Chapter 1

Being Called To Be More

A journey of a thousand miles must begin with a single step. — Lao Tzu

Why do nurses decide to become NPs? What initiates or precipitates their journey? What are they looking for? What might they be running away from or toward? What more do they want? How do they know when to start out?

Certainly, the call to be an NP is not always clearly heard or understood at first, and for many the destination is also unclear. Some nurses take the leap without a moment’s hesitation, while others lag behind, watching the experience of others and then following their lead. For some, the desire to be an NP is driven by a vague pull toward something more. Not quite satisfied with who they are as nurses or what they are currently doing, they are willing to test new waters and set sail for destinations unknown, unsure of what they are looking for but hoping that
it will be revealed along the way. Nevertheless, knowing what they value and what they no longer want becomes their North Star. For others, setting out on the journey begins with a dream: they are motivated to pioneer the NP role and continue to be fortified during the journey by reflecting on what it could mean to patients or nursing. Their reflections bring them to a new consciousness of nursing; they are almost able to feel a new relationship with it.

“Joan” worked as a CNS in a program whose patient population had outgrown the number of staff members that could effectively provide the complex clinical service needed. It came to her attention that the provincial government was looking to fund programs that would deliver health care in innovative ways. Joan used this external call as the opportunity to submit a proposal for a five-person interdisciplinary team — composed of a physician, an NP, a social worker, a pharmacist, and a clinic nurse — that would deliver one-stop care to the patients in the program. She lobbied across the institution for the NP position, with herself in the role, seeking support from the service’s clinical team members including the medical and administrative directors. In her own words, what Joan really wanted to do “was to be able to marry the kind of things that are called physician practice, things that the physicians are felt to be responsible for, and bring them into [her] nursing practice” and “really focus in on a certain group of individuals who [she] felt were falling through the cracks in our health care system.” The new program received funding, and the group, with Joan as NP, provided holistic care for the province’s entire specific patient population (approximately 900 people) from 2001 on.

For nurses like Joan, the dream of being an NP is fairly detailed: they are weaving careers from their dreams, setting out to find or create a nursing role that is the perfect fit. As weavers of their roles, some nurses first create a mental picture
of their destiny as NPs — a vision of who they want to be and what they want to accomplish. They select the patterns, colours, and textures of their lives in this role. It is up to them to judge how pleased they are and to decide what changes are needed in order to create their desired role. Being a pioneer makes this creation possible, and the vision becomes the sextant used to navigate their journey.

This is not to say that the nurses’ dreams or desires include a navigational chart, or even what the exact destination will look like. Yet whether they are visionaries or seekers, as they struggle to find a place within their clinical program, organization, and profession as NPs, they find that their desire for more is what they need to help them deal with the tensions and turbulence they experience throughout their journey. The constant refocusing and reflecting on what first called them to the NP role in the first place helps them to visualize the difference that they wish to make, the people whom they want to help, and the goals that they hope to achieve. Ultimately, their desire for more helps them determine when they have reached their personal destination of being an NP.

In seizing the opportunity to become an NP, nurses perceive possibilities for who they can be as nurses and what they can bring to their nursing practice that they may not have seen in any other nursing role. They have found only a partial fit with who they want to be as nurses but are hopeful that the NP role will offer a perfect fit. Being in direct clinical practice is an integral part of that fit. For at the heart of being an NP is, as one NP noted, “the opportunity to work with patients, hands on, all the time.” For nurses already in patient-care roles (e.g., bedside or transport nurses), the NP role offers the possibility of being more in clinical practice without requiring that they leave the profession. For those who have been away from hands-on care, becoming an NP offers the possibility of returning to that which they love and
miss but combining it with the opportunity to include more of that which they have found in other nursing roles (e.g., administrative leadership or education).

The desire for more is inherent in the reasons for initiating the journey to become an NP. “Kerry,” a neonatal NP, had worked in a variety of settings over the course of her twenty-five-year nursing career — obstetrics, pediatrics, public health — intertwined with various stretches back at school. Yet, she had always come back to the neonatal area. She had pioneered a neonatal transport program and she loved the autonomy that it provided. The attraction was the critical thinking needed on transport, the ability to put the pieces of the puzzle together. Kerry loved making a diagnosis, finding the solution, and working collaboratively with her medical colleagues. But she realized that she was still not fully satisfied; she wanted more. The transport role had whet her appetite for the possibilities of what more she could be and do as a nurse, what more she was capable of, and what more she could offer to the patients. She discovered possibilities within herself for being as a nurse that she liked and desired, and she chose to bring them into the light. When the prospect arose for her to pioneer the NP role, she felt that it provided the opportunity for her to learn more, maximize her potential, and contribute and make a broader difference to patients, their families, and nurses at the bedside. At the same time, it would complement who she already was as a nurse.

There are five dominant forces for being called to be more: being more connected, being more in control, being more visible, being more challenged, and being able to make more of a difference. Rarely is only one of these forces involved in the process.
Being More Connected

Being connected, physically and emotionally, to patients and families is a strong force for becoming an NP. “Laura” had worked in a cardiology clinic where she enjoyed being recognized as an arrhythmia expert. She also cherished the freedom bestowed upon her by the physicians to detect and diagnose pacemaker dysrhythmias and to reprogram them as necessary to fix the problem. However, she felt that she had become very technical in her nursing role. Laura felt a loss of nursing and so returned to an inpatient bedside nursing role in which she could feel more connected to the patients and their families. Yet in this role she felt the loss of self-sufficiency and recognition that she had formerly experienced. Consequently she was searching for something more when an NP program at the local university opened its doors. Laura knew immediately that it was what she wanted to do. Others similarly described being in clinical management or clinical educator positions as being too far away from patients. As one NP noted, the role opened the possibility of “being able to combine teaching with team leadership and a bit of research, while allowing me to stay close to the patient. This is a good fit for me. It gives me all of the things that I think are important about nursing.”

Establishing meaningful connections with patients and their families and being involved in a personal way is at the heart of caring and commitment in nursing. Bishop and Scudder (1990) found that even if individuals are not initially attracted to nursing for this reason, the sense of connectedness becomes embedded in their personal sense of nursing if they choose to remain in the profession. “Abby” recalled how restless she had become in her work as a clinical educator, in large part because she was afraid she had begun to move too far away from the bedside. The driving force behind her decision to pioneer the NP role had been to be more personally connected with patients and families, while still
being able to connect with and make a difference to her immediate nursing colleagues in the education component of the role. In addition, she could make larger systemic changes within nursing, something that she had experienced as an infection-control nurse. As Abby continued in her reflections, she revealed the circular nature of her nursing journey: “It’s fascinating to go back and look at where your career path has taken you and the steps that you took that you weren’t sure where they were going to lead, but in fact, in hindsight, do lead up to you integrating those skills.”

Having worked as a candy striper during her adolescence, Abby had been drawn to the sciences. But even at that time, she knew she would not enjoy the episodic nature of their patient-care service: “I didn’t want to be in a position of just popping in and popping out. I wanted to actually understand and develop relationships with people over a longer period of time.” Instead, nursing provided her with the opportunity to be with patients and families over a longer duration and to be immersed in learning the sciences. However, the traditional bedside nursing role had ultimately not been challenging or autonomous enough for her — hence the sojourns in other nursing roles that took her away from hands-on clinical practice, the only alternatives at the time. The creation of the NP role finally offered Abby the possibility of being intellectually challenged in the multiple dimensions of nursing, while at the same time being more intimately connected with patients and families over long periods.

Being More in Control

Majestic eagle
In gilded cage, her wings clipped
Her spirit sundered.

— Mika Yoshimoto (2008, p. 6)
Some nurses are strongly attracted by the possibility of finally having both increased responsibilities and the autonomy to act in their clinical practice. In other words, they seek to have control over their practices, which they feel has been missing from or has eluded them in their role as bedside nurses. Indeed, the frustrations with practice limitations and the inability to experience their own potential in the traditional bedside nursing role has led many nurses to consider either applying to medical school or leaving the health care field altogether. However, the NP role offers them the opportunity to remain rooted in the nursing profession, in direct clinical practice, in a position that holds the promise that they can have more independence and more control over the decisions about patient care, including the treatment plan and the way in which the care can be delivered. Greater knowledge and skill, combined with the authority to use all of their abilities more holistically, potentially enables nurses to make a greater difference, a finding equally expressed by a group of American primary-care NP pioneers in the mid-1960s and throughout the 1970s (Brown and Draye, 2003). One NP explained her attraction to the role:

At the time I was in a staff role and I wanted to do something different. . . . The focus wasn’t on delivering the best patient care, it was on who has the appropriate title to do X amount of care. Just one example: 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 for plain Tylenol. I found that kind of thing incredibly frustrating because it wasn’t a matter of the nurse not having the knowledge and expertise; it was the role limitations, the barriers to optimal practice. So the patient’s suffering while you’re jumping through these hoops to get something that the nurse should be able to deliver. . . . So I thought to myself, I either jump ship or
go into medicine, which didn’t really appeal to me because I love
nursing. . . . And I finally decided that . . . I was going to stick it
out but I would do my masters preparation, which would give me
the background to have more options. And at that time the NP role
had been piloted at [hospital] . . . they were trying new territory . . .
and I decided that it might just fit for me.

Suzanne Gordon’s journalistic work, Nursing Against the Odds (2005),
passionately describes the health care systems that severely restrict
what nurses can do without a doctor’s order, which both creates
problems and reinforces status and power hierarchies between
nurses and physicians, a deadly catch-22 situation. She described
this situation from the physician’s perspective:

Every night, a thousand times a night, all over the coun-
try, nurses are calling doctors reporting that a patient has
a fever and asking doctors what they should do about it,
or asking the doctor whether they should give the patient
Tylenol. And every night, doctors are berating nurses for
calling them up and bothering them, because they are
reporting a fever, and the doctors are thinking to them-
selves, “Why are you so stupid that you are asking me
whether you should give Tylenol?” (p. 48)

Akin to wanting more control is the desire for more flexibil-
ity. Wanting to be more involved in all aspects of the patient’s
care (“the social, the emotional, helping patients cope with the
stressors, the medical care”), liking the flexibility in meeting the
patients’ needs, and appreciating the additional responsibility and
accountability results in nurses being attracted to a role in which
they believe they will be able to direct care in collaboration with
physicians. Moreover, they are drawn to the possibility of being
able to spend time with patients and their families.
Being More Visible

It was about diagnosing and coming up with the solution and being able to really work collaboratively and build those partnerships with our medical colleagues. . . . And I felt as a nurse that one of the opportunities to present itself would be to become a neonatal nurse practitioner. . . . Well I guess, it’s like that power, not power, but the sense of fulfilment that you have at the bedside when you work together . . . being part of the team in terms of how could I, as a nurse practitioner, be more part of . . . working collaboratively with making that plan . . . but working with the nurse, working with the whole team in how we can make a difference, but really being part of that discussion.

Becoming an NP is also about the call to be more visible: the search for a more collaborative practice, of being able to contribute more to the team and to experience the feeling of being truly valued, all inherently speak to this. Nurses who become NPs want to have their voices heard and to be recognized and acknowledged for their own agency. They are frustrated with being viewed as “just a nurse” (an implication that nurses are engaged in insignificant work) or “just temporarily borrowing the doctor’s agency” (Gordon, 2005, p. 50). NPs view their role as an opportunity to be affirmed and recognized for what they know and do, rather than having their actions attributed to the physician. For instance, “Sally,” in her role of transport nurse, was tired of the evasive and roundabout language that demonstrates deference to physicians. She no longer wanted to play the doctor–nurse game of arriving at the identification of the problem or plan of care without venturing on the medical territory of diagnosis, treatment, or prescribing:

So you have an air leak happening and the baby’s telling you what symptoms he’s having; you’re looking at an X-ray that’s telling you, this baby has a pneumothorax. And the parents are asking me,
“Well why are you putting that needle in the chest?” And so, you’re going, “Well he has symptoms that are suggestive of a hole in his lung, an air leak.” No. He’s got a pneumothorax. It’s a diagnosis. It just boggles my mind to try and get the wordsmithing around just to stay within the scope of nursing.

Gordon (2005) observed that even in settings in which nurses can change ventilator settings, wean patients off inotropic agents, insert catheters, and initiate intravenous fluid therapy, after which they get the physician (resident) to write an order, the treatment interventions are presented on rounds in such a way that the nurse seems to have acted on the physician’s behalf. As these participants confirmed, it is common to hear staff physicians inform new residents that nurses know their preferences. All of this reinforces what physicians admit that they have been taught through informal or formal lessons and socialization: “The nurse is stupid, because she uses dumb language, makes dumb suggestions, and doesn’t know anywhere near what the physician knows” (Gordon, 2005, p. 49). Nurses “have no real agency of their own” (p. 50).

The term doctor–nurse games was coined by Leonard Stein (1967) to refer to the implicit or explicit relationships of power between physicians and nurses and the social game played by both parties to maintain that balance. Such “games” conceal nurses’ mastery of their knowledge and skills and their importance to patients. Nurses remain barely visible to physicians, except as objects of derision and disrespect. One participant bemoaned that nurses are visible to society only as individuals who carry a bedpan for a living. According to Gordon (2005, p. 148), nurses continue to be viewed as individuals “who operate on a field that has already been prepared for them by the doctor.”

In Hegel’s (1971) parable of the master and the slave, presented in Phenomenology of Mind, two individuals approach each other from opposite directions along a path. As they approach each other,
they desire recognition — for they do not really know who they are until they see themselves in another’s eyes, until they are recognized by an Other. They desire the recognition of one person by another as equal human beings. Yet each fears that the Other will deny him this recognition, will force him to submit to his will by moving off the path. So, they fight until one submits. In this story, Hegel informs us that our very sense of who we are — our identity — is constructed in relation to the Other and has no autonomous meaning. For example, I cannot be a master, act as and think of myself as a master, unless the slave acts toward me as slave to master and treats me as a master. And vice versa for the slave. For Hegel, consciousness (one’s sense of self; one’s identity) is always limited by its embeddedness in history, and thus neither the master nor the slave is able to think outside the modes of consciousness that are available in the culture at a particular point in time. It could be argued, then, that if nurses are never able to rise outside the history and positionality of nursing as it is currently constituted in our culture, they will remain invested in their historical role as the physicians’ handmaiden, a position perceived as unequal and lacking in recognition and freedom. Hegel further proposes that the process of recognition is “a battle” (p. 171), a “life and death struggle” (p. 172). Charles Taylor (1994, p. 50), a Canadian philosopher, explicitly draws on Hegel to argue that “the struggle for recognition can find only one satisfactory solution, and that is a regime of reciprocal recognition among equals.” Yet Hegel (1971) proposes that for the slave, who has not the courage to risk his life to win freedom, that man deserves to be a slave; on the other hand, if a nation does not merely imagine that it wants to be free but actually has the energy to will its freedom, then no human power can hold it back in the servitude of a merely passive obedience to authority. (p. 175)
Viewing freedom from this Hegelian perspective, is it possible that nurses who wish to be NPs have perceived the physician-nurse relationship as an asymmetrical one such as that of master and slave, and that, by remaining in this traditional relationship, they will be unable to experience a full flourishing nursing life? Is it possible that nurses who wish to be NPs recognize this pioneering journey as an opportunity to be active agents of culture and history, shaping what nursing can be, and therefore act in ways that lead to the recognition that has previously been denied nurses and nursing?

**Being More Challenged**

A lot of the excitement is in making the diagnosis, in the seeking of information, putting the clues together. . . . And 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? . . . I was ready for another challenge, another learning opportunity.

Thomas Henry Huxley wrote, “The rung of a ladder was never meant to rest upon, but only to hold a man’s foot long enough to enable him to put the other somewhat higher” (Bartlett and Kaplan, 1992). Some nurses, once they possess a sense of ease with the nursing terrain they have already explored, are challenged to extend the horizons of their actions and risk their stable identity for a different identification with their world. They seek to feel more challenged in their practice, more stimulated in their work, and more motivated that they can continually grow and learn as nurses. Although this can be accomplished by transferring to another type of specialty nursing, advancing one’s education, or moving into an administrative, education, or research role,
none of these options was perceived as the perfect fit for those nurses seeking a multiplicity of “mores” while engaging in direct patient care.

A desire for personal growth, woven into a need to be challenged and to feed one’s inquisitive nature, to expand one’s wings, is another common thread among NPs. Indeed, many participants expressed a sense of good fortune and gratitude at having had mentors along the way who saw their potential, encouraged them, and provided opportunities to push themselves. The mentors spoke to the individuals’ desire to maximize their potential, although many were uncertain of their capabilities when they initiated their journey. As one NP noted, the NP role is perceived as initiating the opportunity to be able to continually move, which is the perfect fit for someone who loves to study and wants to constantly strive for more knowledge and skills that can be used at the bedside, close to the patients and their families. The role provides more academic and clinical educational opportunities, thus offering the potential for NPs to challenge their intellectual abilities, and revealing the multiple possibilities for being a nurse in clinical practice.

Some NPs are strongly attracted to the scientific focus of medicine. Some expressed this as a desire to study more anatomy and physiology in particular, or the study of math, biology, chemistry, and physics, although they were reticent to frankly admit to something that is now deemed to be politically incorrect in nursing — an outcome, intended or not, of the discourse of nursing scholars such as Gail Mitchell and Marc Santopinto (1998), Martha Rogers (1972), and Margaret Sandelowski (2000). The NPs had chosen less depth of knowledge in the hard-core sciences in order to achieve the broader perspective of human life and the human condition that nursing offered. A desire to learn more technical skills, to be mentally stimulated by the complex problem-solving inherent in making a diagnosis, and to feel that they are doing
something that’s making a difference to someone’s care in terms of their biological status, was, as several NPs noted, a real incentive for them. Yet, the acknowledgment of being drawn to this level of knowledge and skill is always embedded in the recognition that this is not nearly enough for them in their practice. They envision that becoming an NP will give them that little extra they want, in terms of more knowledge and skill, embedded within a connected relationship to their patients and families. “It really is an ideal role,” summarized one NP, “that offers the opportunity to attain more depth in the medical sciences, which, when combined with nursing knowledge, better enables nurses to meet the patients’ needs in a more timely and holistic manner.”

Some nurses are enticed by the opportunity to integrate many different aspects of practice, to feel, in some NPs’ words, “more well-rounded.” This appears to be particularly true for NPs who have held a diversity of nursing roles throughout their careers. One NP explained why she had been drawn to the role:

Being able to bring all of the experiences that I’ve had throughout my career, being able to work with a variety of people, being able to make a difference at the bedside, but also being able to do some of those other more advanced practice roles, being able to go to conferences, present, publish, do research, mentor colleagues, being able to interact with different people, different organizations — I think all of those things were really critical for me.

Finally, for some nurses there is the call toward leaving that which is familiar in order to explore uncharted territory; the challenge of being a pioneer is, in and of itself, an exciting opportunity to test one’s abilities, creativity, and initiative. Itching to develop and use their full expertise and potential, these nurses exemplify what it means to risk what is known in order to open up to new possibilities for the purpose of securing a greater hold on their
world within nursing. One NP explained, “I really felt it was important to move along and see myself as taking on a challenge that not many people have taken. So I felt I was one of the first people that saw the nurse practitioner [role] as a way to expand my wings and went for it and got in and it was just really exciting to be moving in a new direction.”

Traditionally, nurses have been socialized to be nice, to be compliant. Perhaps this socialization can be viewed as “shrink to fit”: shrinking oneself to fit what others expect. As Brown and Draye (2003) found — a finding confirmed in these participants’ stories — the NPs’ struggle is for autonomy not for its own sake but as a means to transcend the limitations in the traditional bedside nursing role. They are in search of a new fit that challenges their personal abilities and provides the opportunities to discover their own possibilities for being.

Being Able to Make More of a Difference

A desire to deepen, broaden, and strengthen one’s knowledge, skills, and abilities regarding the medical aspects of patients’ care, matched with authorized application (which is associated with being more in control), is intimately linked to a desire to provide more effective and holistic nursing care. The NP role, perceived as offering the opportunity to know the patient’s clinical condition in greater depth, speaks to a practitioner’s desire to better understand the patients’ underlying disease processes and have a larger repertoire of tools and skills with which to help the patients and their families. NPs envision that the additional knowledge and skill will enable them to make more of a difference.

Waiting is part of the lived experience of being a nurse. Nurses wait for the physician to be of the same mind regarding the needs
of the patient as brought forward by the nurse on behalf of the patient or family. They live with having to wait for physicians to respond to patient care needs: “Nothing bothers me more than to see a patient writhing in pain while the nurse is struggling to get hold of a physician who won’t answer his page or having to wait until the physician gets out of the operating room, or whatever they’re tied up doing, before the patient gets an analgesic.” Becoming an NP includes the vision of being able to provide more timely care.

Arising from the increasing fragmentation of care in the modern health system is a vision of being able to provide consistency and continuity of care over time, rather than the snapshot, episodic, or sporadic contacts that tend to occur within the medical model of care in the hospital setting. Achieving this vision will better facilitate meeting the holistic and multiple health care needs of patients and their families:

[W]e were talking about bringing in a care provider, a physician, who could be some doc from a doctor’s office, or a replacement who’d come through the city who didn’t know our babies well, maybe didn’t have a whole understanding of neonatology, and definitely not the dynamics of neonatal programs and family-centred care and developmental care, just the general pathologies that we see in the neonatal population. We have nurses working at the bedside who are experts, who do have an understanding of those, working with our families day to day with certain groups of babies. And yet we were having strangers come in and look after them and write the orders. And here was an opportunity for nurses — and the literature supported that nurses could be given the education [as an NP] and be able to be that care taker . . . [who] know our babies and provide the continuity of care, the consistency of the relationship with the families.
The NP role offers the opportunity to make change for patients and families not only in relation to the patients’ biological needs, but also in terms of the variety of other needs, such as quality-of-life issues, that are present as a result of physical illness. It is also seen as an opportunity to utilize creativity and initiative in new and expanded ways to bring about system-wide change that may result in better service to patients and their families.

Some nurses, particularly those who have been in CNS positions, are also drawn to the possibility of making a difference to the nurses with whom they work and the nursing profession as a whole, while retaining a focus of clinical practice at the same time. There is a strong desire to greatly help the staff nurses by connecting teaching, research, and leadership with advanced nursing care at the bedside. One NP reflected that she felt the role offered a greater chance to demonstrate to junior nurses a whole spectrum of options in the clinical setting, as it is now rare for nurses to stay in one area for 25 years. She hoped that by being a role model for her nursing colleagues, she would be able to heighten others’ awareness of what nursing brings to patients and families, and thus retain nurses at the bedside and attract others into the nursing profession.

Answering the Call: Initiating the Journey

It is not always easy to hear the voice from within, let alone heed it. But once it is noticed, some form of action is required. At this point, some nurses may decline to journey further. Even when they gain a fresh insight into their discontent, they may swat it away like an annoying fly. Others disperse this uncomfortable energy by talking about it incessantly, and so they never gather and hold the energy to do anything about it. But some nurses say yes to the call. They seize or create opportunities to initiate
their quest in search of more, even though it is at this point that saying yes to the journey means facing the first challenge: fear of commitment to a journey with an unknown destination. Commitment, in fact, can be quite sobering. In answering the call, they must step into the uncertain waters of the unknown and enter the sea of risk. Yet saying yes to the journey is an invocation that can connect them to all those who believe in its power, and once they are ready to commit, opportunities and circumstances seem to open in a most serendipitous unfolding.

In the history of nursing, in both Canada and the United States, many nurses have seized an opportunity to follow their dreams as a result of questions and concerns about the lack of resident coverage in the academic teaching hospitals. Pioneering NPs in acute-care practices have been privy to the debate about who can and should best fill the service gap, through discussions with their immediate supervisors, many of whom have been recognized and acknowledged as visionaries. For some nurses in this study, the desire for change and personal growth, particularly in the direct clinical practice arena, had been present for many years. However, without the creation of the NP role in this setting by nursing visionaries, they may have remained as bedside nurses, turned to management or teaching, or left nursing altogether.

And [the Nursing Department] felt that what they needed to do was to look at the clinical gaps in the hospital around the resident, but also around nursing. On the surgical floors one of the gaps they felt that there was, was accessibility to surgeons during the day because they were in the operating room, or in clinics, and [the nurses] couldn’t reach them and so there were communication gaps. . . . They felt there needed to be more nurse education, there needed to be more mentoring and nurse experts in the building; so the role came about with looking at all those gaps. . . . I was in the right place at the time . . . and I was ready for a change.
It is equally important that there are visionary physicians who embrace the role. These pioneering NPs were cognizant of their “good fortune” in working with physician colleagues who were not threatened by the idea of sharing their practice knowledge with nurses in a new role, and who viewed the NP role as a possible collaboration, not a replacement for residents.

During the 1990s, hospitals all across Canada reduced the number of CNSs or phased out the role entirely. Some nurses chose to become NPs because they either heard unsettling rumours of change or were forthrightly informed that their CNS positions were to be declared redundant; they needed to change with the times. CNSs felt lucky when their nursing directors guarded their welfare by suggesting that they combine the CNS and NP roles. Some were fully supported financially to obtain the additional NP educational qualifications, while others had staff physicians who assisted them in securing clinical internship placements. They chose to seize the opportunity to pursue advanced knowledge and skills as a means to augment their effectiveness. Similarly, nurses returning to school for a graduate degree in the hope of opening up other career opportunities suddenly found acute-care, hospital-based NP programs being offered to them. Other nurses who had left the clinical area in search of new challenges as clinical educators, managers, and research assistants jumped at the opportunity to return to direct clinical practice when they were approached or supported by their nursing leaders or physician colleagues to create an NP position in their area of expertise. In one narrative, a physician not only encouraged the nurse to become an NP, but also made it a realistic venture for her. In addition to making it possible for her to return to school full time while working flex hours in her full-time position, he helped to create an environment of support among all the physicians within the service, and then mentored her during the clinical practicum.
Sometimes the opportunity comes in the form of a personal invitation to join the pioneering team. Such external recognition from a reliable and respected source prompts nurses to consider the possibility that they might be able to take on this new challenge. Without this recognition, many doubt that they would ever have considered such an undertaking, let alone believed they were capable of such an endeavour. As “Caitlyn” admitted, her first response when asked to consider applying for a temporary NP position was “to go into the corner to the other nurse clinicians and say, ‘Do you think I can do this?’” Encouraged by another NP in the institution, Caitlyn found the courage to test the waters. Surprisingly, she said that she had initially left bedside nursing because of a lack of confidence in her own abilities and an overwhelming fear that she would harm her patients because of her perceived lack of appropriate knowledge and skills. Anticipating that she would have to leave nursing altogether, she had been offered clinical project work, a job that helped her to see the bigger picture and think system wide. In this position, she met others who recognized her potential and encouraged her to return to the bedside as an NP. Caitlyn had been an NP for nearly a decade at the time of my interview.

Many nurses also develop the confidence and courage to enroll in graduate school, pioneer the NP role in their institutions, and persevere when the journey becomes particularly treacherous, the obstacles overwhelming, and the number of battles lost outnumber those won, because an Athena has supported them in challenging the status quo early in their nursing careers. “Jill” recollected that as part of her consolidation experience, she had spent a month in an outpost nursing facility, where she witnessed an expanded-role nurse in action. There she had the opportunity to see and do things that she would never have seen and done in the city. This experience encouraged her to be a risk-taker and independent thinker. She also noted that at the beginning of her
nursing career, she had worked for a wonderful head nurse who strove to develop a strong sense of professional nursing identity and patient-care responsibility in each staff member by instituting primary nursing care, a nursing orientation that she believed she would find once again in the NP role. This mentor had a “maybe we could” philosophy that Jill found empowering and that helped to “set her up for down the road.” This “can do” message is one that some nurses hear throughout their personal and/or professional lives, providing them with the impetus necessary to seize the day when it finally presents itself and to initiate the journey.

In summary, it is often because of the encouragement of others that nurses who initiate the NP journey are willing to explore the possibility of answering the call. These leaders are perceived as wings-beneath-their-feet mentors, leaders whose message is always, “If you believe in something, do it. Don’t worry about things, have integrity, but don’t not do something because you think that you can’t.” Inspiring nurses to dream big, take risks, and to believe in themselves, to see their abilities and their potential, these leaders are the winds necessary to help them set sail. And so the journey begins.