Introduction

In this book, I examine the experience of nurse practitioners (NPs) working in acute-care settings within tertiary-care institutions across Canada. The material for this book came from a study employing hermeneutic phenomenology, a research genre intended to construct a full interpretive description of a given human experience as we meet it in the world, to cause us to engage in reflection, and to challenge the way we have previously seen and understood the world. In this book I describe the different perspectives from which people view their reality as they undergo a transformational journey of becoming and being in the acute-care NP role. I also explore how they struggle to engage in a meaningful practice that fulfills what they desire as nurses, and examine how their journeys are promoted and hindered. A natural inclination is to assume that this book is intended only for NPs, particularly those working in acute-care settings. But this would be an erroneous assumption. We have all undergone transformational changes in our lives — moved away from home, become a nurse, physician, educator, administrator, spouse, or
parent — all of which resulted in journeys that were fraught with complex emotions, thoughts, and actions. Therefore, parts of this book may resonate with many readers irrespective of their roles in the health care system. I also hope that the information in this book will help all of us who work alongside, receive care from, mentor, teach, or supervise NPs to better understand what is most common, most taken for granted, and what concerns us most about the lived experience of being an NP.

Much of this book is based on extensive interviews with acute-care NPs who perceive themselves as living professional lives and who have a sense of ordinary, daily routine. Yet in the ordinary activities of their day-to-day practice the extraordinary is made visible. Because of this extraordinary, complex, and multidimensional nature of the NPs’ experiences, I make use of the works of poets, authors, and artists to construct a more animated and powerful description and interpretation of their journey. Furthermore, although I acknowledge that every individual’s journey is unique, there are universal meanings that are more evocatively revealed in poetry, literature, or painting. Therefore my conversation with others, including other theorists and researchers, is an important part of this book, because “it is in this material that the human being can be found as situated person” (van Manen, 1997, p. 19), not only in this moment, but also through time.

The Research Journey

I understood from Beth’s explanation to the mother that the baby was showing signs of a systemic infection and needed to start antibiotics right away. She was preparing to insert an intravenous catheter into one of the baby’s central veins, which would be the best way to administer the medication over the next week or so. Beth was a neonatal nurse practitioner with five years of experience
in this role. Her movements were methodical as she gathered the equipment from the shelves. She explained the procedure she was about to undertake with this sick infant in a soft, gentle voice, offered the mother the choice to wait outside the unit or to remain at the bedside, then situated the stool across from where she would be working, facilitating the mother’s access to the proceedings. She gently positioned the baby, intermittently stroking his head and massaging his feet, and then, with the bedside nurse’s assistance, she silently undertook the procedure with composure and self-assurance embedded within demonstrations of caring. Upon completion of the procedure, Beth cleared away the debris while the bedside nurse and mother resettled the baby. When the mother returned to the rocking chair by the bedside, Beth sat down beside her and I heard her ask the mother what was the most pressing concern she had at that moment. The mother was crying as she expressed her regret that the strides she had finally been able to make with her baby taking the breast would be halted, just another reason to feel like a failure as a mother. Beth gently took the mother’s hands into hers and in a soft, tender voice she began to explore with her what it was like to be the mother of a sick premature infant.

Researchers are drawn to study that which has personal significance. I am not, nor have I ever been, a nurse practitioner (NP). However, in my previous nursing management role in a tertiary-care institution, I frequently heard physicians say to student NPs, “You need to think more like a physician.” I heard student and novice NPs express regret about the decision to become an NP because they no longer felt like nurses and did not want to be physician replacements. Through their tears, they repeatedly asked, “Where is the nurse in what I do?” I was involved in administrative decisions that determined whether NPs or physicians would provide the medical care in areas that were experiencing resident shortages — decisions that focused entirely on discussions
regarding cost-effectiveness and overlapping functionalities. Yet the above story of how the NP cared for a sick infant and his mother was not an isolated one. I had seen NPs massaging their patients’ limbs before and after performing potentially painful procedures, and hugging fathers and mothers when they had just informed them that their child was dying.

I came to this study because I had found myself caught up short every time I witnessed these types of caring actions. Was it because they were incongruent with what I had heard and read about NPs? Had I been unduly influenced by the dominant discourses? Was what I had observed an aberration or had it not been given a voice? Was the way I viewed NPs working in hospital-based practices not so much about incongruence but more about incompleteness?

**Background of the Study**

Nurse practitioners are “registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order, and interpret diagnostic tests, prescribe pharmaceuticals, and perform specific procedures within their legislated scope of practice” (Canadian Nurses Association [CNA], 2009, p. 1). The role was first introduced in the United States in the 1960s. In the 1970s, the concept of an expanded practice role for nurses gained momentum in Canada, and six Canadian universities offered programs to prepare NPs to provide primary health care, particularly in Canada’s northern and rural communities (Patterson, 1997). Approximately 250 NPs educated in these programs between 1970 and 1983 filled the perceived health care gap created by physician shortages in the 1960s. The creation of the role, while at times controversial in terms of title and function, provided the nursing
profession with an opportunity to expand its scope of practice and begin to demonstrate nursing’s impact on the health status of Canadians.

Competition for patients occurred as the number of physicians increased in the late 1970s and early 1980s (Kaasalainen et al., 2010). This, combined with the absence of an effective payment structure and little public understanding of the NP role, resulted in the underutilization of these practitioners and a subsequent lack of practice opportunities, despite the Boudreau Committee’s recommendation that the development of the NP role in primary health care be given a high priority (Boudreau, 1972). The NP educational initiative was withdrawn by the early 1980s; a lack of recognition of the nursing component within the NP role was a significant factor in closing NP programs. The result was a stigma that NPs were physician replacements, perpetuated in part by increasing resistance to the role from both the medical and nursing communities (Gortner, 1982; Rogers, 1975; Sandelowski, 2000), a resistance that continues in Canada thirty years later.

Then, in the late 1980s and early 1990s, the need for cost containment and efficiency resulted in demands that innovative approaches to Canadian health care delivery be quickly developed and initiated, causing a renewed interest in the role. Moreover, advances in technology, higher levels of acuity, and shortened hospital stays, combined with the downsizing of residency programs in teaching hospitals, resulted in increasingly fragmented care and shortages of in-hospital medical coverage for acutely ill patients (Barer and Stoddart, 1992a, 1992b, 1992c), all factors that have been cited as the impetus for the widespread introduction of acute-care NPs (Hravnak et al., 2009; Paes et al., 1989; Pringle, 2007). In 1988, the number of Canadian universities offering graduate-level nursing programs to prepare NPs for tertiary care began to increase (Canadian Institute of Health Information [CIHI], 2006; Canadian Nurse Practitioner Initiative
This number has continued to rise as a result of provincial funding and legislative initiatives (CIHI, 2010), demonstrating ongoing political and economic support.

All 13 provinces and territories in Canada have NP legislation and regulation. Ten of these jurisdictions recognize NPs working in hospital-based practices (CIHI, 2006; CNA, 2006; Health Professions Regulatory Advisory Council [HPRAC], 2007a, 2007b). In New Brunswick, the Northwest Territories, and Nunavut, only primary health care/family NPs are eligible for registration (HPRAC, 2007a, 2007b). Nurse practitioner is now a legislated protected title across Canada. The CNA, in partnership with the provincial nursing associations and regulatory colleges in Canada, developed entry-level competencies for all NPs, recognizing three streams of practice: family/all ages, adult, and child. NPs who had previously informally adopted the term acute-care nurse practitioner, such as graduates educated to work in NP roles in teaching hospitals, wrote certification exams for the first time in 2008.

Two types of discourse — instrumental and economic — have dominated the NP research (Rashotte, 2006). Instrumental discourse, which objectifies NPs in their role, has described, studied, and discussed their activities within an overarching framework of business, with the intention to build an adequate representation of the NP role. Researchers have analyzed and discussed the NP role in terms of NPs’ demographics, educational preparation, geographic region of practice, years of employment, and type of employment setting (Hurlock-Chorostecki, van Soreren, and Goodwin, 2008; Sidani et al., 2000); position titles and reporting relationships (Centre for Nursing Studies, 2001); role clarity and role utilization (Donald et al., 2010); role classification, responsibilities, and functions (Kleinpell, 2002, 2005; Kleinpell et al., 2006); decision-making processes as compared to those of physicians (Carnevale, 2001; Offredy, 1998); and facilitators and
barriers to implementing hospital-based NPs (Cummings, Fraser, and Tarlier, 2003; Kilpatrick et al., 2010; Reay, Golden-Biddle, and GermAnn, 2003, 2006; Roschkov et al., 2007; Schreiber et al., 2005; van Soeren and Micevski, 2001). Judging from the results of more than 30 years of research, the quality of care provided by NPs has equalled and, in some instances, exceeded that provided by physicians in the same practice, and has enhanced collaborative relationships with all members of the health care team (Carter and Chochinov, 2007; Hoffman et al., 2005; Mitchell-DiCenso et al., 1996; Russell, VorderBruegge, and Burns, 2002; Sidani et al., 2006). In addition, studies have confirmed that patients are accepting of and satisfied with NP services (Fanta et al., 2006; Sidani, 2008).

Many of the studies have been embedded in Hamric, Spross, and Hanson’s (1996) framework for the advanced practice nurse centred on five domains of practice — expert clinician, consultant, educator, researcher, and leader/change agent — or on the Canadian Nurse Practitioner Core Competency Framework (CNPI, 2004). In Canada, NPs and clinical nurse specialists (CNSs) have been recognized as advanced practice nurses (CNA, 2008) and as a result, these roles share a number of similarities. Both, for example, require education at the graduate level and share the core role competencies associated with advanced nursing practice: direct patient care, research, leadership, consultation, and collaboration (CNA, 2008). Both, under the umbrella of advanced nursing practice, are involved in “analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole” (p. 10). However, the extent of NP and CNS involvement in the activities associated with each of the competencies has varied depending on the expectations of the administrators and physicians in the organization (Donald et al., 2010; Kilpatrick et al., 2010).
Economic discourse has concerned issues of costs of care within the context of striving for optimal outcomes, with its purpose of building a case for the use of NPs as alternative health care providers. NPs have repeatedly been promoted as an inexpensive, albeit excellent, alternative to physicians. Multiple studies in a variety of settings and patient populations have confirmed that NPs provide cost savings to the health care system (Hoffman et al., 2005; Meyer and Miers, 2005; Williams and Sidani, 2001). For example, studies have compared NPs’ and physicians’ care provision in terms of volume of patients seen per day, average length of hospital stay, rate of readmission, mortality and morbidity, number of drugs prescribed, diagnostic tests ordered, consultations and referrals made, correct diagnoses, days on oxygen and/or ventilator, and monthly cost of care per patient.

It becomes clear that the prime focus of discourse within these domains has been the NPs’ direct clinical practice activities. Because of their link to procedural activities, their role has been strongly associated with the highly valued medical model of cure, and is easy to visualize, articulate, cost-analyze, and cost-compare. The degree of responsibility in the advanced nursing practice areas of research, education, program and policy development, quality assurance, and professional activity involvement is known to vary widely and is often a small component of the job because of direct patient-care responsibilities (D’Amour et al., 2007; Roschkov et al., 2004).

There is little critical discourse that focuses on the ontological nature of the NP role. A few nurse researchers have attempted to broaden the discussion with their studies of NPs working in the primary health care sector. Their findings reveal that NPs engage in responsible risk-taking, the skilled healing practice of personal persuasion, engagement in the mutuality of decision-making, and proficiency in the art of listening and attending (Brykczynski, 1985; Brykczynski and Lewis, 1997; Lewis and Brykczynski,
These caring relationships are personal, egalitarian, and collaborative (Beal and Quinn, 2002; Brown and Draye, 2003). Such insights are just beginning to transform the understanding and study of the NP movement. The power of this emerging discourse lies in its ability to uncover some of the qualitative distinctions and commonalities in the practices of NPs and physicians, and to elucidate and give voice to NPs’ unique contribution to health care. I am not suggesting that in order to strengthen this discourse we need to move away from the instrumental or economic discourses. In fact, that would be as harmful as the present situation. However, it is readily apparent that our way of knowing the NP is incomplete. Bowker, Timmermans, and Star (1995, p. 363) wrote, “A light shining in the dark illuminates certain areas of nursing work, but may cast shadows elsewhere.”

As I undertook this research journey, I understood that the picture is a complex one, but that it was time to make the invisible visible. I believed that it was a matter of “getting in on the conversation” (Jardine, 1998, p. 29) in a new way, for only in this way can the conversation be kept alive, even though it may be full of conflict and ambiguity. Therefore, the pressing question that guided my work was, “What is the experience of being an acute-care NP?” I wanted to bring into fuller view the NPs’ lived experience from their perspective, and to seek a deeper understanding of the nature of their nursing practice.

Connecting Voices

In order to enrich understanding of the experience of being an acute-care NP, I engaged in a qualitative method based on hermeneutic phenomenological inquiry grounded in the philosophical writings of Martin Heidegger (1962) and Hans-Georg Gadamer (1989). Although there is no actual method (i.e., technique or
procedural requirements) to this type of research, Max van Manen (1997) and Patricia Benner (1994) offered methodological structures that provide a meaningful guide to the process of this methodology; therefore, my work was both descriptive and interpretive in nature.

I searched for NPs who had been working in their role for at least two years and were employed more than 20 hours per week in their NP position so that they had had time to accumulate experiences as an acute-care NP, to begin to make sense out of them, and to embody the experience of being an NP within their practices. Participants were drawn from four adult and paediatric teaching hospitals in three provinces in the central and western regions of Canada that had been employing, for more than two years, NPs who had graduated from university-based nursing programs designed to educate nurses working in NP roles in hospital environments. Once ethics approval for the study was obtained from each participating hospital’s research ethics boards, I accessed the lists of NP names by various means: the professional nursing association, the institution’s human resources departments, and/or nursing administrators. I then distributed letters explaining the study via intra-hospital mail, as per each institution’s directives.

Twenty-six NPs volunteered to each participate in one face-to-face, audiotaped, in-depth interview, which was carried out in a quiet setting of the participant’s choice, such as the participant’s home or a room within the workplace away from the patient-care area. Interviews ranged in length from two to three and a half hours. I generally began each interview with the prompt, “Share with me a day in your life as an NP,” and proceeded gradually, at the participant’s own pace and own direction, to conversations concerning what drew him or her to the role, his or her education and learning, seminal influences that shaped him or her in the role, key relationships, accounts of what he or
she found satisfying and dissatisfying about work in the course of a day, real-life clinical decision-making, and visions of his or her future.

Of the 26 women and men who volunteered to participate in the study, all but one had graduated from a designated acute-care nurse practitioner program; the one exception had been trained as a primary-care nurse practitioner. Six had initially been prepared at the graduate level to be CNSs and had worked in this role prior to further advancing their education as NPs. They presented with a diversity of ages, nursing specialties and subspecialties, educational backgrounds, years of experience, and types of previous nursing experience. They came from neonatal, pediatric, and adult critical-care units. They worked in a variety of subspecialty services, including neurology, neurosurgery, oncology, cardiology, cardiovascular surgery, nephrology/dialysis, orthopedics, family medicine, gerontology, and subspecialty services within infection control. They are, therefore, characteristic of the NP workforce in Canada in the acute-care sector (Bryant-Lukosius et al., 2007; CIHI, 2010; Hurlock-Chorostecki, van Soreren, and Goodwin, 2008).

All but two of the NPs worked full time. Six had 10 or more years of experience in the role; 10 had between five and nine years of experience; and 10 had less than five years of experience. Only one had just the required two years necessary to be involved in the study. Total years of experience in nursing ranged from 14 to 35. However, having the most years of nursing experience did not necessarily mean that a participant was the most experienced. In fact, six participants with more than 20 years of total nursing experience had less than five years in the NP role, while three of the participants had spent more than 15 of their 20-plus years of total nursing experience in this role.
Introducing the Nurse Practitioners

An understanding of the lived experience of acute-care NPs begins here with three stories. They are an amalgam of the many stories shared by the participants in this study; none relate to one particular NP. For example, consider “Paula,” who earned a bachelor’s degree in science, majoring in anatomy and physiology with the intention of going to work in a research laboratory. The field of health care had always been in the back of her mind, so she continued in school and trained to be a respiratory therapist. It happened that in her first job she spent a great deal of time attending to patients in a critical-care environment, in which she frequently observed that the nurses appeared to take every opportunity to involve their patients or families in the decision-making process. She was impressed that they always seemed to be concerned about what was best for each particular patient and family, even when it meant being in conflict with other members of the team. Paula reconsidered what it meant to provide health care and realized that what she envisioned for her career was more than being involved with the technical aspects of patient care. She acknowledged that she was drawn to the philosophy of nursing, the idea of treating the person as a whole, in mind-body-spirit, and soon thereafter found herself pursuing a career as a nurse. She worked in a variety of settings and nursing positions, most recently pioneering the new NP role in oncology. Paula loved the NP career path that she had chosen. When asked if she had ever regretted this choice, she quickly responded that she “wouldn’t trade in her job for all the tea in China.”

Unlike Paula, “Susan” was interested in nursing from an early age. As a child, she loved to play first aid, applying bandages and trying to “make the hurt go away.” She attended nursing school right out of high school and, having developed a passion for the care of babies, she secured a job in a neonatal intensive-care unit
immediately upon graduation. Over the years, she had held a variety of neonatal nursing positions in transport, management, and education. She felt that her nursing career was one that continually offered learning, growth, and other endless options. Susan is a neonatal NP — a role that she, too, felt she had pioneered.

Then there is “Stephen.” His mother was a public-health nurse in Ethiopia, and at a young age Stephen often accompanied her on home visits or to community clinics, acting as her translator. He witnessed up close how his mother cared for and developed relationships with patients, and how she had a high degree of autonomy and responsibility. For a time, Stephen considered becoming a physician, but after various volunteer experiences in acute-care settings and in-depth conversations with various health care professionals, he realized that what he envisioned for his career was not related to providing diagnoses and treatments. He wanted to empower patients through health education, advocacy, health promotion, and counselling — all aspects of a role that he had seen his mother perform. He received a bachelor of nursing degree and then worked as a nurse in Northern Canada. Stephen is now a nurse practitioner in a gerontology subspecialty, a role that he pioneered.

Most of us in the nursing profession traverse paths that have already been well trodden by numerous others before us. We are seldom faced with charting new courses in foreign waters, discovering new worlds, or creating new roles. However, the NPs in this study considered themselves pioneers of this role in acute-care practices. Being pioneers has meant that they leave their safe harbours without navigational charts and with no straight course to follow:

There are no handbooks on lighthouses and perils and signals for navigating on land. No prescribed routes, no updated charts, no outlines of shoals measured in feet or
fathoms, no markers at such and such a cape, no red, green, or yellow buoys, no conventions for boarding, no clear horizons for calculating latitude. (Pérez-Reverte, 2001, p. 19)

Of all the bewildering things about pioneering a new role, the absence of landmarks — what Etienne Wenger (1998) has termed reifications — is one of the most challenging, frustrating, and sometimes disheartening. Just as the pioneers settling the wilderness experienced the absence of landmarks, these NP pioneers have faced a new world that lacks a community of practice. This new role within the traditional world of acute health care has not yet been captured and tamed in the form of social structures that have been historically tried and tested and then gradually sanctioned and reified as true. Canadian NPs in acute-care practices, as a group, are just beginning to develop their own routines, rituals, artifacts, symbols, conventions, stories, and histories that bind them together across time and space in such a way that there is a common sense of belonging and identity.

Wenger (1998, p. 5) pointed out that we learn from our social communities at work about the practices — the shared historical and social resources, frameworks, and perspectives — of a given role, through a collective language. This way of talking enables us “to sustain mutual engagement in action.” In fact, we even take for granted the way we learn and know about which enterprises within our work are deemed worthy of pursuit, of how and when our participation in those activities is recognized as competent and trustworthy by the community. That is, we learn to know when we have met the criteria that qualify us to belong. Ultimately, we take for granted that how we have changed, learned, and come to know who we are — even within our own personally created work histories — has occurred within the context of our communities of practice. Nurses who pioneer the NP role leave behind such well-established communities in order to build new
ones. Typically, the NP s in my study noted that they faced this endeavour alone in their respective areas of work — an additional challenge to be overcome in their quest for a viable identity and a sense of belonging.

This does not mean that NP s develop or preserve a sense of themselves in isolation from other communities of practice with which they work. We all belong to and work alongside several such communities at any given time, and we may even share some goals and actions with a number of them. In order to fulfill the requirements of their employers and patients — no matter how disparate and vague — NP s must create a practice in order to do what needs to be done with the set of people and the communities they work with on a day-to-day basis. As Wenger (1998, p. 6) pointed out, “In spite of curriculum, discipline, and exhortation, the learning that is most personally transformative turns out to be the learning that involves membership in these communities of practice.” The experiences of pioneering NP s in dealing with the various agendas of multiple communities of practice, as well as those of their patients, shape their journey. Both the eye-opening character of the novelty or foreignness of being NP s and the remembrance of the taken-for-granted familiarity of the elements of the established nursing community of practice caused many of the struggles, tensions, and battles that these NP s faced in their transformational journey.

Nurse Practitioners’ Transformational Journey

One of the most famous journeys in literature is to be found in Herman Melville’s Moby Dick. In this novel about the adventures of a wandering sailor, Melville spoke to the journey as the possibility of self and Others being realized in a much fuller sense;
the journey is about the ability to change and adapt in a more meaningful way. Melville suggested that some people are “landsmen” who only “water-gaze,” leaning against the rails of piers, trying to catch a glimpse of life beyond land, beyond safe harbours, caught up in the desire to begin a new journey. But in the end, they choose to stay with what is comfortable and safe. Others, however, have deep desires and needs for something more than what their personal or work lives have to offer. Consequently, these people orient themselves toward change, yearning for something more. These people long to set sail, to embark on an adventure and experience the untried, for staying moored to the familiar and comfortable is limiting to them. Yet setting sail means leaving what is known, feeling increasingly burdened with uncertainty, facing fears and confronting challenges, and then forging a new self-identity as they let go of old ways of being and belonging. But we are also warned that upon our return to the harbour, we are faced with the challenge of explaining what we have seen and experienced in a new way to those who want to see only what they have known from the pier.

Becoming an NP involves a journey from one mode of being as a nurse to another: from being disallowed to engage in a set of activities authorized only to physicians to being legally engaged in these activities. At first glance, this appears fairly simple. However, attention to the journey itself reveals elements of a transformative process embedded in a dialectical experience. Indeed, the NPs’ journey is directed both outward, into the world, and inward, into the self. The journey outward is a series of triumphs and conflicts encountered along the way. The journey inward is a series of struggles within oneself, culminating in a union with the forces against which one struggles. For example, on the one hand, NPs are not satisfied with the traditional model within which they are required to deliver nursing care in the acute-care setting. They do not want to embody Homer’s Penelope, waiting patiently,
endlessly weaving and undoing the same pattern. They need to embark on their own journey in order to find a way to fully embrace their potential and value themselves as nurses. On the other hand, there is the constant danger of seeing the activities of diagnosing and prescribing as the major identifying characteristics of being an NP — and, indeed, the primary reason for the role’s existence. They do not want to be seen as physician substitutes, simply an advanced model of handmaidens in the physician-dominated health care profession. Consequently, theirs is a very important journey toward being a fully integrated, balanced, and whole person within a new nursing role in the acute-care system.

The NPs’ journey is not linear or unidirectional. A linear view does not account for the intertwining, dynamic, and iterative nature of the learning, growing, doing, struggling, and accommodating within relationships to be found in this journey. Nor does such a view accommodate the depth of change that this journey entails. New experiences reach back to earlier experiences, which are now understood in a different way. Similarly, earlier experiences reach forward to envelop present experiences with transformed significance. Some transformations are dramatic, but most are of an insidious and cumulative nature resulting from day-to-day experiences. For some, the transformative journey takes longer or is more intense than for others. Some NPs begin to sense their dependence and vulnerability in new ways and to doubt their abilities, and therefore feel ambivalent about the magnitude of change in their lives.

The NP’s journey is not a definitive or fixed experience. For some NPs it may be a never-ending process, changing and developing with various events that they experience. Phases or periods in the journey often overlap. But ultimately, the transformative journey opens up previously unimagined new selves, new areas of responsibility, fatigue, anxiety, ambivalence, satisfaction, and joy. Just as Ishmael, the sailor in Melville’s Moby Dick,
becomes who he is as a result of wounding and healing processes, NPs learn to let go of their old ways of being and belonging, and as a result their journey becomes existential. Once this transformation occurs, their self-conceptions become harmonized with their duties, and they fulfill the Nietzschean charge to “become who you are.” In a Hegelian view, this journey requires a circular perspective. It has no beginning and no end: everything finds its place and is understood as an integral aspect of a whole.

In this book, the journey is the unifying theme that links the chapters in the participants’ stories of their ways of being and becoming NPs working in acute-care practices, and of the long transformational process that they must make if they are to claim the power of their own minds, voices, and practices. In describing their lived experience, these NPs commonly used metaphors involving water: “paddling as fast as I can,” “keeping my head above water,” “treading water,” “being thrown a lifeline,” “murky water,” “calm waters,” “feeling adrift,” and so on. Wherever possible, I have attempted to maintain this metaphor in keeping with their voices, just as I have used their words to title the various themes and meaning units of the journey. This book is as much about the NPs’ pain, frustration, and fear as it is about their finding professional satisfaction. At the time of the interviews, a few NPs were in the midst of considering professional change, and they shared with me both recent and distant transitional experiences that had shaped the way they perceived themselves and the world around them. Not all of the stories were happy ones. This book is also about “the roar which lies on the other side of silence” (Eliot, 2002, p. 185) — the opportunity to have the acute-care NP voices heard in a new way, to help to make the discourse about who they are and what they do more complete.

In the first chapter, the journey begins with nurses’ desire to search for something more in who they can be as nurses and what they can offer to others — the search for being more connected,
more in control, more visible, more challenged, and being able to make more of a difference in their nursing practice. This beginning requires either the seizing or creating of an opportunity, with the NP role perceived as possibly offering “the perfect fit.” Chapter 2 tells the story of the NPs’ turbulent journey through the uncertain waters of engaging in medical responsibilities previously denied them in other nursing roles, a time of being adrift, experienced as being disconnected, uncertain, and lost, but also of staying afloat. In chapter 3, the story shifts to the emergence of NPs’ feelings of inner security that emerge from being competent, confident, and comfortable in their performance of the various elements of their clinical practice, which opens the way for being committed, connected, and content. During this part of their journey, NPs fully sense their direct clinical practice role. Chapter 4 reveals that the journey is not yet over. NPs discuss new tensions that arise from the shift in internally or externally driven performance expectations in other dimensions of their role as advanced practice nurses; a time during which they experience being pulled to be “more.” In chapter 5, a further transformational process is revealed: that of being more, experienced as being an advanced practitioner. At this point in their journey some NPs experience the unification of the direct practice, research, leadership, consultation, and collaboration competencies of the advanced nursing practice role.

Despite being burdened by a struggle enmeshed with politics and history, NPs eventually navigate their own course as they journey toward self-knowledge, personal transformation, and authentic living as a nurse. Consequently, they experience an odyssey of learning — learning to find a new place where they feel they belong, learning to engage in and contribute to their communities of practice in a new way, and learning to inhabit a new identity — all of which are part of the quest for more, for finding the perfect fit.
Steps slowed
Head bent low
But still along the way

Hopelessness pervaded
Doubts persuaded
But still along the way

Time and again
Fear shouted “You’re no man”
But still along the way

Sweat and tears
Poured through years
But still along the way

Stumbling, crawling
Crying out, calling
But still along the way

Searching blindly
For destination and finally
Finding it one glorious day

— Jana Justice-Olivieri, “The Journey”