discourse suggesting that NPs are only resident replacements.

There are several limitations to this study. The investigation was restricted in terms of geography and health-care settings. NPs working in other provinces or in secondary-care institutions might have had different experiences to recount. Another limitation is that the broad experience of being an NP was explored. The findings are suggestive of Benner's (1984) stages of clinical competence. Yet NPs experienced a sense of hyper-responsibility at the beginning of their journey, not at the competent stage in the novice-to-expert continuum that Benner identifies. This may be because the NPs knew what it means to be a compe-

tent nurse and therefore understood the tensions and risks involved in managing a clinical situation. Additional research is needed to investigate the stages of clinical competence for acute-care NPs.

The findings make it apparent that the whole picture is a complex one, much of which has been invisible. For example, the ways NPs make a difference embedded in a moral imperative of caring as integrated with medical curing activities raise questions about the structure of their practices. If the time spent with patients and their families is conducive to holistic care, should NP practices be restructured so that more time is afforded them to do so? Explication of the nature of their journey also calls into question the tendency to underestimate the complexities of taking on this role and the duration of the transformational process. Educators, administrators, nurses, and physicians need to acknowledge the profound effect the journey has on NPs. Further research could investigate specific strategies for addressing the turbulence encountered by novice NPs and for helping them to enable caring practices.

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