Being Adrift

tangled in.
sinking wreckage
of present.
anchored to
disillusionment
of dying past.
adrift on
engulfing tide
of future
with flagging sails set
in no particular direction.

— Jana Justice-Olivieri, “Adrift”

“In the port is safety, comfort, hearthstone, supper, warm blankets, friends, all that’s kind to our mortalities” (Melville, 1992, p. 116). Melville begins his epic novel Moby Dick in the safe harbours of New Bedford, a town that exists as a place of departure
and return for whaling boats. In the harbour, everyday life is intel-
ligible and predictable. The daily routines and rituals provide a
terra firma. Melville suggests that safe harbours are places where
people anchor themselves in what is comfortable and secure, in
a fixed sense of who they are, either as members of the domi-
ant culture or as others given a space at the margins.

Nursing, as known by NPs prior to initiating their NP journey,
is like New Bedford, a particular type of community: safe and
secure in itself, with most of them absorbed in the everydayness
of their lives. Work life is predictable. Yet in order to grow and
develop, to realize their fuller possibilities, like Melville’s pro-
tagonist Ishmael, nurses who become acute-care NPs are those
who become weary of comfortable spaces and are prepared to
sacrifice the safety of the harbour and venture forth. Once they
commit themselves to the journey, however, they are cast adrift; as
Melville metaphorically observes in the narrative of Ishmael’s jour-
ney, “In the gale, the port, the land, is the ship’s direst jeopardy”
(p. 116).

Patient care by NPs requires sophisticated skills, advanced
critical thinking abilities, political savvy, and a high level of deci-
sion-making, and thus necessitates their full focus and energies.
For the most part, nurses who embark on the journey are confi-
dent and expert in the nursing roles they are leaving. When they
commit to the launch, they must leave this comforting port of
competence and enter a new position with different and unknown
expectations. Because the NP role continues to evolve over time,
and is influenced by many environmental factors both internal
and external to the hospital setting, their journey is barely begin-
nning upon completion of their formal NP training. Certainly, as
students, they will have had experience making diagnostic and
treatment decisions. However, as noted by Buehler (1987, p. 50),
these are made as a “guest” in training sites and with full rec-
ognition that they are, after all, “only” learning. New NPs face
the major tests of their clinical judgment in their first positions. Being adrift then is a time of transition.

The work of cultural anthropologists Arnold van Gennep (1960) and Victor Turner (1969, 1974, 1984) on rites of passage helps us to find meaning in NPs’ experience of being adrift. In his book The Rites of Passage, van Gennep distinguished three stages of transition. During the initial stage, a person is separated from his status in society. This leads to the second stage, a marginal and liminal state, or state of ambiguity, which has none of the attributes of the past or future states. After an initiation, the person is finally reintegrated into the social structure in a newly achieved role-status, the third, or post-liminal, stage. Viewed from this perspective, journeying through “being adrift” is the NPs’ experience of the second transitional stage; that is, literal or symbolic removal from normal patterns engenders the NPs’ experience of marginality or liminality.

the place/spacetime
the situation/
leaning on the membrane between one dimension and
the next you will find it flexible as well as transparent.
moving between dimensions requires a leap of faith.

— Peter Beckett (2009), “Luminality”

Liminality, sometimes referred to as luminality, has etymological connections with words such as limit, limbo, preliminary, sublime, and subliminal (Barnhart, 1988). As the Latin root of these words limen, meaning “threshold or boundary,” implies, NPs find themselves “betwixt and between” social categories and states of being. Turner referred to people in this place as “threshold people” (Turner,
living in “a place that is not a place, and a time that is not a time” (Turner, 1974, p. 239), as if they were in a tunnel between the “entrance” and the “exit” (Turner, 1974, p. 231).

New NPs experience a sense of being disconnected, which may involve both a physical and mental separation. In many cases there is simply a mental separation as the NP still engages in some of the regular nursing activities. For them, the liminal state incorporates a time and space in which they are transitioning from being in a nursing role assigned traditional laws, customs, and conventions to being in a role that has new and different laws, customs, and conventions. Therese Schroeder-Sheker (1994, p. 92) described this state as a “scared condition in and out of time, where bonds between people ignore, reverse, cut across, or occur outside structural relationship.” Liminal activities tend to be extreme; they appear strange, and sometimes disturbing and dangerous, to those living and working in the regular routines and following socially accepted rules (Turner, 1974). To use Turner’s (1974) terms, since new NPs are in an unclear and contradictory interstructural situation, they are apt to be perceived as being “contaminated” or impure, looked on as aberrations, disturbing, and even a threat to the status quo. As a result, they do not always have the support of their communities as they transition between roles. This only accentuates the experience of feeling disconnected.

The time of being adrift is also characterized as one of turbulence, “alternating emotions and perceptions with an overall range from easy to difficult and many in-betweens” (Heitz, Steiner, and Burman, 2004, p. 417). Waves of turbulence are commonly experienced by NPs as feelings of insecurity, disequilibrium, disorientation, anxiety, apprehension, and disorganization, along with the numerous and varied emotions that come with the loss of relationships, confidence, and control. One is immersed in an experience of feeling overwhelmed, inadequate, vulnerable,
and confused — all emotions associated with being uncertain at a time when one experiences an intense awareness of being responsible for the protection of others. This uncertainty comes from the loss of previous reference points, abilities, and activities; the disruption of relationships and roles; incongruity between access and needs; discrepancies between what is anticipated or hoped for and what actually evolves; and having few or no NP role models. NPs’ feelings of isolation and loneliness are thus heightened as a result of being disconnected — a time of waiting for that which is not yet known.

A situational change occurs when nurses move into the job titled “NP” and begin to engage in the new activities of performing detailed histories and physicals, making medical diagnoses, and prescribing treatments. However, the internal changes happen much more slowly. As a result, many NPs find themselves struggling in a kind of emotional abyss: they are not quite clear who they are or what is real. They experience emotional suffering and intense vulnerability as a result of taking on the characteristics of a persona that has no classification, for “it is as though they are being reduced or ground down to a uniform condition to be fashioned anew” (Turner, 1969, p. 95).

Perhaps one of Winslow Homer’s most famous works, The Gulf Stream, helps to illustrate this time of being adrift. Painted in 1899, the canvas depicts a solitary man lashed to his boat, which is nested in a trough of waves. The mast and bowsprit have snapped, the tiller and rudder are gone, and a school of sharks circles the boat in blood-red water. On the horizon to the right, a looming storm presents a far more ominous outcome. Yet, if we look at Homer’s painting more closely, the man appears to be strangely calm as he rests on his elbow, his mind seemingly alert as he searches for ways to manage the situation. On the horizon to the left, through the fog, there are both light and the silhouette of a ship under full sail: a possible rescue.
Painful though it may be, the time when they are adrift offers NPs the best opportunity to be creative, develop into what they need and want to become, and renew themselves. As they struggle to stay afloat, a path opens to innovation and revitalization. It is thus both a dangerous and an opportune time, and is the very heart of the journey. NPs are introduced to new and special knowledge not previously accessible, and rapid and extensive learning and growth may occur. New NPs may begin to experience a transformation of identity, find new energy, and discover the fit for which they are searching. In being adrift, NPs have a perfect beginning for the process of transformation or metamorphosis, because being lost is just what is needed to properly prepare for the experience of being found.

The NPs’ experiences of being disconnected, being uncertain, being lost, and struggling to stay afloat, all elements of being adrift, neither follow a linear pattern nor are necessarily limited to a single time in their journey. They experience these elements recursively, each weaving a unique design in the cocoon of change. In this respect, as well as being “a space in its own right”
transition is also a process of becoming, a mode of being. Being adrift may last for years, is not a single or simple initiation, and involves numerous experiences, each of which refines the outlook and lives of those engaged in the journey. The meanings attributed to this transitional experience are affected by such factors as the catalyst or call for the change, the individual’s emotional and physical well-being, the individual’s level of knowledge and skill preparation, the environmental resources and support, and the expectations of others who are themselves in transition. In fact, the NPs’ transitional experiences are part of a matrix of transitions taking place simultaneously, such as the staff nurses’ and medical colleagues’ transition to accepting the presence of the NP, the nursing profession’s transition to this advanced nursing practice role, and society’s transition to this new health care provider. And finally, by its very nature, there is a mystery in what occurs during the hidden marginality or liminal state.

Being Disconnected

I am like a flag by far spaces surrounded.
I sense the winds that are coming, I must live them
while things down below are not yet moving;
the doors are still shutting gently, and in the chimneys is silence;
the windows are not yet trembling, and the dust is still heavy.

Then already I know the storms and am stirred like the sea.
And spread myself out and fall back into myself
and fling myself off and am all alone
in the great storm.

— Rainer Maria Rilke (1938), “Presentiment”
Although many NPs admit to having “horror stories about those nurses who eat their young,” they hold great regard for their fellow nurses and speak about them and nursing with affection and loyalty. This is apparent in the jovial social atmosphere they describe as missing, particularly on nights and weekends, when there is a more relaxed and informal work environment. They miss the support that nurses give each other through difficult times. The change in their role brings about the loss of old ways of being that comes from working side by side, doing the same type of work, taking breaks together, and sharing stories in which there is a common sense of purpose and loyalties. “Being part of the team, but not really part of the team in terms of being at the bedside because they’ve flipped sides to giving orders” results in a sense of alienation. A special collegiality has been lost, and many NPs miss these previously taken-for-granted relationships. There is a sense of no longer belonging, a sense of loss of acceptance by the community of practice to whom they had once been strongly connected. With the realization that they have inevitably been changed in the process of becoming NPs, they also understand that this loss is permanent. Even if they should quit the NP role, a thought that often passes through their minds, the acquisition of new knowledge and skill means that they are no longer the nurses they once were.

You go through separation, the letting go. I guess it’s more like grieving for a secure position that you were in. And yet the challenge and the excitement and the opportunity of a new role still keeps you, has your appetite whetted with curiosity and wanting to develop those skills and have those learning opportunities. But at the same [time], it’s a part of you that you were good at, and you are still good at, or I was still good at, but just along a different pathway. And it was sad to let go of it, to not be part of that team in the same sense of the intricacies. . . . Now you’re always on the periphery.
Being disconnected is like being anchorless. As one NP reflected, in traditional bedside nursing shifts are structured around the to-do list of activities that are engrained in nurses’ routines from the first days in clinical practicums. But in this new role, the NPs’ sense of being disconnected is heightened by being uncertain about how to structure their days using the autonomy that they now have.

**The independent practice part of it was the biggest piece. . . .**

Going into a new role where — Oh, I don’t have that anchor of having a patient assignment with specific tasks. What does that mean? There were no real roles and responsibilities written to clearly define — Okay, today I’m going to come on and every two hours you’re going to do this, this and this. . . . It was fairly loose, and that independence and having to be responsible for my own autonomy and my self-learning activities was really new for me. So, trying to organize my day and people trusting me to be accountable for my hours. And so being given that autonomy wasn’t something I was used to and so that autonomy piece was probably a bit of a transition.

Some NPs are instructed by nurse managers to refrain from wearing a uniform, answering bells, or helping other nurses in the giving of patient care so that the NP role can be differentiated from that of the traditional staff nurse. Despite their desire to demonstrate to nursing staff, patients, and families that they are both capable of and not above engaging in traditional nursing functions, some NPs see wisdom in this advice. Therefore, they disconnect themselves from familiar activities that provide them with some sense of purpose and meaning. Others remain engaged in these activities, recognizing that if there is an immediate patient need, then everyone should put their hands in the work that needs to be done. They feel that the priority
must always be the patient, not what tasks are assigned to each person. Yet even they acknowledge the internal and external tension created when they realize that they must sometimes turn away from assisting nurses with hands-on patient care, turning instead to their own tasks, which are of equal importance and priority to patient well-being.

The simple fact that NPs spend the majority of their time interacting with staff physicians, fellows, and residents, eating, and socializing with them in the wee hours of the morning as they wait together for a new admission, may lead to the feeling that they are leaving the bedside nurse in the background. This loss of a sense of belonging to a community of nurses and the resulting grief that is experienced is palpable:

I guess just to reconnect with nurses is part of what needs to be done. And I’m not sure what that means or how to do it exactly. I mean, we sometimes do these little education things and that helps, but there’s more to it, and I’m not sure exactly what it is. But it’s like you take a step up from bedside nursing if you will — I’m not sure that it’s up, or if it’s just over, I don’t know — so you make this change, and you kind of just abandon nurses, maybe not nursing, but nurses. There has to be a way to integrate the two better. And we don’t even eat in the nurses’ lounge and I don’t know what that means either, but it’s just there. And nothing would happen if I stopped eating with the residents and ate with the nurses. No one would say anything. They might say, “Where were you at lunch?” And the nurses might kind of look at you but they wouldn’t say anything either and they certainly probably wouldn’t make me feel like I didn’t belong there. But I have no idea if it would change their conversation at break time or not. I don’t know if you’re really so different that you would influence conversation or if you’re really not that different in their eyes. . . . I miss it when it comes time to have their social things, and you’re not sure if you should go or not.
How are NPs to re-establish their relationship with others in this new role? With whom are they to align themselves in a role frequently established as an “N of one” within their subspecialty practices? Wenger (1998) maintained that in order to do their job, individuals must align their activities and their interpretations of events with structures, forces, and purposes beyond their community of practice and so find their place in broader role processes. Yet during this time of being adrift, particularly because they are pioneers, NPs do not do this because structures are not yet known and understood, if indeed they are in place, and a sense of purpose has not yet been discovered. Turner (1974) suggested that individuals experiencing this in-between status tend to form a “community of passengers” in which they experience what he termed *communitas*, a spirit of comradeship and fellowship among those undergoing the same transition. But how can NPs develop or sustain the sense of “being in this together” when many of them are single passengers on the journey once they leave the educational setting?

There were two or three primary NPs in the hospital but again they were very busy and so it was hard to speak to similar events, or, it just wasn’t the same. I don’t know how you describe that, but it just would have been helpful to have had someone who’s been there and done it before and knew exactly what you were experiencing. Because some days you’d go through it and you’d think, “Am I losing my mind? What am I doing here?” . . . Everything is just all jumbled up [with] sort of that overwhelmingness and feeling so all alone.

If NPs work so frequently in isolation, can being disconnected be a transient, time-limited experience of passing from the centre of one cultural group to the centre of another? Or are NPs destined to find themselves in a more permanent marginalizing situation as a consequence of the context of their practice environment?
Perhaps the expression “I am afraid I’ll miss the boat,” commonly used by many NPs, takes on a new meaning when one considers that NPs are no longer “in the same boat” with others. This sense of being part of the team but not part of the team, “being in a place all of your own” that has no meaning, includes both the immediate care of the patient and a sense of not belonging to any group within the organization. One NP shared, “It’s hard because you should be, from a clinical perspective, on the physicians’ team, but they’ve got their own little intensivist team too. And so there’s 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.” NPs experience a loss of identity since they are neither traditional nurses nor physicians.

NPs are also often unknown to each other, and thus feel disconnected from their own genre of nursing. One highly experienced NP lamented, “I still want to go and talk to someone, another NP. It’s been something I’ve been wanting to do for a long time, to just work with another nurse practitioner for a week or so, because I never did work with anyone and I’m sure I could learn a lot about being a nurse practitioner.” Most, even if they are not the only NP within their work setting, lack the time to invest in close relationships with their colleagues or to develop connections with others. Many work within institutions where the administration provides limited to no opportunities for NPs to get together, or they do not receive support from nursing management or their physician team so they can leave their clinical responsibilities in order to attend meetings. Nor do they have the energy to initiate a support group that can help them work through their feelings. A few join established local advanced nursing practice groups, most of which have been founded by CNSs. However, at this period in their professional development, there is virtually no connection between what they are experiencing.
in their clinical practice and what is being discussed. Again, they
can find no sense of meaning or identity as NPs within a work
structure in the course of their journey. The irony is that while
they strive to carve a unique role that allows them to be more
autonomous, more in control, and more connected, the very
nature of these goals seems to highlight and heighten the experi-
ence of being disconnected.

As NPs describe the barriers to acceptance of their role, the
relationship with physicians, nurses, and other health care provid-
ers inevitably surfaces as an issue. Support, encouragement, and
assistance from professional colleagues are expectations learned
from past experiences but not always present in this role, which
results in the feelings of alienation, loneliness, vulnerability, anger,
and frustration. Despite findings in the literature that have con-
sistently identified lack of support as a problem (e.g., Brown and
Draye, 2003; Heitz, Steiner, and Burnam, 2004), the degree of
resistance and resentment, along with the depth of antagonism
they experience from nurses, inevitably takes NPs by surprise.
With alarming consistency, they describe senior staff who lacked
care and concern for them, and who verbally abused them. How
are identities shaped when NPs are forced to wrestle with the
outright hostility that they encounter from some of their nurs-
ing colleagues as they try to begin to practise in their new role?

When bedside nurses challenge who they are and what they
do in front of patients and families, or refuse to acknowledge
the orders that they write, how does it affect their self-worth,
the shaping of their identity, and their sense of being valued as
NPs? One recounted, “And right in front of the patient she’s like,
‘So what do you think you are? Do you think you’re better than
everybody else around here? So if you think you’re better than
other nurses, is that why you’re doing all this doctor stuff?’” Bed-
side nurses are in a central position to help NPs function more
efficiently, but they can also undermine the NPs’ confidence and
effectiveness. When they do, they enhance the NPs’ sense of being shunned by the clan and contribute to their experience of being disconnected, while prolonging the sense of being lost about who they actually are in this new role.

In the beginning some of [the nurses] were very rude. And I don’t know if it was a sense of their being angry at someone else having the opportunity. I don’t know if it’s the “we–they” or I don’t know what you would call it. It took about five years before the unit actually valued the role and had respect for its uniqueness. And some of it was a lack of understanding of what it was and the added skills opportunities and the implications of those. And so you’d have nurses in the unit saying, “Oh they always get everything. They’re very specialized”. . . . And so maybe that’s just a felt need that you need to be valued in the position before you get that sense of security and ownership to a new role and the letting go of the old one.

NPs readily admit that they come into the workplace unprepared to assume the full scope of the direct clinical practice component of the role, especially in the subspecialty for which they will be responsible. Key to the successful development of competence and confidence is the support and encouragement of physicians. Physicians, especially the staff physicians to whom they report for clinical management issues, are also essential in helping to establish their credibility with others. In the absence of NP role models and mentors, they are dependent on the close clinical supervision of the physicians who either lobbied for, or at least agreed to incorporate, the NP into the complement of professionals providing medical care to their patients. As they expend so much energy trying to master the knowledge base underlying the components traditionally identified as medical practice, NPs naturally lose sight of the science and art of nursing, a phenomenon described in research examining the family
practices of primary health care NPs (see Anderson, Leonard, and Yates, 1974). NPs become obsessively task-oriented and this, for a period, becomes an end in itself. They describe being the physician’s shadow for months or even several years. As they spend large amounts of time alongside physicians immersed in the diagnostic and therapeutic activities of medicine, their nursing identity is naturally submerged, further augmenting a sense of being disconnected.

But how can NPs who are “attached at the hip” to their medical colleagues feel so disconnected or marginalized from this group, even as they feel lucky enough to be fully supported by them? Why do they not become the centre of the physician’s social environment? NPs are foreigners to the medical world; they are invited by some and denied entry by others. As such, they are positioned at its periphery, but being pioneers and lacking acute-care NP guides, they are unsure of the dimensions of the practice in which they are involved and therefore even have difficulties identifying its borders. Schultz (1971) captured this bind:

He who wants to use a map successfully has first of all to know his standpoint in two respects: its location on the ground and its representation on the map. A foreigner has to face the fact that he lacks any status as a member of the social group he is about to join and is therefore unable to get a starting-point to take his bearings. He is, therefore, no longer permitted in considering himself as the centre of his social environment, and this fact causes again a dislocation of his contour lines of relevance. (p. 99)

NPs may feel disconnected from the medical group because they remain in a traditional one-down relationship with it. Anderson, Leonard, and Yates (1974) argued that without their own nursing base of information, philosophy of care, standards, and rationale,
which have been temporarily set aside during this phase of learning, NPs are at the mercy of physicians, who, ultimately, remain in charge of patient care. As a result they cannot have a sense of truly being connected with their medical colleagues.

The social and political climate, both internal and external to the acute-care institution, continues to evolve and it remains unknown how this evolution will influence the presumed potential for movement between subordinate (nursing) and dominant (medical) worlds. This “not knowing” predicates an uncertain and unfixed acceptance of, and full functioning within, the confines of their world as NPs. For example, until recently, there was no legislation in Quebec that granted NPs the authority to write orders within acute-care institutions. In addition, the concept of medical directives, which facilitate at least some degree of autonomy in acute-care NP practice in Alberta and Ontario, does not exist in Quebec. Therefore, the majority of NPs in that province are able to assume little of their potential in their new role, and consequently increasing their sense that NPs are marginalized is sustained. Moreover, although they may be allowed to engage in some of the traditional functions of the medical cultural group, there is not an acknowledgment that they are, or will ever be, at its centre. Just as importantly, they do not want to be.

Most NPs describe at least a few episodes where physicians have been antagonistic and unwelcoming toward them. Worse yet, some reveal being consistently and blatantly ignored. Particularly frustrating are the occasions when NPs seek physician consultation but are refused or bypassed, making them feel invisible and ineffective. Physicians who fail to return their calls and surgeons or anaesthesiologists who state, “I cannot give my report to a nurse, I need to speak to the doctor to give the report” complicate the NPs’ efforts at managing the patients’ care. Some feel like second-class citizens when physicians do not attend medical
rounds if an NP is scheduled to present, or NPs are refused admittance to resident teaching sessions even when the sessions concern their subspecialty service.

Certainly, under such circumstances, this part of the journey is experienced as chaotic, painful, and even traumatic. As a consequence, the sense of being disconnected and the accompanying feelings of vulnerability and alienation are even more accentuated and prolonged. This experience is made clear through an incident shared by an NP who, after two years in her current NP position and four years total as an NP, was only just beginning to feel a sense of belonging to the team:

I didn’t have any [specialty] background when I started but . . . they said, “Don’t worry; we will provide this and this;” and I was promised some clinical mentorship from the physicians. . . . So when I get there, I’m in the operating room, I get paged for my first consult and I’m told by the person who’s supposed to supervise or direct the inpatient care, “I’m really sorry but I don’t review consults with you.” And I said, “Well who’s going to?” He said, “That’s a very good question.” So I was stuck. But I was so new, like I was just in a different world and a different language, it was really very different. And so for more than six months, I tried various strategies of helping myself learn. And I was unsuccessful. And then I went to my boss . . . and she said to me, “To learn, go to Dr. X’s clinic.” So I would go to the clinic and he would say, “Well I have a medical student and I have a resident and I only like two learners at a time.” So I said, “Well, can I round with you?” Well, my office wasn’t in the area and they would never call me. It was awful. . . . I had to do everything myself and sometimes the doors were really shut in my face. . . . I wasn’t sleeping; I had to take more sick days in the first year of this job than I had in 22 years . . . but I was determined they wouldn’t break me.
The necessary focus of the NPs’ learning at this point is the medical agenda, as they are kept busy clinically learning how to independently apply the knowledge and skill learned in school. As a result of this intense and narrow focus, they have no time to be present with the patients and families. The search for being more connected in their nursing practice seems more distant and elusive than it had ever been in their traditional nursing roles. “I just don’t have enough time; I’m ordering the pills and I’m doing the spinal, while the nurses are talking to the mom, teaching her how to give the Septra and comforting the child,” said one NP. “I miss bedside nursing; I want to be on the other side of the fence and be that comforting person at the bedside again.” The resulting turbulence leaves them questioning their choice and reminiscing about what they have left behind.

Feelings of marginality and lack of connection are also a direct consequence of frequently being involved in defensive encounters with colleagues, patients, and patients’ families: “Are you my resident today?” “Well, you’re ordering things; you’re prescribing things; you’re diagnosing. Look at the number of years you’ve spent in school with your master’s. Why didn’t you go through to be a doctor?” How does one retain a sense of connectedness to nursing when nurses identify the NP role as belonging to medicine?

Being Uncertain

[A]nd while I supposed myself to be looking as salt as Neptune himself, I was, no doubt, known for a landsman by every one on board as soon as I hove in sight. . . . In a short time . . . we began to heave up the anchor. I could take but little part in all these preparations. My little knowledge of a vessel was at fault. Unintelligible orders were so
rapidly given and so immediately executed; there was such a hurrying about, and such an intermingling of strange cries and stranger actions, that I was completely bewildered. There is not so helpless and pitiable an object in the world as a landsman beginning a sailor’s life. (Dana, 2001, pp. 6–8)

Acute-care NPs provide care to patients with complex, acute, and often life-threatening health problems. Hemodynamic instability, pulmonary compromise, and nosocomial infections are frequent concerns. Many hospitalized patients have multisystem diseases, which can contribute to atypical presentations of symptoms. Acute complications of chronic illnesses can develop in response to therapeutic treatments for other conditions (e.g., an acute exacerbation of congestive heart failure after a blood transfusion). The complexity of health problems is compounded by therapeutic interventions or technologic modalities, many of which obscure important physical assessment findings. The risks associated with the physiologic instability of patients and the potential for life-threatening complications often require NPs to make rapid clinical judgments in tense situations. Data may be simultaneously overwhelming and incomplete. These factors challenge the diagnostic reasoning process, potentially impeding hypothesis generation and evaluation, problem identification, and treatment decision-making. Yet NPs, like physicians, are tasked with the job of accurately diagnosing and treating their patients’ health problems. They may doubt their abilities to use what they know in order to care for patients safely, and be concerned they should know more than what they have been taught. This creates the experience of being uncertain, a sense of being overwhelmed, as they continue to learn from the ground level up how to attack patient-care management on top of learning to master the procedural skills required in their practice.
I wondered at the expectations. I wondered at the other NPs who do it and do they think they’re doctors and I wondered if I had the skills or the knowledge to do it. I wondered if I’d make a fool of myself. I’d always given someone the information and just done what they told me to do. Well now I was going to be the teller and that’s so much responsibility and it was just so scary thinking that one day maybe I would make a decision that would be harmful or wrong. It was just so very overwhelming. Very scary.

Suzanne Gordon (2005, p. 10) observed that within a traditional health care model the physician is seen as “the captain of the medical ship” in the acute-care setting. The charted course regarding the daily medical plan of patient care is handed down in the form of orders that nurses are expected to carry out. In the NP role, one is in the position of performing in the “captain” capacity. However, NPs do so without a navigational chart or dedicated guide familiar with the NP journey. This leaves them in the position in which most pioneers find themselves: thrilled and exhilarated about the potential opportunities for autonomy and intellectual challenge, but also shocked and overwhelmed with what they do not know, with few institutional supports to assist them with integration into their new practices.

NPs are persistently made aware of their uncertainty by the stressful thoughts and feelings rooted in their day-to-day consciousness as they engage in the new activities of their practice. Some NPs describe being uncertain as merely unsettling. However, most admit to feeling terrified, being scared, and being frightened; feelings that are present to some degree most, if not all, of the time and then heightened each time they are required to perform something new.

It was very frightening at the beginning. For my first two years, 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.” Seriously! “Help me make the right decision.” People are lying if they don’t tell you they’re scared for those first two years.

For many months, or as long as two to three years, NPs can live with the uncomfortable awareness that they may make a mistake that could cause a patient’s death. Not knowing if the outcomes of their decision-making will be the right ones creates a disequilibrium born of fear for the patient’s safety. Many NPs are preoccupied with “terrible things you just can’t imagine,” particularly after they leave the clinical area and have quiet time to dwell upon the daily course of events. Even after two years of experience, one NP described that at the end of each day she still lived with niggling doubts that she may have missed something. Faye Ferguson (1991) gave insight into this experience of being uncertain: “When faced with uncertainty . . . the emotions can easily hold sway, carrying one away with thoughts of disaster. During these moments or hours one feels trapped, captive to the terror of what might be possible.” (p. 316)

A certain gravity is associated with being uncertain that is expressed as mental turmoil. Each decision feels like a narrow escape from causing a deadly outcome. Treading water and barely keeping afloat, while trying to keep their “heads above water, trying not to kill anyone, and trying just to get comfortable,” creates an overall state of exhaustion, the result of constantly being mentally on guard and second guessing oneself. One NP recalled that for nearly three years she worked frantically to absorb as much academic knowledge as she could while attempting to make it have practical meaning in her decision-making with each new patient. An inability to sleep and having nightmares or dreaming all night long about their patients are common issues:
One of my fears is that I will write an order and it will be misread or incorrectly processed or something and then something harmful could happen. . . . The first time I wrote an order I shook for probably a day. . . . Again the mental turmoil is [that] I spend a lot of my time after work more or less just going through my head the events of the day. . . . But I always look at — What have I done? What have I ordered? Was there something better? Should I have done it differently? . . . So there have been a few times when I’ve actually gotten home and I’ve had to turn around and come back because I’ve second-guessed myself. And it’s been silly, but I’ve needed to do that in order to put my mind at ease.

NPs’ mental fatigue is compounded by the drain of energy required to hide their inner turmoil. In the following passage, an NP describes the heaviness, or gravity, of being uncertain. This passage was delivered in a tone that invoked the arduousness and tiring nature of not knowing.

I was very tired. I was so tired from making decisions. I just remember thinking I don’t want to make another decision today about anything. And it was such hard work, such hard work to do this. And you know — Lasix q6, q8, q12? 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. I can remember going home after these 24-hour-call shifts, and not [being] physically tired from being up, but just mentally tired from having to make these decisions.

Questions, rather than answers, dominate. Do I have the ability to make the decisions? How should I approach this problem? How do I solve it? Do I know what to do? What do others want me to know and do versus what do I need to know and do? Similar to Benner’s (1984) nurse as the advanced
BEGINNER, NPS ARE UNCERTAIN ABOUT THE TENSION BETWEEN WHAT THEY PERCEIVE THEY KNOW AND WHAT THEY SHOULD BUT DO NOT YET KNOW. FEARING THEY WILL NEVER MAKE OR BE CAPABLE OF MAKING ACCURATE CLINICAL MANAGEMENT DECISIONS, WILL NEVER BE ABLE TO CARRY THE WEIGHT OF RESPONSIBILITY THAT RESULTS FROM MAKING THOSE DECISIONS OR UNDERSTAND THE EXPECTATIONS REQUIRED OF THEM, THE MILESTONES TO BE MET, AND WHETHER OTHERS WILL BE THERE TO SUPPORT THEM — THESE ARE ALL ELEMENTS IN THEIR UNCERTAINTY.

NPS ALSO FEAR THAT POOR DECISION-MAKING WILL NEGATIVELY IMPACT NPS’ PROFESSIONAL REPUTATION, AND THEY REPORT THAT THE BURDEN OF REPUTATION PROTECTION IS HEAVY. THEY MUST NOT ONLY PROTECT THEIR OWN PROFESSIONAL REPUTATION BUT ALSO THE REPUTATIONS OF PHYSICIANS ASSOCIATED WITH THEM. ULTIMATELY, EACH BELIEVES THAT THE REPUTATION OF THE WHOLE ACUTE-CARE NP MOVEMENT IS IN HER OR HIS HANDS — A FINDING ALSO REPORTED IN BUEHLER’S (1987) RESEARCH WITH PRIMARY-CARE NPS. THIS IS REFLECTED IN ONE NP’S COMMENTS:

I MEAN, YOU’RE ALWAYS AFRAID THAT YOU’RE GOING TO SCREW UP AND BE CAUGHT SCREWING UP. AND THERE IS THIS ONUS ON NEW PRACTITIONERS BECAUSE IN THIS PROVINCE AND IN THIS CITY NURSE PRACTITIONERS ARE NEW; LIKE THREE YEARS IS ABOUT IT WHERE I WORK. SO THERE’S ALWAYS THIS ONUS THAT YOU DON’T WANT IT TO BE, “OH, THOSE NURSE PRACTITIONERS!” YOU DON’T WANT THAT EVER TO BE HEARD. YOU WANT TO PROVIDE EXCELLENCE ALL THE TIME. OF COURSE THAT’S NOT REALISTIC THOUGH... YOU WORK SO HARD TO GAIN CREDIBILITY AND GAIN TRUST AND BE TAKEN SERIOUSLY, THAT YOU DON’T WANT TO DO SOMETHING STUPID, BECAUSE ONE LITTLE THING CAN UNDO SO MUCH HARD WORK.

LIVING WITH A PERSISTENT SENSE OF UNCERTAINTY ABOUT THEIR ABILITIES TO ENGAGE IN A NEW LEVEL OF DECISION-MAKING IS LINKED WITH NOT KNOWING HOW TO THINK LIKE A PHYSICIAN. YET FROM THE TIME THAT THEY WALK INTO THE CLINICAL SETTING, THEY ARE REQUIRED TO MAKE NUMEROUS AND VARIED MEDICAL DECISIONS AND PROVIDE SAFE CARE FOR PATIENTS:
When I first started I had a lot of on-the-job learning to do, even though I went through the NP program. It was great but there were a lot of knowledge gaps . . . things like how to manage a diabetic patient for instance; or, though we had microbiology and that kind of stuff and prescription of antibiotics, when you actually get into the clinical area and you’re dealing with infections and organisms and sensitivities and antibiotics and this whole thing with resistance, there’s a huge learning curve to that. And then more critical-care stuff, stuff like gut ischemia and oesophageal varices and bleeding ulcers and peritonitis and pancreatitis and adrenal insufficiency and it just goes on and on and stuff that I didn’t know and I’m like, “Oh my God.” Like here I am in this critical-care environment and look at all this stuff, and I’m like “Ahhh!!” And what if I compromise all these vulnerable patients?

Acute-care NPs understand that the “NP part” of their job requires a form of medical apprenticeship in the first several years in order to learn clinical management of patients in their specialty population. But despite whether it is what they expected or wanted, for a number of months they suddenly find themselves unsure of what to do because, as nurses, they have “not been trained to think the way doctors do. It’s a whole different way of thinking and it’s really hard.” Although they have a sense that there should be more to the NP role than being a physician replacement, that is exactly what they do during the apprenticeship period. Many of them mention that they function from a medical model instead of a nursing model of care but, in hindsight, realize this is necessary at the beginning — an understanding that has also been noted in the primary-care NP literature (Kelly and Mathews, 2001).

One of the characteristics of belonging to a homogeneous community of practice is the development of a shared culture. Wenger (1998, p. 83) noted that the culture of a community of practice includes routines, words, tools, ways of doing things,
stories, gestures, symbols, actions, or concepts that the community has produced or adopted and which have become part of its practice. It also includes the discourse by which members create meaningful statements about the world and the styles by which they express their forms of membership and their identities as members. Acute-care NPs, however, as pioneers in their practice and as people frequently working in isolation from other NPs, usually have no community of practice through which to experience their world and find meaningful engagement related to their role. Nor has the wider Canadian acute-care NP community of practice yet been able to establish a historically recognizable culture such that everyone knows what NPs are to be doing. In other words, other communities of practice such as nursing, medicine, and pharmacy do not yet know, appreciate, and therefore trust who NPs are and what they can do. As one acute-care NP commented, NPs are thus required “to prove [they are] legitimate in providing care, because until others understand the NP role and have insight into our training, [NPs] will always be compared to other physicians, other residents; whereas if they came up to them as a medical resident and I’m X year, then they have a certain conception of what that person should be capable of doing, what they have been exposed to or not exposed to.”

Initially, then, the negotiation of meaning for NPs is created primarily in their social relationships with physicians, on whom they are reliant for the delivery of safe practice, along with the nurses with whom they work. Yet, once they enter clinical practice, NPs find themselves on the fringes of medicine’s community of practice, of which they have limited knowledge and know-how. In order to belong to communities of practice, they must engage in the practices, routines, language, and conventions of those communities. In other words, they need to do whatever it takes to make mutual engagement possible. This means that they must demonstrate that they know how to think like the members of a
given community. Yet, not knowing how to think like a physician is partially the root of their uncertainty, because not knowing how to think like a physician is to some extent a measure of not yet knowing enough of the language of a physician.

Words that aren’t my own
Language foreign to my mind
I’m spinning my wheels.

— Mika Yoshimoto (2008, p. 22)

NPs simply do not at first have the depth and breadth of terminology that is associated with advanced anatomical, physiological, pathophysiological, and pharmacological knowledge. Not knowing the language results in either not understanding others or not being understood by others. Mutual engagement is impeded and the feeling of being uncertain intensifies.

Understanding how distressful uncertainty can be, and understanding the tendency for uncertainty to diminish a person in his or her own eyes despite the previous level of confidence and competence, is revealed in the manner in which this NP expresses the experience of not knowing.

It is hard because you don’t know if you’re on the same page. And when I think of describing an X-ray to somebody — because even to this day you can say, “Well, he has that kind of blah, blah, blah” — but they don’t necessarily use the same words that can mean the same thing. And X-rays are quite hard, because there’s something there and they want to know what it is. Well, I think it’s this because I see a shadow, and you don’t call it lucency or darkness, or it’s fluffy. And I know them better now, but at the time — near the
heart, near the thymus or the hilum. They ask you so you end up saying, “Well, I’m not sure that I see that or not. I can’t tell you.”

In fact, learning to speak with the physicians’ terminology is what makes mutual engagement with the medical discipline possible. Physicians’ speech is associated with the way in which text is formatted and presented, the way in which information is edited, so that it is orally represented to the medical audience in a manner they accept and appreciate:

The type of information that physicians want to hear is not the same as what nurses want to hear. . . . I remember when I was a novice NP, I would report everything in tremendous detail and the comments were frequently, “This is very thorough but I don’t need this. As a nurse I can understand that you would want to know these things, but from a physician’s perspective this is not what I’m interested in.” And the difference was learning that when you’re talking to physicians to communicate what they want to know, and in that way you communicate that you understand what’s important to them.

Being uncertain with regard to their use of medical language and speech becomes critical in relation to such actions and artifacts as medical rounds, the order sheet, physician notes, and discharge summary records. Although nurses are familiar with and have shared points of reference regarding such traditions, these traditions do not impose the same meaning when viewed from a bedside nurse’s perspective as when viewed from the perspective of being a new NP. The particular nature of nursing’s understanding of these elements of practice lies in the rules and regulations, or structures, applied to these artifacts and conventions, which are determined as much from within nursing as from without.

In his classic work Truth and Method, Gadamer (1989) interpreted
the concept of play (both literal and metaphorical). He reasoned that play has its own essence in the fact that it becomes an experience that changes the person who experiences it, “independent of the consciousness of those who play” (Gadamer, 1989, p. 102). Gadamer’s interpretation helps us to understand that, once nurses make the choice to play as NPs, they expressly separate this new playing behaviour from their other nursing behaviours thereby indicating they are “choosing to play this game rather than that” (Gadamer, 1989, p. 107). They must learn to play anew in the game’s designated spaces: “The space in which the game’s movement takes place is not simply the open space in which one ‘plays oneself out,’ but one that is specially marked out and reserved for the movement of the game” (Gadamer, 1989, p. 107). NPs must learn to carry themselves with a certain type of comportment, inclusive of both linguistic and non-linguistic genres, and to use the predetermined choreography between players:

That all play is playing something is true here, where the ordered to-and-fro movement of the game is determined as one kind of comportment among others . . . even if the proper essence of the game consists in his disburdening himself of the tension he feels in the purposive comportment. (Gadamer, 1989, p. 103)

Gadamer demonstrates that in successfully performing the tasks of the game, “one is in fact playing oneself out. The self-presentation of the game involves the player’s achieving, as it were, his own self-presentation by playing — i.e., presenting — something” (Gadamer, 1989, p. 108).

Now previously known linguistic and non-linguistic elements take on new interpretations when used to new effect by the NP and viewed from a new trajectory. For instance, NPs describe medical rounds, a quintessential medical play, as a stage where
they are now players who are placed front and centre without the requisite skills to stand upright and not feel exposed. In this once familiar but now unfamiliar metaphorical playground, NPs constantly experience uncertainty due to not knowing what to expect, how to articulate the limited knowledge they have, and what level of knowledge is expected of them. During medical rounds, they have a sense of no longer possessing the protection of being a spectator but being required to actively perform without the requisite tools:

It was like having to go into an exam every morning [with] no idea what the exam would be on. Furthermore, it’s an exam in front of ten other people and they’ll all know what you know and don’t know, and that was very stressful. . . . And because you would get quizzed on rounds, everyone’s watching and listening. . . . And we are treated very much like a resident and so then you’re asked why this and why that and what do you know about this and what do you know about that and tell me about this or that. So, I mean, I haven’t been to medical school; half that stuff I’ve never heard of, and all of a sudden I’m expected to know it. It’s quite daunting.

Acute-care NPs appreciate from their years of working in acute-care teaching institutions that medical rounds are part of medicine’s initiation process. Rounds are, in Turner’s terms (1969), a rite of passage, part of the ritual process created by the medical community of practice to assist in the transition from one place, state, and social position to another. In this milieu, others, particularly physicians, actually judge NPs against their definition of competent NP performance, a definition that mimics their own particularistic philosophy of medical practice. NPs understand that it is within their capabilities to articulate their understanding and summarize the plan of care such that members of the team
will develop a respect for their abilities, the NP role, and themselves as individuals. Being uncertain in this milieu brings about a strong awareness that “everyone is judging you.” NPs feel that perhaps others are seeing them for the very first time in terms of what they are lacking, not for the competent or expert nurses they had been previously. What really makes being uncertain so discomforting is the constant awareness of one’s deficiencies that this visibility and awareness of uncertainty invokes.

Similarly, NPs are required to engage in medical discourse using the written format within medical artifacts. However, not knowing how to write medical orders, medical progress notes, and discharge summaries adds to NPs’ feelings of uncertainty, which are further intensified by the uncertainty that comes with crossing boundaries to spaces that had been previously forbidden to them as nurses:

So having to learn the language and really not being given any course on how to write an order per se, and there is a format on how to write orders, what needs to be included; there is a process around that. And that isn’t part of the orientation or internship or whatever it is called. And there needs to be more value put on it because the significance of that is huge, and it was an area where I didn’t have any experience with it.

New NPs are also unsure of how to interpret information in a new and different way, which culminates in generating a possible problem list, a differential diagnosis, and a treatment plan. Not knowing how to make a diagnosis or whether it is the right one is frightening, sometimes even paralyzing, and this is only accentuated when new NPs have limited knowledge and experience within their specialty area, precluding them from identifying patterns. Not knowing routines and what the various doctors in their practice want and will accept compounds their feelings
of uncertainty. They immediately realize that knowing how to make a differential diagnosis is not something learned in nursing, and it is a concept that can be quite difficult to grasp. Learning to think of all the possibilities, particularly when one has limited knowledge, while at the same time being able to prioritize a plan around the most likely possibility when scant information is available, is like climbing the mast of a ship without a safety line:

Making the diagnosis is difficult at times. I personally struggle with it unless it’s fairly obvious. I never have done very well pulling differential diagnoses out of the hat and I think that’s where I need to do a bit more. . . . We get a lot of our patients from Emergency and they’ve got the diagnosis down in front of us. So I look at the diagnosis and I think, “Why did he choose that? Well alright, belly pain. Oh my God, there’s probably a gazillion things that cause belly pain”. . . but if I have to see somebody cold turkey that’s where I struggle a bit. We can diagnose congestive heart failure easily; if you come in with high sugars, well you’re obviously in a diabetic state. It’s the not-so-clear cases — I’m thinking, well, some guy’s diagnosed dengue fever; where did that come from? Why did he diagnose that? Well, I’m not familiar with the pattern of that; that doesn’t even pop into my mind. And then again, I think, “Well goodness, should I know that?” And then this self-doubt thing overcomes me: “Well, my God, I wouldn’t have written down dengue fever.” So that’s what goes through my mind.

Even when they are able to make the diagnosis accurately, verbalizing or writing the diagnosis can be overwhelming in and of itself, as it too is a boundary not previously crossed:

I guess one of the things that stunned me the most and took me a long time to get over was being able to actually write that the man
had a nose bleed rather than saying the man had blood coming from his nose; so that as an NP I can actually diagnose that nose bleed. So the hardest thing to get my mind around was now I could suddenly do these things that you were always told you couldn’t.

Buehler (1987, p. 50) wrote, “Educators and physicians repeatedly point out that the single most important attribute of an NP is [their] ‘knowing and practicing within [their] limits.’ The clinical judgments that they make determine how others evaluate their compliance with this norm.” Yet, the fact that what they are questioning is beyond their scope of practice reveals the NPs’ struggle to determine the set of expectations about the level of knowledge and skill required within their practices. The acute-care NPs’ uncertainty is accentuated because there is not yet an aggregate of NPs performing the same role within the same context, except, perhaps, in the field of neonatal nursing. There has been no historical determination of what exactly they do, how they are to do it, and the level to which they are to perform it. Ironically, they cannot discover independence within their practice until they know their limitations — limitations that are defined by their scope of practice.

For NPs, worrying is a common response to living with uncertainty. They feel a sense of dread about “the worst thing you can imagine happening,” which looms over them until it does happen. They worry about whether they will be able to independently reproduce the decision-making sequence without missing critical steps. Have they gathered all the information necessary to make an accurate diagnosis and treatment plan? Can they successfully repeat what they do, such as performing a psychomotor skill under pressure or in a different circumstance?

Worrying is also associated with the desire to do what is right and to do what is good for the patients entrusted to their care. Acute-care NPs carry a mature and practised understanding of
what it means for the patient and family to provide (or fail to provide) the “right” treatment. Knowing how to provide the right care is essential to clinical judgment and ethical comportment. Central to their feeling adrift is concern about being able — or unable — to respond to patients’ physiological needs, protecting them in their physical vulnerability and helping them to feel safe in the NP’s hands. Typically, there is a sense of hyper-alertness and hyper-responsibility, and NPs deliberately engage multiple coping mechanisms. In contrast to Benner’s (1984) findings, this sense of hyper-responsibility is present in the initial part of the NPs’ journey, not at the competent stage of the novice-to-expert continuum. This may be because they know what it means to be competent nurses and therefore understand the tensions and competing risks involved in managing various clinical situations. In addition, as experienced nurses they have long lost their naivety about the absolute trustworthiness of the environment and the legitimacy of co-workers’ knowledge. Benner noted that naivety normally allows the beginning learner to absorb information as fact and truth, and for this reason they experience a sense of certainty about the outcomes of their actions, along with an excitement about learning. Yet for many NPs, this sense of fun and exhilaration is not experienced until later in their journey.

NPs readily acknowledge that as experienced bedside nurses they believed they had the experiential knowledge to determine what treatment was required in the clinical situation, although they did not possess the authority to act upon it. Yet ironically, when permission is finally granted for them to act upon their knowledge and skill, they immediately realize that being able to do what needs to be done involves much more than being permitted to use advanced theoretical and experiential knowledge. One NP noted, “When you actually have that accountability or decision-making or responsibility for the decisions, it becomes
much different than just suggesting, ‘What do you think about _______?’” With the granting of authority to diagnose, prescribe, and treat in ways previously denied them, NPs must not only acknowledge that they may and can do what needs to be done for patients, but also acknowledge and accept responsibility for it. Ironically, they may now experience a lack of self-confidence and hesitation as a consequence of being faced with increased responsibility and accountability for the patient’s health, which results in uncertainty.

Why is the NPs’ relationship with responsibility so personal and intense? Is it possible that having been an expert nurse, with a high degree of knowledge and skill embedded in a strong sense of moral responsibility, only serves to heighten the tension and apprehension around issues of responsibility and their consequences? Throughout the course of their careers, they have seen the negative outcomes of errors in clinical judgment. They are also imbued with a strong nursing ethos that emphasizes moral and ethical standards, a duty to practise informed by an ideology of “conscientiousness” and a “high ethical and professional standard” of care (see Nightingale, 1992, p. 3). It is an ideology that emphasizes caring for those with illness rather than curing illness. Therefore, NPs experience an internal angst that may arise from a clash between their own values and expectations of self and the “what if” consequences of those expectations when they engage in acts associated with curing illness.

NPs are not originally educated within an ideology that facilitates objectification of the patient as a diseased entity or a bodily part that requires repair or cure. Rather, they have been indoctrinated in a caring philosophy that asks them to react “responsively and responsibly” (van Manen, 1991, p. 97) to the call of the vulnerable. Yet they now find themselves engaging in risk-taking, seemingly in direct opposition to this very call. To take risks, which is what is demanded in situations of informational ambiguity as
it is applied to medicine (Haas and Shaffir, 1987), is a characteristic that neither comes naturally nor has been learned through their previous training as nurses. In fact, as one NP noted about the mindset associated with risk-taking and its application to clinical decision-making, “I think that’s a difference between nursing and medicine: medicine is sort of ‘the buck stops here,’ where for a lot of nursing practice it’s ‘call the physician.’” Subsequently, because of uncertainty, NPs worry and experience premature guilt for what might occur if the “what if” situations comes to pass.

“Being-guilty,” Heidegger (1962) wrote, “has the signification of ‘being responsible for’ [schuld sein an] — that is, being the cause or author of something, or even ‘being the occasion’ for something,” and “‘being-guilty’ as ‘having debts’ [schulden haben] is a way of Being with Others in the field of concern, as in providing something or bringing it along” (p. 327). These two ways of “being-guilty,” when experienced in combination, define a kind of behaviour that Heidegger (1962) called “making oneself responsible” (p. 327), which he argued results from one person “having the responsibility for the Other’s becoming endangered” (p. 327). “Being-guilty” in this sense results from “the breach of a ‘moral requirement’” (Heidegger, 1962, p. 328), even if that breach is only an anticipated one.

Thus we may say that NPs experience intense feelings of vulnerability embedded in feelings of future-oriented culpability concerning their clinical decision-making when they realize that they could inflict harm upon the Other. For French philosopher Emmanuel Levinas (1996, p. 131), the face is a mode in which the vulnerable Other is revealed, and we recognize that we have been summoned to responsibility: “The Other becomes my neighbour precisely through the way the face summons me, calls for me, begs for me, and in so doing recalls my responsibility, and calls me into question.” Levinas acknowledged that in this ethical imperative, responsibility to Other “goes beyond what I may or may not have
done to the Other or whatever acts I may or may not have committed” (Levinas, 1996, p. 131). Thus, the emotional and mental unease NPs experience in being uncertain can be seen to result from the moral imperative to be vigilant in the face of the Other.

As most NPs are quick to point out, learning to write physician orders and fill in the physician order sheet causes them trepidation. They come face to face with the weight of the responsibility that they carry in the act of writing. On one level, the writing of medical orders on the doctor’s order sheet, medical progress notes in the physician’s section, and the discharge note, along with their signature, are clear examples of the operation of micropower. Yet at the same time, this writing carries heavy symbolism and strong structural connections to explicit, hierarchical power structures:

*We write orders all the time as nurses but we take verbal orders and we just transcribe them. . . . The first time I wrote an order, I have to say, it was somewhat exhilarating. . . . And once you get over that, the responsibility part of your brain kicks in and . . . again you need to think through your orders, and think through your decisions as to why you are ordering something, and what you’re going to do with that information once you’ve ordered it. . . . So it was very exciting . . . to have this little power that we have, but again there’s a lot of responsibility with that, which again, I take quite seriously when I’m writing those orders.*

However, at another level, the writing of orders and the transcribing of thought processes in progress notes is about the NPs’ willingness to accept responsibility for setting into motion a series of cause-and-effect activities and simultaneously appreciating the gravity of those actions. One NP said, “Always in the back of my mind is that the pen is the mightiest thing. You know, you must always be very careful with what you’re writing because
with a pen stroke, you could harm someone.” The writing of an order and the use of the pen, once a taken-for-granted activity with a taken-for-granted tool, now takes on new significance; pen put to paper has become a potential weapon, and NPs wield the instrument of potential harm, even destruction:

I guess the biggest adjustment . . . was the writing of the orders on the order sheet. It was a real funny feeling . . . that physician territory of physician order sheet and a nurse writing on the physician order sheet. It seems so silly. But anyway, I mean . . . it seems so legal and liable and it was interesting. And you didn’t want to make an error because it was in copies and when you see it in [a] court of law years down the road, and you recognize your writing on that physician sheet, you realize just how significant it is.

This power of the pen has also been described in Richard Peschel’s recollection of a haunting incident from his medical residency in his story “The Ritual and the Death Certificate.” This story appears in a remarkable book, When a Doctor Hates a Patient and Other Chapters in a Young Physician’s Life (Peschel and Peschel, 1986). In this story, Peschel described the first time he had to pronounce a patient dead. Having held the stethoscope to the patient’s chest listening for some sounds of breathing and a heartbeat, and having “stood around for a while so it would appear that [he] had spent a respectable amount of time determining that the patient was dead,” (Peschel and Peschel, 1986, p. 71) he felt “somehow disappointed” (p. 71) in the whole process. In other words, Peschel had found there was “little reflection about a human life having just ended” (Peschel and Peschel, 1986, p. 71) However, when he went to complete the death certificate, and was instructed that he must use “the Brady pen” (p. 72) — Brady being the name of the morgue — he was suddenly confronted with the gravity of the responsibility he carried.
Prior to taking on the NP role, when nurses use pens and physician order sheets, they have no need for focal awareness of themselves and these tools. The skills and practices that they bring to the activity are so familiar to them that they are simply unaware of their existence. However, when they become NPs, they encounter the pen and order sheet in a way that brings about a state of unease. As a result, they have an opportunity to reflect, detaching themselves from ongoing practical involvement in the project of writing orders and progress notes, to better understand the significance of what they do when engaged in these activities. The resulting stepping back from “I” and the recognition of “I” in this situation creates not only self-reflection but also self-conflict. What is the meaning of all this? Who am I? Am I becoming alienated from myself as a nurse and from nursing as part of my world by engaging in these acts of writing orders or making these types of clinical decisions? But perhaps, just as Heidegger (1962, pp. 293–301) philosophically argued about the experience of worry and responsibility, NPs are uncomfortable with every role they can play in the world of health care during the period of being adrift, because in the act of acknowledging they may cause the death of an Other, they have to face their own mortality. Simply stated, NPs find themselves being forced to realize the importance of choosing a possibility and defining themselves by it.

The NPs’ sense of responsibility to the Other is not limited only to the patient. However, when NPs refer to the level of responsibility that they carry, they are not referring to a hierarchical level, which would then have a tendency to diminish or denigrate the responsibility that staff nurses bear. Rather, the level of responsibility speaks to a different sphere of influence and the layers of responsibility that NPs bear, which are different from and broader than those of the traditional bedside nursing role. When NPs write orders that will be carried out by others, they are responsible for being the clinical authority on medical management issues, and
they know that the health care professionals who carry out their orders “take on some degree of faith” that they are correct. The impact or consequence of a wrong diagnosis or treatment may not only result in a negative outcome for the patient but also may compromise the emotional and professional integrity of all the health care providers involved.

Joan Cassell’s (1992) study of the work of surgeons provides further insight into NPs’ experience of being uncertain as it relates to the new sense of responsibility that they carry. The outcomes of their actions are attributable; that is, the NP and the patient, the family, and the team know the NP is responsible when events go well or poorly. Also, as noted earlier, much of their work is now more visible; their actions take place before a public composed of the patient and family, nurses, and often the staff physician, residents, and other physician subspecialists, all of whom admire success and note failure. The NP’s every move is now more closely scrutinized and publicly judged. “Marjorie,” a critical care nurse, described the shame she felt when she accidently cut an umbilical artery catheter instead of the venous one she was attempting to replace. Although she had requested that a vascular surgeon be paged to assist her with its retrieval, “half the hospital” responded to the stat call that had been placed, a request the NP had not made:

And my face was burning; I felt like I didn’t want to be there anymore but I kind of coped until I was thinking — God, how am I going to tell these parents? They weren’t there, so that was better. If they had been there I would have had to explain how all these people had to get involved and what needed to happen to do [retrieve the catheter] and I would have been much more mortified.
One day you leave, you go to school, and the next day when you come back you’re a different person because you do something else different. . . . It’s the same place, I’m the same person, but I don’t know anything anymore, because finishing school you don’t pretend that you know the role very well. . . . I’m physically the same person. I didn’t change. I could be of some help to nurses but in a different way, but nobody, including me, knows exactly what I can do or what I’m allowed to do. And so I’m different, yes and no. But who am I? I mean I knew I was a nurse, but maybe I was trending toward the medical model at the time . . . and you just don’t know who you are anymore.

Being lost is the experience of a loss of identity; NPs are unsure of how to respond to such questions as Who are you?, Are you a nurse or a resident?, or Where do you belong? Instead, these questions are answered by asking more questions. The constant focus on the instrumental nature of their role leads them to wonder: Is this what being an NP is all about? Could it be that I am a physician substitute? Where is the nurse in the NP role? Is this what I really want? Should I quit? These types of questions suggest that NPs experience disillusionment during this initial period. Disillusionment is the internal perception created by role realities, and, as noted by Heitz, Steiner, and Burman (2004) in their work on role transition, it leads to self-questioning of why one endures the role, given the internal and external challenges. NPs say it is difficult to adhere to the ideals of holistic care and health promotion while responding to the various expectations of self and others, none of which may even seem attainable. They articulate a constant struggle with holding on to who they were and what they did, in the face of who they are becoming as a result of what they are now doing. Because of the situational pressures, they often feel it is difficult to hold to the NP ideals and establish a role that is different from that of physicians.
Even the familiar world of nursing is now far off and inaccessible. Many NPs do not realize how loyal to nursing they are until they are away from their “home.” As a result, they become more aware of what belonging to the community of nursing means to them, because now a sense of belonging is re-experienced in a different way, more like being “a drop of oil on the water” (Wu, 1991, p. 274). Zhou Wu (1991) addresses analogous feelings in his writing on the lived experience of language learning and acculturation:

The meaning of the old world . . . is often elusive. It is very hard to measure its volume. This body of water in the heart of a foreigner can be as vast as an ocean, as it often occupies his or her whole inner world. . . . I am homesick, but I don’t know what I am missing. (p. 274)

Feeling like an impostor or fraud is a common experience for new acute-care NPs: “For nearly a year I felt like I didn’t belong here; this wasn’t home; this wasn’t welcoming and I was an impostor in my role.” An inability to articulate what they do and how to do it, rather than “this is where I can be found throughout the week,” contributes to this sense of homelessness and lack of self. Feeling like an impostor is also an experience born out of being uncertain. NPs feel as if they are trying to pass themselves off as insiders while being outsiders to a special group of people who all have qualities or traits that they do not. They are plagued with nagging self-doubt and a fear that their colleagues will realize that they are not “one of them.”

On the one hand, as NPs experience being disconnected, they may feel that they are nurse impostors because they no longer belong to nursing. On the other hand, by the very nature of working on the margins of the medical community of practice, particularly during the time of being uncertain, they may feel like physician impostors. As a result, they may feel that they are
not who they should be and are somehow falling short of the expectations and standards for someone in the physician’s position. And yet this is not quite true either, for they know that they are not physicians, even though they need to have some of the same knowledge and skills.

Perhaps NPs do not fail to measure up to the ideal of what they are supposed to be; rather, they fail to see who they truly are. NPs qualify for the positions they occupy and are deemed competent at what they do for the level of experience they have attained, as signified by a licence to practice. But part of feeling like an imposter is the belief that everyone else fits the ideal except them. A few compare themselves to other NPs whom they have seen in action during their educational experience, or to other NPs within their own practice setting. Others have created their expectations for the NP role based on a combination of the discourse (e.g., NPs perform at the level of a second-year resident), their own personal expectations for ideal performance in the clinical arena, and the expectations of those to whom they report in the work setting:

I just assumed she [the NP] knew everything. . . . If she said something, it was gospel. . . . It was the way she carried herself — she just had a presence about her. . . . And I remember when I started and she’d go through the list — GSW, GSW, GSW — and I’m like, “Oh my word. This is like ER. I can never do this”. . . . There wasn’t even a resident affiliated with the team; she was the resident and the nurse. I didn’t even see the nursing part of what she did; I just knew she was a nurse who knew — God — more than I’d ever know, and seemed as knowledgeable as a physician and worked in a field that boggles my mind, but she was able to pull it all together. And it wasn’t until long afterwards that I could see her doing the nursing piece, the counselling with the patients and their families because I was just too caught up in the medical efficiency piece she did. . . . I didn’t even know that I didn’t see it that way until I’d been in the NP role for quite a while.
NPs experience an acute awareness of how others may see them. There is a sense of split between the “I” who experiences the world through their own eyes and the “me” whom they see through the eyes of others. As they squirm under the Other’s gaze, they fear being “found out” for who they “really” are behind their façade. They are afraid that if others were to know the truth about them, those Others would feel betrayed or disappointed, with the consequence that they could be rejected or disgraced. They tend to live with a sense of dread and foreboding that it will only be a matter of time before they are found out. The result is often a sense of incredulity that others actually have placed their confidence in them:

And I always thought it was strange that when I would see a patient and would say to the patient, “Do you want to see the [medical specialist] today?” and they would say, “No, I don’t want to see him today.” . . . And the physicians would seem quite confident for that to happen, that I would have my list of patients to see, the resident had theirs and the physicians had theirs. . . . And it always felt so strange that they seemed to have an overwhelming confidence in me. They probably had more confidence in my decisions than I did at the time. I always felt strange about that.

But perhaps being an impostor goes even deeper. NPs may feel that there is a layer surrounding and concealing their real identity when they can only focus on what they are learning and doing within the medical sphere of their role. At some level, NPs are aware that although they are playing a role, they do not yet embody it. It may be that they do not yet completely identify with it. In this sense they are “betwixt and between.”

The more we identify with a role, the less separate and distinct we feel from it. Conversely, the less we identify with a role, the more aware we become that we are not the role we play. Possibly,
feeling like an impostor means that NPs are not yet able to identify with what they are doing because it doesn’t yet feel morally like who they are. This might cause them to feel even more distanced from their nursing colleagues. It has been recognized that instrumental work and rational thinking stand outside the philosophical foundations of nursing when they are not embedded in a relational ethic of care. Wicks (1998) wrote that nursing celebrates closeness and connectedness in a relational approach to care that links the physical with the emotional aspects of caring. Perhaps NPs become uncomfortable when they experience a disconnection of themselves and their role — the experience of being lost.

The irony about being betwixt and between is that many NPs make interesting discoveries about themselves as nurses during this period. Being lost is a form of un-knowing what was previously known and knowing things anew, a constant trying on of roles for size, of evaluating how well they fit. As Altrows (2002, p. 9) explained, “When we find a role that suits us, we may become so identified with the role and so accustomed to it that we forget that it is a role at all. It is as if we become asleep to our true selves.” Perhaps NPs feel like impostors as they become aware of the ever-shifting tension between themselves and the roles that they play. Without this awareness, they risk losing themselves in the role, thereby losing the freedom to try on new roles and discard those that no longer fit. “In the end, our experience of feeling like an impostor may awaken us to our true selves and what it means to be free” (Altrows, 2002, p. 9).

NPs recognize what it means to be a nurse through what they do, by having it brought to their attention by physicians, and by what they miss, such as being connected and being a provider of holistic care. This recognition puts them on alert. As if they were standing in front of a mirror, they notice many things about themselves that they did not see before. A recognition of “me” occurs. Yet this “me” is not the “self” they are familiar with; the

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“mirror” that they are facing is a distorting mirror, and the person in front of them is not who they had expected to see. Some NPs may even become cautious and carefully adjust themselves to create a better image depending on the community of practice with which they are engaged. This is not an easy period. Feeling like strangers, they cannot satisfy themselves with what they do. Their eyes become so keen that all they can see is their flaws and who they are not. Not only are they strangers to others, but they are also becoming strangers to themselves. They are lost. They wonder who they should be.

NPs come to their role understanding their way of being in the health care world from a nursing perspective, an understanding built on a tradition of holism, a perspective more often particularistic and subjective rather than objective and distant, as is the medical perspective. But under the circumstance of becoming an NP, a person’s focus shifts from dwelling within the healing model, with its emphasis on knowing the patient fully and optimizing health and comfort, to the notion of patient as body to be observed, known, and treated, using the language of domination and control, as is evident in the scientific model of medicine (Gadow, 1980). NPs spend their days focused on deductive reasoning, constructing hypotheses, and using established procedures and algorithms. During this initial period, the dominant aspects of their role are both mechanistic and reductionistic. They are continuously informed that if they have the right facts and a full understanding of pathophysiologic processes, they will be able to predict and control events. They are explicitly told to “stop thinking like a nurse” by their physician colleagues. Through their concentration on increasingly detailed aspects of physical dysfunction, it is not only easy for them to lose sight of the patient as specific individual, it is almost essential that this happens. In this way, their focus is kept clear and their energy is consolidated while they learn what they need in order to perform safely when clinically caring for their patients.
But this language and focus for being, however necessary, often feels foreign and wrong. It involves a detachment or disconnection from the patients’ suffering and pain, and they struggle with it, even though “the art of describing facts is the supreme art in medicine: everything pales before it” (Foucault, 1994, p. 146). Some NPs are torn between their admiration for the “coolness and presence of mind” needed to perform well in this role, particularly under pressure, and a fear that to acquire that level of knowledge and skill will require the sacrifice of the philosophical tenets of nursing. In order to master the knowledge domains within medicine, along with being situated within the medical world, albeit on the edges, they wonder if they will have to give up their connections to nurses, nursing, patients, and patients’
families. It seems to contradict one of the main goals of the journey — to be more connected to the Other. While in medicine involvement is a by-product of the quest for knowledge, in nursing it is a central and pleasurable part of the work (Wicks, 1998). In this sense, whole days, weeks, and months spent predominantly in discourses that focus only on objectification of the patient, with limited time for relational activities, is in opposition to what NPs traditionally value and thereby creates an internal struggle or tension. Are they co-opting their values related to nursing for goals that are not achievable except at the expense of those values? What do they have to lose in order to gain?

Inner conflict may lead to great distress. In fact, learning to care for patients from a medical perspective is not only destabilizing, but it is also polarizing. NPs experience this struggle as needing to make a choice between a practice incorporating autonomy and skill that is based on the scientific paradigm and a practice within a “cosmology of healing” (Wicks, 1998, p. 72). Being lost is experienced as a dichotomy of two mutually exclusive and contradictory paths. From this new viewpoint, their past is severed and they have become two unconnected pieces. Thinking like a physician is experienced as oppositional to thinking like a nurse. It is experienced as moving to the physician side of health care, which implies necessarily leaving the nursing side. Am I a nurse or am I a physician replacement?

Being lost makes NPs feel like their own “self” is falling away, and their old self clashes with their newly discovered self. As noted previously, there are two Is, perceived as dichotomous, bipolar, and opposing each other. There is the nursing “I,” with whom they are familiar and feel connected, the “I” they enjoyed and were proud of and wished to promote and enhance when they chose to depart on the journey to becoming an NP, and they do not want to let it go. The other “I,” the “I” engaged in traditional medical acts and seen externally, is a stranger, like a
distorted figure who always reappears during moments of disconnection. They feel they cannot accept this “stranger” self because they do not want it, but they cannot reject it because it is becoming part of their new self — the new knowledge and skills that they are acquiring are necessary to being more challenged, more visible, and more in control. Being lost means NPs possess a disorganized inner world and inhabit an unconnected outer world, and as a result much of their world as an NP is experienced as paradoxical.

To be a castaway is to be a point perpetually at the centre of a circle. However much things may appear to change — the sea may shift from whisper to rage, the sky might go from fresh blue to blinding white to darkest black — the geometry never changes. Your gaze is always a radius. The circumference is ever great. In fact, the circles multiply. To be a castaway is to be caught in a harrowing ballet of circles. You are at the centre of one circle, while above you two opposing circles spin about. The sun distresses you like a crowd, a noisy, invasive crowd that makes you cup your ears, that makes you close your eyes, that makes you want to hide. The moon distresses you by silently reminding you of your solitude; you open your eyes wide to escape your loneliness. When you look up, you sometimes wonder if at the centre of a solar storm, if in the middle of the Sea of Tranquillity, there isn’t another one like you also looking up, also trapped by geometry, also struggling with fear, rage, madness, hopelessness, apathy. (Martel, 2002, p. 239)

Operating from a dichotomous position is not dissimilar to this passage in Yann Martel’s (2002) critically acclaimed contemporary novel The Life of Pi. The story concerns the transformational
journey of a sixteen-year old boy named Pi Patel, who, after the sinking of a cargo ship, finds himself alone for many months on the only surviving lifeboat, with a group of wild animals. Being a castaway, as Pi is, offers an example of being “caught up in grim and exhausting opposites” (Martel, 2002, p. 240). On the one hand, what NPs originally seek on their journey seems to have collapsed into pieces and becomes elusive to grasp. On the other hand, this new world is experienced as gigantic and overwhelming, making them feel small and dwarfed in the unknown but powerful world of medicine. How can NPs feel that they have no centre when they also feel as if they are perpetually at the centre of the circle?

And I started writing orders and people started doing them, which I found very odd. Why are they doing what I’m telling them to do? Don’t they know I’m just like them? Here I’m in this role, I felt very much — not powerful, but you know that you have the final say, and what you say goes, and people are actually listening to you.

When NPs begin to experience the overwhelming nature of carrying the responsibility that comes with autonomy of practice, they immediately seek solace in the ultimate responsibility belonging to the staff physician. When they are called upon to defend their choice of action, the visibility is frightening. But surprisingly they can also feel moments of exhilaration.

When you’re first doing [intubations] you’re not sure that you can repeat it even though you’ve done the skills; like can you do it under this pressure and can you do it in that situation? But at the same time, when you did it, it was like, “Oh, I did it! I accomplished it! It’s great! This is such a great day, I did this and this.”
NPs feel excited and exhilarated with their success in the advanced instrumental nature of their practice, and they feel that they have made a difference in the lives of their patients. It is during these fleeting moments that they experience real pleasure, a glimmer of the perfect fit for which they are searching, a feeling of being close to home. Is this swing of the pendulum from exhilaration to terror not the worst pair of opposites with which to live, particularly when they are experienced in the same moment? For indeed these two opposites do not remain distinct. Life at the time of being lost is not much of a life. Pi reflects, “It is like an end game in chess, a game with few pieces. The elements couldn’t be more simple, nor the stakes higher. Physically it is extraordinarily arduous, and morally it is killing. . . . You reach a point where you’re at the bottom of hell, yet you have your arms crossed and a smile on your face, and you feel you’re the luckiest person on earth” (Martel, 2002, p. 241).

In this time of being lost, NPs undergo a disintegration, and a reshaping of self is needed to regain peace and confidence. In so doing, they undergo a profound and irreversible change. The process is threatening because they have to alter their identities in order to accept this transformation.

Staying Afloat

During this time of tension and struggle, NPs are being called to inhabit the present by seizing the opportunity to listen to their consciences and to take responsibility for making something of themselves on the basis of who they already are (Heidegger, 1962, pp. 318, 344). This may mean choosing a very different course for their nursing career or struggling to stay afloat. In either case, they must gain a clearer understanding of who they are, what is truly important to them, and what they need to do in the nursing world. They must enter into “the situation” (Heidegger, 1962,
to find an authentic way of being. As Heidegger argued, genuine decisions involve taking a risk in the context of a unique situation. During this time, NPs are being continuously requested to authentically reaffirm their desire to be NPs. If they choose to struggle to stay afloat, they are ultimately called into action.

The turbulence experienced in being adrift creates a need for stability that is achieved through the influence of positive forces. NPs use what Heitz, Steiner, and Burman, (2004) referred to as “optimistic self-talk”— comments such as You’ve got to keep working and You’re prepared to do this — a form of internal reinforcement, a personal coping mechanism, that helps them maintain a positive mental attitude.

Despite the turbulence encountered, staying afloat becomes a self-reinforcing motivator. The will to succeed is a matter of pride for NPs, a need to hold on to the belief in their abilities and the right to discover the sense of fulfilment for which they are searching. Staying afloat is about refusing to be a pawn in the health care game of resource management. Preparing the way for others to follow and being successful in meeting this challenge are some of the rewards of journeying through being adrift, and NPs hold fast to the possibility of such attainment. Living through the struggles and tensions is perceived as a necessary sacrifice in order to experience the rewards: “I think the challenge of being the first graduate nurse practitioner in the province was something that keeps you going. You say, ‘Well, we’re going to be the first ones out; we’re going to be out of the gate before everybody else.’ Also, I think it’s a bit of a pride thing to keep going. Plus you always think that it’s going to get better with time.”

All of the feelings associated with being uncertain need to be quickly contained if the NP is to survive the experience of being adrift. NPs must actively employ ways and means to successfully face and overcome their uncertainties. Therefore, if being uncertain is seen as a challenge, then there is a requirement to engage
in a battle to subdue it: “I guess the challenge is what keeps me
going. I’m one of those ‘keep-going’ persons. . . . If I find that
the challenge is becoming uncomfortable then maybe I need to
do something about it.”

Jumping into the fray, studying and using their desire to pro-
mote learning and professional growth become strategies for
coping with their worries. Perhaps they feel as Melville (1992,
p. 25) wrote in Moby Dick: “I have swum through oceans and
sailed through libraries.” NPs speak about the need to simply
immerse themselves in a constant state of learning; as such, aca-
demic learning is seen as a positive force. They recognize that
the theoretical knowledge and skill that they have acquired in
the classroom setting is but the tip of the iceberg. In fact, one
NP said, “the more you learn, the more you want to learn. Oh, I
wish I knew a bit more and then a bit more, and then a bit more
after that. So I did a lot of reading.”

But the key issue during this time is to be able to mobilize
problem-solving skills enough to function and to meet the respon-
sibilities of diagnosing and treating patients. Doing and learning
become essential partners. NPs recognize that theoretical know-
ledge, or “knowing that,” must be translated into “knowing how”
(Schön, 1987), and immersion in their work as clinical practi-
tioners is critical: “I think sometimes you just have to pluck up
the courage to just say it, just write it. . . . I mean, my pockets are
full of stuff because I always want to have a back-up if I’m not
sure. I never write stuff if I’m not sure about it . . . so I have the
NP’s Guide to Diagnosis and Treatment or whatever and my Palm Pilot.”

NPs strive to create a safety net or lifeline that will protect both
self and others; it is a way to deal with their fear of harming their
patients through their possible mistakes in clinical decision-mak-
ing. This safety net comes in a variety of forms, most of which
are used repeatedly, frequently, and concurrently. Checking and
rechecking their work and asking the same question multiple times
or of multiple people are natural responses to being worried, and they encourage confirmation that the right action will be taken. There is a hope that someone will be alert to a potential error and will catch them before they do harm: “I came back; I reviewed the chart; I looked over everything and decided that yes it is done right. This is what should be done; everything is correct; okay, now stop it; now go home. But you know, there’s one or two things that just pop into my head and it is like, well it’s either go back or I’m up all night reading a CPS. . . . Sometimes that’s what I have to do.”

Even engaging in the diagnostic reasoning process comes to be understood as part of the safety net. Examining all possible causes for the patient’s signs and symptoms becomes the way to ensure no stone has gone unturned: “Your assessment might lead you to believe this is what the issue is, but you always want to build a safety net in case you make a mistake. . . . The focus is always on protecting the patient and making sure that the patient is not exposed to unnecessary risk.”

For the first few years, the NPs’ priority is to get the knowledge and skill that they need to perform safely. Weeks into the new role, they begin to develop their own navigational charts. Being practical people, trained and experienced in the ways of nursing, many NPs look toward immediate development of policies and procedures in the form of protocols, clinical guidelines, or medical directives that serve as maps to help them safely navigate through the clinical decision-making process that is required of them:

And I developed protocols for certain things that I do that would sort of guide me along. Like, how I deal with somebody who’s bleeding, or how would I deal with somebody who is having arrhythmias, and what pathway would you take, and having the clinical guidelines with the knowledge and the theory behind what you do, and those kind of things. Versus just doing what the doctor tells me I should do, or this is what the doctor does so this is what I should do.
These guidelines and directives serve to anchor NPs to something that feels stable and sure at a time when they feel as if they are drifting. If artifacts and practices are not available for adoption — which normally enables engagement with our community of practice and contributes to shape the relations of accountability by which we define our actions as competent (Wenger, 1998) — then they must be constructed through a process of negotiation. The interesting outcome of the formalization of these new practices is that the process allows NPs to engage with others around the dimensions of the various practices in which they may be involved. This then affords them the power to negotiate their enterprises and thus shape the context in which they will work, and they begin to experience an identity of competence. In addition, the creative imagination required to construct the guidelines and directives is anchored in social interactions and communal experiences and thus fosters a mode of belonging.

The following example demonstrates the construction of these artifacts. Within the first month of being in the role of NP, “June” was informed by her director of nursing that the hospital could not legally support her in any expanded role activities. Attempting to deal with the mixed message of “do the job but don’t step outside the scope” was clearly a challenge of being a pioneer. However, this challenge set in motion the creative process of negotiating a scope of practice that would be acceptable with respect to both her subspecialty and broader institutional communities of practice, as well as establishing a structure that would legally protect both her and the institution. Creating such a context in which to proceed with her working life while maintaining a sense of self that she could live with in this new role shows how NPs develop a sense of belonging and their sense of identity in larger contexts — historical, social, cultural, and institutional — with specific resources and constraints:
One of the things that became clear very quickly was that in order to be effective I needed to have medical directives. They’d never been devised at the hospital before. . . . There wasn’t a lot written on them at that time. . . . And I said, ‘Okay. Well we need to do this because I have to have some structure to order analgesics, to order IV fluid. I can’t just be ordering these things. There has to be a structure that protects me legally, protects the institution legally.’ And because there was no template at that time, although I did receive advice from the College of Nurses, I developed what seemed workable for me which was approved by the physicians.

June’s story also illustrates that where there are obstacles there is an Athena ready to assist NPs in navigating them. Sometimes NPs have to actively seek such assistance, while at other times they need only to seize the opportunities that are presented, a finding revealed in the work by Reay, Golden-Biddle, and GermAnn (2006). As June further shared:

But [the medical directive] was blocked by my director at the time because she wasn’t too sure about it because, while she’d acknowledged that I needed it, she wasn’t sure if it was the right time to present it to the organization. So I got quite frustrated because I was practising and I was trying to find a way to make sure that I was covered legally. . . . So what I actually had to do was to run around using the political structure. I actually had made good friends with a nurse who was on the committee . . . that looked at all practice-related stuff . . . and she said, “Why don’t we just do a back-door thing. You give it to me and I’ll take it to the committee for approval without going through the director. . . . Once it’s approved, she can’t say anything”. . . . I was quite happy when that got approved and then I could sort of be on firmer footing to do some of these things.
June noted, “When you’re the first one there, there’s no process, and people don’t really know what the process should be,” but as a result of meeting this pioneering challenge, policies, procedures, and protocols were now put in place for others to use. There was also the beginning of a shared history, one that facilitates new NPs’ sense of belonging within this institution’s community of practice.

NPs, like “Cody”, who work in a province where the concept of medical directives is non-existent, and where legislation denies them the right to advance their scope of practice independently into the arena of prescriptive and diagnostic authority, describe how they “need to constantly cover” themselves, all the while feeling like they are “walking on eggs.” Not being covered or fully certified, they feel they’re in between two groups, constantly confused as to their status and frustrated that they have not been recognized as an entity.

Giving a diagnosis is a big No in our province. But how can you decide on a lab test, how can you decide a plan of treatment if you can’t say that you saw pneumonia on the X-ray? . . . So we say it’s a pneumonia not yet diagnosed. . . . Then, actually, I have to go to one of the fellows and say maybe we need to start antibiotics because the child has a fever, because the white count is high, because of the type of secretions, and because of the findings on the X-ray. And then I write the order and I have to get the fellow or the staff physician to countersign it.

Because NPs like Cody do not have a solid basis in terms of legal recognition or the use of medical directives, they create a safety line by “always backing themselves up” by having everything countersigned. But as a consequence, they frequently find themselves struggling with the tension of “playing politics and doing footwork” for the physicians, both of which negate the raison d’être of the journey.
I cannot work without my physician colleagues being there. Within this hospital we only work as an NP when there’s an attending physician in-house. So this makes it a relationship where I totally depend on them to be here and in a sense they depend on me because a lot of what I do is footwork — call for tests, call consultants, speak to people. And sometimes that’s frustrating. It just depends on how I look at it. It depends if it’s a priority for me. If I see it as this is my patient, this is the plan of care, this is where I want to go, then it doesn’t bother me because that’s what I do. If I’m calling people and doing things which I don’t think are necessary for my patient or appropriate, then I feel like I’m doing footwork. . . . I guess the footwork is when I’m told, “You will call so and so and say such and such a thing.” “Well, pick up the phone and do it yourself.” . . . I feel like a secretary. . . . And it doesn’t challenge me to move beyond or that I’m in a relationship where I feel that what I have to say or what I have to offer is important or valued.

NPs argue that the strongest determinant of whether they are going to be successful is the physicians they are going to work with. One NP declared, “Those acute-care NPs who have been assigned to work with lousy physicians with bad attitudes are struggling before they even set foot in the door.” NPs who are “left out there just hanging in the wind to make diagnoses and clinical decisions on their own, be they right or wrong,” often come to see themselves as working for their physician rather than with them, as “physician extenders.” Unfortunately, in these circumstances some NPs are unable to stay afloat. Some experience depression, which results in the need to take a leave of absence early on in the process. Therefore establishing open dialogue and a rapport with the staff physicians in their practice as quickly as possible is essential to their well-being. Being aligned with staff physicians is one means by which they create a lifeline, and they work hard
to develop and maintain this alignment. Alignment helps them to manage the level of complexity in their clinical practice that they do not yet know how to manage and gives them a sense of hope that they can stay afloat.

The lifeline emerges from belief that the physician will always be there, recognizing their limitations, helping them to navigate through all the trials and tribulations of clinical management of the patient. This is experienced as a feeling that they will never really be on their own, a sense of the physician being present to provide reassurance, or a sense of security that they will do the right thing and that they are providing the best standard of care. Physician presence as a lifeline, either through being there physically or being with them by making room for dialogue, conveys to the NPs that they have not been abandoned, particularly during this time of being disconnected. In the face of uncertainty and the subsequent state of worry that emerges, NPs must turn to the outside to make that which is in doubt certain, or at least less uncertain.

Physicians’ willingness to share information, teach, coach, and demonstrate what needs to be done implies a desire to nurture the NPs’ professional growth and development in the direct clinical practice dimension of the NPs’ role. Lacking confidence in their abilities to clinically care for patients, NPs need their fears and concerns dispelled in almost every new situation by having their opinions and impressions confirmed as correct. Although they realize that they must eventually make decisions independently, the lifeline seems most secure when they believe that they will not be penalized if they cannot make a decision. They feel instead that they can “check in” or “run something by” their staff physicians any time they have questions or concerns. Physician presence creates a trusting relationship that prevents NPs’ fears and worries from becoming paralyzing, thus allowing them to test their abilities and eventually to risk carrying the responsibility they seek:
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 percent of the time except in this case” . . . Or I’ll go back and say, “What do you think I could’ve done differently?” One of the physicians is very good at that, very supportive. . . . I remember, I went to him once and I said, “I don’t know what else to do. This is the problem. I’ve done this. I’ve done this. I’ve done this. I did this and it’s still not fixed. What else can I do?” And he looked at me and he said, “Witchcraft. [laughs] Like there’s nothing else that you could’ve done.” So just that reinforcement from him that no, there’s nothing else here to the situation.

The length and tautness of the lifeline is always determined by negotiation in the NP–physician relationship. While some NPs have the expectation that the physician will supervise them until the NP expresses comfort with managing the situation, others desire the freedom to take risks without the physician standing over them. But in either case, they are grateful and feel fortunate when their physician colleagues understand what they need, are there to support them as necessary, and then are willing to let them become independent through a gradual weaning process, all the while being willing to be available whenever their assistance is required.

This bi-weekly meeting with my consultants is something that I’ve created to get my questions answered, and if it’s urgent then there’s a resident on call, or I’ll even call my staff consultant. You always have the lifeline of the phone. . . . And just being clear, as all nurses have to be, that either I just want to chat with them to get their reassurance and they can stay at their desk, or “No you need to come and see this patient.”
There is a clear understanding and appreciation that the lifeline available to acute-care NPs is different from that available to NPs working in primary care. Some NPs feel more protected in the hospital because if they are unsure, they always have someone to call. Noting that their patient populations can “be so wide with diseases that are seen only once in awhile,” or rare conditions that are not straightforward, some NPs admit that they would feel uncomfortable with full autonomy. Because the Canadian Public Hospitals Act provides that the final authority lies with the admitting physician, there is a sense of security in the knowledge that NPs do not bear the ultimate responsibility and authority for the clinical management of the patient. Yet, tension arises as a result of their living with the paradox of searching for independence and more control while holding on to the comfort of the security of the physician’s presence.

I think I feel more protected in the hospital because, if I ever am not sure, I’ve got somebody to call. I mean even if there’s not always a resident, there’s always a fellow or a surgeon that I can double-check with. . . . So if I were working out in the community or way up North and you’re the only one there, it’s either sink or swim. But I think that would be a really valuable experience too. I’d love to go to the North, to be there for three months just to know that it’s me, me, and me. . . . So I’d say the fear is less when you work in the hospital because you’re not alone. You’re working in a team. However, you don’t have the ultimate authority to make decisions like the physicians do.

Unfortunately, staying afloat becomes more of a struggle when NPs do not trust the staff physicians with whom they are partnered. Doubtful that the physician will back them up if a mistake is made, they contain their scope of practice to what they feel they can manage without any risk, frequently defaulting to the
physician. In these situations, the strength of the lifeline — its ability to enable NPs to engage in their work and learn to take the risks necessary to become more independent — is also its danger. The lifeline becomes a cord that ties them to the medical team in a dependent and disabling manner when fear of loss of their approval and the need for their affirmation becomes more important than the goals for which they strive.

Creating a lifeline through an alignment with their physician colleagues not only expands the scope of NPs’ influence on their world within nursing, but also gives them new and different understandings about those with whom they now engage in some shared activities. Along with feeling privileged to develop a personal relationship with staff physicians, to “really know each other better,” NPs also undergo a growing awareness of and appreciation for some of the experiences that residents live through on their journeys to becoming independent medical practitioners.

I think a lot of residents are scared. Some of them will voice it right out but not many because it’s not very doctor-like. . . . I think that’s one way that I’m privileged. I think a lot of them when you see them on the unit wouldn’t appear that way. But some of the residents, they’ll be asking me, “Do you think I did this right? Do you think that’s right? Do you think that’s correct?” And I think that’s because they understand how scary it is.

As a result, NPs begin to rethink their own experiences and way of engaging in and contributing to the practices of their communities as an NP. Perhaps because of this growing understanding they do not feel quite as isolated; rather, they sense a connectedness with others who struggle as they do, others who are also attempting to survive in their quest for a career, albeit a different one. In spite of the curriculum, discipline, and exhortation, the learning that is most personally transformative for NPs turns
out to be that which involves membership in these various communities of practice, in which there is a sense of shared lived experience that can amplify their sense of the possible. Because they are able to consider a new mode of belonging to this community of practice, new ways of seeing themselves as NPs open up that may ultimately reconstruct their experiences of power and identity.

NPs quickly learn that the lifeline becomes even stronger through the creation of team solidarity. Drawing on their nursing foundations, they turn toward the belief that clinical decisions need to be “spread out over a number of people” through the formation of partnerships, rather than being made in isolation. Nurses, physicians, social workers, physiotherapists, dieticians, pharmacists, respiratory therapists, and others, including the patient and family, are seen as friends whose input must be taken into account in the decision-making process. When this is done, there is a sense of relief that treatment plans are “on the right track” and possible mistakes will be foreseen by others before they are made.

I often rely on my nursing colleagues. . . . I ordered magnesium not so long ago. Magnesium is not something we give very often here, so I ordered it with the protocol, and then I went to the nurse and said, “Well look, this is what I’m ordering for this patient; I used this protocol; Is this the way you understand it? Does this order make sense to you?” . . . So I think that’s one way that I can help myself not be constantly worried. So I think my nursing colleague is a good safeguard for me.

Striving together becomes an important enterprise (Wenger, 1998), not only as a mechanism for preventing mistakes, but also as part of NPs’ larger quest for a viable identity. They must find ways to organize their lives with their immediate colleagues and
patients in order to learn what they need to do. Thus they develop or preserve a sense of themselves that they can live with and so have some inkling of belonging, all the while learning to fulfill the requirements of their employers and patients. For example, they quickly find that they need to cultivate respect with nurses by being effective and efficient from day one, even though they lack the requisite knowledge and skill to be able to do this in their new role. Thus, they strive to create opportunities to make and maintain connections with their nursing colleagues, stressing the importance of earning their respect, which takes a great deal of time and effort. Some do so by attending nursing handover rounds, appreciating that the areas of concern for nursing are of significance to the plan of care, as well as the fact that nurses usually have greater depth of information about their patients than the residents. In addition, they enjoy the camaraderie that takes place during this event. Other NPs make conscious efforts to be part of the nursing team by negotiating the time that will work best for them to undertake the procedures required by patients. Some ensure that they remain involved in traditional nursing activities, such as suctioning patients’ secretions, emptying bedpans, and reprogramming intravenous pumps as the need arises, demonstrating that they want to work side by side with nurses, not above them, just as they wish to work side by side with the physician, not below them. Some NPs invite nurses to participate in writing orders by creating opportunities for their input, thus ensuring that their concerns are heard, and respect for their ideas is demonstrated in a way that empowers them, so the safety net is strengthened and the relationship with nurses is solidified in a new type of partnership.

It’s not easy to flip over to writing on the physician’s order sheets and then directing your colleagues in terms of giving them orders as well . . . But you develop techniques of how to get around
that. Yes, there’s specific directions from a litigation and liability perspective that need to be written on the physician order sheet, and most of those directives are medical directives, but others of them are inviting the nurse to be part of the decision making and order writing as, well, not just being a scribe . . . So, in terms of inviting the nurse — “Well, what do you think of the plan? We’ve had this team discussion so let’s summarize and I’ll write these orders on the physician order sheet. So NPO, the IV solution, the TFI. How does this look to you? We’ve calculated out that the TFI’s going to be about 8 ml per kilo per hour. What does that mean to you?” And having them check them — “Does this look okay to you? Is this what we talked about?” . . . And I’m not telling the nurse what to do. I mean these are medical orders, but we have to work together and they’ve had their input on how they are going to look; I’m just putting them down in black and white.

Despite living in a potentially turbulent time during which they experience being disconnected from that which is familiar and feels like home, NPs find that the work of staying afloat allows them to also experience moments of undeniable joy and satisfaction, moments — however fleeting — of awe and wonder at the things that they do and accomplish. It is these moments that provide them with a glimpse of what the future holds, the possibility of finding the perfect fit somewhere on the horizon.

Polaris, my guide
Shining on the thorny path
Painfully traversed

— Mika Yoshimoto (2008, p. 23)