Chapter 3

Being a Nurse Practitioner

“I’m not afraid of storms, for I’m learning how to sail my ship.”
— Amy, in Little Women by Louisa May Alcott

The first time I felt like a real nurse practitioner was my first night solo with a real critically ill infant and getting through all of the trials and tribulations and then thinking that I had made it through the night. It was a baby that the transport team had brought in from a local hospital. . . . We suspected that this infant could be in overwhelming strep sepsis and was deteriorating rapidly. . . . At the beginning it was mostly the skills . . . so I worked with the respiratory therapist, the attending physician, and two of the nurses who were going to be the admission nurses and we had everything ready. I had all the orders done, we had all our calculations, we had all our pumps all lined up and labelled and so it was going to be as efficient an admission as we could possibly have or that we could have control over. . . . So then getting the airway efficiently, getting
the lines in and pushing fluids, and getting the orders, and managing a cardiac arrest, those kinds of critical things, the technical part of it, and the sense of accomplishment with having that expertise of being able to do those skills. . . . So being able to be successful, being able to facilitate such a critically ill infant through admission and stabilization and the family as well. I mean, it’s tough being able to do that with the parents in the room. . . . I don’t think you ever get really comfortable with it, but the fact is, they need to be there. So it’s having their trust and their confidence in that you are doing your best that you can for their baby. Then to have the attending physician’s confidence that I could manage this type of patient competently also was a professional compliment I guess. . . . But it was a team effort. . . . It was a real sense of togetherness. . . . There was a real sense of success and accomplishment and that we made a difference in this family’s and this baby’s lives. And I think that had to be one of the most rewarding parts, knowing I was a key player in that team dynamic. It was an incredible feeling.

Through time, experience, and reflective engagement, NPs gradually journey through being adrift to fully being an acute-care NP. “Feeling like an NP” occurs as a result of being able to do direct clinical practice, which is experienced as being competent, confident, comfortable, committed, connected, and content. The above quotation demonstrates how becoming an NP is a complex process that combines doing, talking, thinking, feeling, and belonging to a clinical practice team that recognizes, acknowledges, and values designated nurses who perform clinical components of practice traditionally carried out by physicians.

Gradually, NPs gain new knowledge and skills in clinically managing patients. This occurs with the help of, and despite any hindrance from, members in their work communities. Opportunities to care for patients with similar health problems facilitate the solidification and refinement of previously learned knowledge. NPs
commonly journey two or three years, sometimes even longer, with an intense focus in the same clinical specialty, encountering the same types of practice issues, and working with the same medical and nursing team, before they feel confident, competent, and comfortable in direct clinical practice. The time may be less for those who have advanced clinical skills or bear increased responsibility prior to becoming NPs, such as neonatal transport nurses or CNSs working in the same specialty service with the same team.

Being competent, confident, and comfortable — feelings that are so integral to each other that it is often almost impossible to distinguish between them — are the performance markers that must be recognized by oneself as well as others before NPs can successfully journey through being adrift. These feelings enable NPs to be committed and connected to their patients, patients’ families, and members of their community of practice in a way that is morally acceptable to the NP. NPs can now experience being content. These feelings, combined with a sense of belonging, of discovering more, and of being able to make a difference begin to prevail and, as a result, they identify themselves as being NPs. Some even find the perfect fit at this point in their journey.

As a result of experiencing clinical practice in this new way, NPs are able to shift their perspective away from the internal polarized discourse and struggle (Am I a physician replacement or a nurse or neither?) toward an acknowledgement that harmony may exist within previously perceived opposites and a new identity may arise from previously antagonistic patterns of practice. As a result of experiencing practice in this new way, each NP is able to experience a coherent sense of self. Drawing on the thinking of philosopher Charles Taylor (1991a, pp. 305–306), we can view this time as the period during which NPs shift away from questioning who they are (because they do not know how to react when it comes to questions of values and issues of importance for them as nurses) toward situating themselves in ethical
space, where they are able to measure up to their obligations. Of ultimate relevance, they are able to meet these obligations in such a way that they now cultivate self-descriptions that include moral or ethical self-characterizations of what is truly important to them. This does not imply that tensions, conflicts, or concessions no longer exist. Rather, NPs now begin to acknowledge that the knowledge and skills that they have acquired from both medical and nursing models of care ultimately enhance their practice. Consequently, they gradually experience a transformation in their lived identity — an identity that continues to be shaped by recognition and that is crucially dependent on dialogical relations with others, for as Taylor (1994) reminds us, “There is no such thing as inward generation [of identity], monologically understood. . . . We define our identity always in dialogue with, sometimes in struggle against, the things our significant others want to see in us” (pp. 32–33).

Being Competent

Competence, a word derived from the Latin word competere (com meaning “together with” and petere meaning to “aim at”) is defined as having a sufficient or adequate degree of knowledge and skill to do a task effectively and safely. Being competent necessarily moves NPs beyond taking on the title to the realm of doing what NPs do, to forming a community of practice that permits mutual engagement in the work that needs to be accomplished, and entertaining certain relations with other communities of practice. In this process, they find a personal meaning in the title “NP.” As Wenger (1998, p. 152) observed, when we handle ourselves competently, experience competence, and are recognized as competent, we begin to feel that we are full members of the community of practice in which we are engaged. These dimensions
of competence then become dimensions of our identity. In this sense, identity is an experience and a display of competence. Consequently, knowledge and skill must be transformed into action; knowing must become doing, which is what Benner, Hooper-Kyriakidis, and Stannard (1999) and Schön (1983, 1987) referred to as the act of transforming “knowing that” into “knowing how,” or the acquisition of knowing-in-action. Specifically, NPs need to be considered by themselves and others to be fit or suitably and sufficiently qualified to independently carry out the task of medically managing the patients within their specialty of practice. This occurs through a process of affirmation during which NPs prove they have passed initiation into the traditions of the medical community of practitioners and the practice world that they inhabit by demonstrating what Schön (1987) described as “the community’s conventions, constraints, language, and appreciative systems, their repertoire of exemplars, systematic knowledge, and patterns of knowing-in-action.” (p. 36)

In the more accurate sense of the meaning of the word competere, NPs, physicians, nurses, and even patients strive together to bring NPs to their rightful place within their larger communities of practice. Being competent must be formed within a context of mutual engagement; it is an outcome of a joint enterprise in which there is a shared or mutually negotiated range of expectations for performance. Being engaged in action with other people in the performance of clinical care activities means that all members of the community must come to some understanding about what being a competent NP means, even if this understanding is not articulated. Community members must not only recognize but also acknowledge competence in the NPs’ performances. NPs must then experience themselves as competent, as observed in others’ recognition of them combined with an appreciation of others’ performances of similar activities and as compared to their own observations of their performance. Undeniably, the unspoken,
taken-for-granted sense of what competence looks like from the Other’s point of view quickly seeps into their expectations:

Well from the nurses’ point of view, I mean you’re expected to be competent in the skills that they want you to do. You should be able to get IVs when nobody else can. So you do these procedures with the expectation that you’re going to get them and that you’ll be competent in the extra skills, and that they can go to you for a decision and get a decision.

What does NP clinical competence look like in action? How is competence affirmed? How do NPs experience competence? How does it relate to being confident and comfortable?

Being competent is initiated with the endowment of both the legal authority and the qualifications to grant admissibility into the medical sphere. Graduation from a legitimately recognized education program authorizes NPs, administrators of employing institutions, and physicians with whom they are partnered to publicly claim that NPs hold an officially recognized position and are qualified by their convincing demonstrations of special attributes, skills, and knowledge to intercede in the matters of disease and death, a position traditionally held by physicians alone. Licensed status adds a further recognition of competence by investing an official social status through a symbol of bureaucratic enterprise. These official sanctions bring about a “professed authority” that demands that practitioners “project an image of trustworthy competence to their clients” (Haas and Shaffir, 1987, p. 1).

Yet, attaining certification or NP licensure does not automatically result in NPs being able to handle themselves competently. Competence develops only with experience and the recognition that theoretical knowledge has been translated into an acceptable form of action. Well-known motivational speaker Dale Carnegie (1964) wrote that there are four ways in which we have contact
with the world and are classified and evaluated by others: what we do, how we look, what we say, and how we say it. NPs must enact the medical professional role if they are to be recognized as competent, in order to take on the clinical decisions traditionally held by physicians. This involves projecting the idea of control and objectivity that is inherent to the medical profession and is accomplished through a process of mystification, what Haas and Shaffir (1987, p. 2) termed a “special or transcendental authority.” Mystification results from the use of certain symbols or rituals (such as abstruse language) that serve to reinforce the special and privileged status of those specially prepared to participate in their world. One such symbol of competence is speaking like a physician.

Learning to speak in telegraphic sentences and being able to look the physician in the eye while defending their treatment choices affirms the NP role and helps others recognize NPs’ competence: “Without appropriate verbalization, how else would others know what you’re thinking? Thinking can’t be seen.” Because the role is a moral one, it requires a drama in which players construct convincing performances of their special role, and in so doing both the audience and NPs are affected. Daily medical rounds are one of the main platforms on which the medical “script” is traditionally enacted and NP performance is legitimized by the audiences present. Being able to articulate and defend one’s position when placed front and centre not only tests NP competence, but also allows for its recognition by the health care team. Recognition is subsequently validated and augmented when the physician publicly acknowledges the NPs’ knowledge and skill. Affirmation helps to shape their emerging professional identity and their changing conception of a competent self:

It has been a huge bonus for us to be recognized and valued as collaborative members of the team. And when residents come into
the unit or will be on rounds, the NP will often be valued and respected for their input as part of the team providing the care for the patient and family that day.

Patients and families also quickly recognize that NPs are deemed competent because they are placed at the fore in the time-honoured drama of being tested by the physician and on these occasions are heard to use the technical language of the medical profession. These practices elevate and separate them from the traditional nursing role and align them with medicine. Their ability to demonstrate their knowledge and skill to the satisfaction of the physician(s) during these times convinces not only the physicians but also the patients and their families that NPs are trustworthy enough to carry out the patients’ clinical management at an advanced level: “And I guess it’s because [the patient] would see me on rounds with the physician every day and I’d be there answering questions with the physician that she trusted me with that decision.”

As one NP disclosed, NPs are perceived as competent when they speak strictly in problem-based terms; provide a running differential diagnosis; place the information into slots; identify the ways in which those problems can best be fixed; and then prioritize problems based on the whole picture. An outcome of developing competence is that NPs are better able to appreciate two key facts. The first is that in order to evaluate their progress in any particular case, physicians need NPs to present their clinical reasoning through their oral presentations. The second is that their oral presentations are effected by the contextual pressures of the acute-care setting; consequently, they need to edit information into bulleted lists.

Similarly, competence is revealed in the written language and form of medical progress notes and discharge summaries, two other privileged medical rituals. NPs’ documentation, like their oral conversation, becomes disease-focused, targeted
to the patients’ chief complaints and related medical problems, and is concise and brief. Psychosocial information is integrated only when warranted, when it’s related to the presenting illness or discharge plan. One NP said she had learned to condense case information to the point where she could do a history in half a page. NPs write what physicians want to know and, in so doing, communicate that they understand what is important to the physicians. Consequently, physicians interpret NPs’ performance as being competent. Jimmy Santiago Baca’s (1992) reflections offer insight into the power of coming into language:

Until then, I had felt as if I had been born into a raging ocean where I swam relentlessly, flailing my arms in hope of rescue, of reaching a shoreline I never sighted. Never on solid ground beneath me, never a resting place. I have lived with only the desperate hope to stay afloat; that and nothing more.

But when at last I wrote my first words on the page, I felt an island rising beneath my feet like the back of a whale. As more and more words emerged . . . I had a place to stand for the first time in my life. . . .

Through language I was free. (pp. 6–7)

NPs recognize that they are the eyes and ears of physicians when they call to give them information; in this way, they help physicians visualize what they are confronted with. This situation is best facilitated when both parties speak a language that results in the same interpretation. Ironically, the expectation that NPs speak only in a manner that reflects competence as defined by the medical profession is gradually waived once their trustworthiness is established. In fact, when they are at a loss for the right words to describe what they are observing, they have only to acknowledge that “the patient doesn’t look right” for their medical partners to
respond to their requests for assistance. Actually, being unable to speak the language now becomes an indicator that an NP may be about to breach his or her scope of practice.

Regrettably, that recognition of competence, with its privileges of leniency, generally remains confined to the physician group and the health care professionals with whom NPs routinely work. It is not automatically conferred by others simply because competence is recognized and acknowledged in other publicly identified ways. Unlike those with an MD title, NPs must continuously prove their competence to each new member of the medical team:

You look at the patient and since you know them you know the patient’s sick . . . and the attending physicians just know if we say the patient’s sick and we can’t come up with the medical diagnosis that they need to come. . . . But we sometimes don’t have the language that I think the residents need to hear, other than, “The patient’s sick, he can’t breathe. . . . I ordered this, this, and this. Is there anything I need to do?” And, then it’ll be, “No. Call me when you get all those things back.” Whereas the attending physician will come and see the patient, and say, “Yeah, you’re right, the patient’s sick. Yeah, we probably do need to admit him. Let’s see what the X-ray shows.”

Thinking like a physician refers not only to speaking like a physician, but also concerns bringing new knowledge to bear on practice situations where its application is problematic (Schön, 1987). Competence in clinical practice is demonstrated by the NPs’ ability to independently initiate and make an individualized medical plan of care for a patient. In any given clinical situation (within the confines of their designated scope of practice) the NPs not only know that there is a health problem that needs to be addressed, but they also now accurately label the problems,
understand their significance, identify possible solutions, articulate and defend the treatment plan, and take responsibility for implementing it, all with a diminishing sense of anxiety. Integrative system-thinking has become second nature when figuring out pathophysiological problems. They make multiple correlations in their minds in the form of running differentials and then narrow the range of choices based on the information at hand. They are able to do this on limited information, having learned to live with the risk of developing and initiating a treatment plan before having all the definitive information. Furthermore, many make their decisions under intense time pressures. NPs and members within their community of practice no longer doubt that their thinking process and skill performance can be repeated successfully under most circumstances. Perhaps being competent is most dramatically revealed when NPs replace the words I don’t know what to do with I know what needs to be done, an outward reflection of an internal belief in their abilities to successfully perform independently.

I mean, as you’re training you’re just learning and it’s kind of like, I better call the physician on that because I’m not really sure what’s going on or I’m not sure what to do. But now, for example, a child with hydrocephalus who’s vomiting and very acutely ill with a bulging fontanel, I know what’s going on and I know what treatment needs to be done. So I call down to CT and I say, “Can you squeeze in [patient] because he’s having another episode.” And I don’t wait for the neurosurgeon to call back. I just know what’s going on and then I just make the appropriate treatment plan.

Being competent means not only completing the newly acquired clinical tasks in an efficacious and timely manner, but also being able to anticipate future problems for both routine and dynamic non-routine events from a medical as well as a nursing clinical management perspective. Attempts are made to control problems
by mapping out a plan of care, helping the team to prepare the environment, having the appropriate equipment and resources at hand, all the while fully realizing that the patient’s actual presentation or responses to the interventions may very well alter these plans. The ability to do this, which Benner, Tanner, and Chesla (1996) illuminated as a major temporal shift in perspective in the novice-to-expert transition of staff nurses, is often the point at which an NP is able to say that she or he feels like a “real” NP.

Being competent is also characterized by NPs’ ability to refocus quickly despite numerous interruptions; they discover that they are able to engage in multiple tasks simultaneously and can direct others without hesitation. They can hold in their minds information about multiple patients, with their complex issues and needs. They can delay some decisions without a pervasive sense of foreboding, knowing that the delay will not lead to negative consequences for the patient, family, or staff. This ability to prioritize demonstrates a shift that is integrally connected with conscious, calculated risk-taking. The number of patients that these NPs can care for efficiently and effectively has increased, so they are now left to manage patient care by themselves:

I come in and check lab work on patients if I didn’t have a chance to do it the day before. I’ll look at what patients are being discharged that might need some follow up by me or make sure they’ve got prescriptions. Some patients might be going on Coumadin, so I need to look up what their INR was, call their GP, fax information to them, make sure the patient has a good understanding of what’s going to happen for discharge. So that’s done quickly. . . . Then I do rounds with the physicians and we determine who’s being discharged, what tests or things need to be done. I try to get all those things cleared up before I go down to pre-admission clinic. . . . Down there, I do the medical or health history, do a physical examination, write the pre-operative orders. I tell them about what they’re going
to expect when they come in for surgery. . . . Quite often the nurses are bringing me the lab results or chest X-ray results (from patients I’ve seen a couple of days before) and then I look at them to decide whether further things need to be done. Occasionally they need a CT scan to evaluate a nodule that might be on their chest X-ray or they might have a urinary tract infection. Some of them don’t have family doctors so I follow up and come up with an antibiotic and fax or call that to a pharmacy to treat it before their surgery. . . . Occasionally there’s an issue that comes up that I have to consult with the surgeon at some point, and I will jot those down and then deal with those at a later time. While I’m down there, I’m constantly being paged from the floor for issues that patients have, so whether they’ve got a low haemoglobin or maybe have some sort of a crisis that sometimes I have to come up to the floor and assess them and order ECGs, troponin levels, things like that too. . . . Occasionally, I might be assessing a patient for a knee replacement, but when I do my assessment I find that their hip is far worse than their knee, and so I change what orders are written. I talk to them that based on the X-rays that are done today we might be changing your surgery to a hip instead of a knee. So I’ll do things like that too and then review it with the consultant at a later date.

When NPs demonstrate they can think like a physician, they are assigned call duties, another sign of affirmation of NP competence. Being on call means being the first notified by any health care professional to medically address patient-care issues throughout the weekday when the attending physician is present within the institution, or on nights and weekends, when he or she is not physically accessible. This act is, in effect, the physicians’ public acknowledgment that they have placed their trust in the NP’s level of knowledge, skills, and clinical judgments. It is what Turner (1969) calls a rite of reincorporation or reintegration (post-liminal) stage. At this point, NPs are brought back into the
health care team and have an approved new status within it. NPs are permitted to belong, even if only marginally: “And if you’ve been here for a while the physicians trust you and so they don’t necessarily come in and so I was responsible for these two small babies. There’s nobody else there on nights, and so I got to do everything — put the lines in and make all the management decisions. It was the first time I felt like an NP.”

NPs also receive affirmation of their competence through positive feedback, both subtle and explicit, from their physician colleagues. The words they hear not only lead to feelings of being valued but also validate their new way of thinking and acting. A more subtle, yet powerful, form of positive feedback occurs when nurses choose to seek answers to their clinical problems from the NP rather than calling the physician, physicians initiate a direct consult to the NP, and staff physicians inform new residents and their patients that they are to call upon the NP’s knowledge and skills. Word of mouth within the medical colleague circle that an NP has the knowledge and skill necessary to care for a specialized group of patients is an equally powerful form of recognition of competence. For instance, an NP caring for a specific patient population with a relatively rare and complex disease process commented that general practitioners throughout the region recognized her capabilities by directly contacting her for advice on medical management issues for these patients. Similarly, an NP working in an infectious diseases subspecialty remarked that both physicians and nurses in the public health community across the province now directly referred patients to her and consulted her about their medical management.

Being competent arises from a certain degree of efficiency in the performance of skills, decision-making, charting, and communicating, and results in medical aspects of practice being gradually taken for granted. Now NPs begin to draw on their nursing background and actively integrate who they are as nurses
into their clinical practice. They actively pursue the integration of thinking like a physician with thinking like a nurse. NPs incorporate nursing assessments into the medical history and physical exam, creating a more holistic health history. They not only decide what medication choices are available as part of the treatment plan, they free up time to explore these choices with the patient and family. After writing a prescription, they integrate patient teaching into their clinical practice. They have time to focus on the anticipation of future needs of the patient and family and can include long-term planning in their care management and integrate potential with actual patient-care needs, addressing multiple physical needs, including those associated with normal healthy living. For example, paediatric oncology NPs discuss potential sexuality and child-bearing issues with adolescent girls being treated for cancer, while cardiology NPs use the opportunity to explore lifestyle choices with patients and engage in health-promotion teaching about smoking, exercise, and nutrition once a myocardial infarction has been ruled out in the chest pain assessment clinic.

**Being Confident**

As NPs acquire more clinical knowledge and skill, they start to believe in themselves and believe that others trust them to do the right thing for their patients and families:

I’ve had to learn to say this is why I’m writing this and I know that this is right and move on. . . . I’m satisfied that I’m doing it right, it’s correct, and nothing bad is going to happen. . . . The first time I felt like an NP was probably when I felt more confident and I felt I was doing a good job and was on the right track and things were coming together.
Little by little, feelings of self-doubt are replaced with self-assuredness. NPs know and acknowledge that they are able to do what is required of them. They find themselves able to give timely responses to others’ questions and concerns without the need to second-guess themselves. They do not constantly check their reference books or double- and triple-check their orders, nor do they need or want to verify every decision with a physician: “Three years later I would say that my confidence has definitely increased, so that for most diagnoses, I know what it is, I communicate it with the parents and talk about the plan of care, and don’t run back to the surgeon and double-check beforehand.”

NPs’ confidence is evident in their ability to discriminate between ordinary and unusual decision-making situations in their specific clinical practices without a pervasive sense of doubt or hesitation. In fact, they now describe parts of their practices in terms of the simple and mundane activities in which they are engaged: “By the time you’ve been doing it for four years, 90 percent of it is routine. So instead of it being 10 percent routine and 90 percent new, it’s now 90 percent routine and 10 percent new. Even reasonably complex patients become routine because you’re used to dealing with them.” This sense of routine comes from an ability to recognize when one experience is similar to another. Such pattern recognition makes NPs feel more self-assured about their decision-making; a process that has been explored in great depth from clinical reasoning and clinical decision-making perspectives (Dowie and Elstein, 1988; Thompson and Dowding, 2002). When NPs are confident, they say that with enough experience they are able to accurately pick out the common or normal sets of problems their patient population presents with. They differentiate between decisions that are easy because of their routine nature, despite complexity, and those that are difficult because of complexity combined with newness or rarity.
Uremic syndrome is a biochemical entity and I can diagnose hyperparathyroidism and I can diagnose hyperkalemia and I can diagnose pulmonary edema and I can diagnose coronary artery disease and myocardial infarction. . . . There’s a lot of cardiovascular problems, there’s a lot of endocrine problems, and I’m comfortable enough making those diagnoses and intervening, and beyond that, I think they probably need a doctor.

This ability to discern what they know and not know helps NPs to diminish their anxiety about the responsibility they bear and their fear of causing harm. The times they feel disabled by their responsibility becomes less frequent and intense over time:

Being scared is not as pervasive. . . . And I think I’ve developed a certain level of confidence in what I know, what I can handle, and also in what I can’t handle, and knowing also, having worked with the medical team for a while now, being able to say, ‘Guys I can’t handle this. I’m going to take care of this patient but I need back-up now.’

The pattern recognition associated with decision-making helps NPs feel secure in their belief that they know, even in unfamiliar situations, the right thing to do. Although knowing what is right is associated with being competent, it is also tightly woven into their experience of being confident. This is evident in her account of the first time “Jackie” felt like an NP. She described numerous behaviours that were indicative of being competent, such as quickly and accurately diagnosing the patient problem, identifying how it needed to be solved, engaging in multiple tasks simultaneously, and directing others without hesitation. Her experience of knowing that she had taken the right actions allowed her to feel confident and to finally identify with being an NP. She accepted that it was permitted to not know everything
that had to be done or even whether the diagnosis was ultimately accurate. She no longer felt that she had failed the patient or that she was intellectually unable to make and act upon the appropriate clinical decisions. This was contrasted to a time in which her hesitancy, indecisiveness, and lack of confidence in the moment necessitated her calling the physician before she could act on her thoughts. Referring to herself as a novice in this situation, Jackie acknowledged that she had been unable to perceive herself as an NP despite titling, education, or others’ perceptions of her competence. Being confident allowed her to experience being competent.

And it was a woman who once again was having her first hemodialysis on an evening shift and I was working this shift. And she had just had a permacath put in . . . and we put her on dialysis, and she started going into acute pulmonary distress. And I listened to her lungs and I could hear nothing on the right side. And she had a diagnosis of Wegner’s, which is an autoimmune disease that causes problems with both of the lungs and the upper respiratory tract, but I didn’t think that was an adequate explanation. And so then I quickly thought about what are we doing to her on dialysis, and this is a new catheter, and I hear nothing here. And I wouldn’t know very much about a shifting trachea but it looked like it [used her hands to demonstrate on her own neck]. So I wasn’t able to intervene here, other than to stop the dialysis. . . . I asked the staff nurse to stop the dialysis — and I simultaneously ordered a stat portable chest X-ray and called the medical resident on call. And she had a hemothorax. . . . [A]nd it stands . . . in contrast to that poor unconscious lady my first evening shift in the unit where the very first thing I did was call the physician; whereas in this situation I had already made something of a diagnosis when I called the resident and I had stopped the dialysis. So I felt confident the right things had happened.
When they no longer feel disorganized, NPs do not automatically blame themselves for being unable to get everything done in a timely manner. Although time constraints continue to frustrate them regardless of their level of expertise, they are able to reflect on what is within versus outside their control to manage or influence. They identify when the workload is too heavy and will ask others to help them with their work. They admit to themselves and others what they have been unable to attend to without feeling shame or personal inadequacy.

There are days where you may have seven kids to see in the morning before rounds; you might only see two, because when you got to number two, things were not good. And so then you’ve got to deal with the fact that you’ve got five more kids you haven’t seen and you’re going to be doing rounds and there’s no way that you can get it done. I’ve learned now to say, like if the fellow is finished [with] his patients, I’ll say, “Do you mind checking or mind going and seeing these?” I don’t mind asking for help or just saying when we get in rounds, “I haven’t had a chance to see this patient.”

NPs discover that they know and trust their own instincts so they can dive into the fray easily and quickly; curve balls do not immobilize them in their thoughts or actions. They no longer need to mentally and psychologically prepare themselves for the problems they might encounter and have enough self-assurance to extemporize when problems present themselves unexpectedly, be they patient-related difficulties or those associated with working with an inexperienced team. “Betty” shared her story of one such curveball. She had been called to attend a routine delivery in which there were “a few fetal variable decelerations, nothing to really worry about.” She expected that she might have to “just do a little drying and warming, maybe a little oxygen,” but found herself in a full-blown resuscitation. She was partnered with a
nurse who had never worked in this setting before and who questioned whether she should be replaced with someone more experienced. Instead, Betty offered praise and assigned specific tasks to specific team members. When the crisis was over, she publicly acknowledged that the situation went smoothly and, in response to the nurse’s apology that she wasn’t good enough, the NP gave her positive affirmations: “You were excellent,” I said, “You did a really, really good job.”

As their self-assurance increases, NPs take responsibility for patients with an even broader range of pathophysiological issues. Yet, because they now know what they know and don’t know, and have more realistic understanding of the limits to their scope of practice and their responsibility within those limits, they also become confident negotiating the boundaries of their practice. Each NP articulates and defends his or her scope of practice for the specific clinical context and emphatically identifies for others what he or she needs to or should know. One NP laughingly said, “I don’t do neuro” and “I’ve never put in a chest tube and I never will. I’m pretty clear about that.” In other words, they confidently place boundaries around the knowledge and skills that they need in order to bring safe and timely care to the patients in their practices:

Some people think that they’re responsible for the entire world and I don’t ever try to assume that. I know there’s one person doing that now and she’ll always say, “But I don’t know everything.” I keep saying, “You don’t have to know everything. I think you know what you need to know and now you have to be confident, be willing to admit when you don’t [know] and seek help and guidance when you don’t”. . . . And so I know that I don’t know everything and I know my limitations and then I’m willing to go out and do that.
NPs’ confidence is influenced by others, particularly the physicians with whom they work and, when applicable, other NPs. For most, it is a continuous process of renegotiation in order to ensure that the boundaries created continue to be honoured. For example, “Nancy,” who bore responsibility for performing tracheostomy changes, described this negotiation process. A staff physician new to their clinical team, having observed her practice, suggested that Nancy, not the ear, nose, and throat (ENT) medical resident, should be responsible for performing the patients’ tracheostomy changes earlier than was Nancy’s current practice. In this case, a change in the timing of the procedure amounted to a change in her scope of practice. She acknowledged her reticence about the request, recognizing that it was born out of knowledge of the deaths of two children during tracheostomy changes — despite having been performed by ENT specialists — before the stomas had been well established. Yet despite her reservations, Nancy was open to examining the various levels of evidence regarding patient outcomes, the additional training required to manage premature closure of the airway, and the system changes that would need to be instituted in order to safeguard the patients. As this example illustrates, NPs’ confidence is demonstrated by their ability to recognize their strengths, link them to the salient issues in the situation and to ways of responding to the problems identified, and then bring them to the fore in the negotiation process.

There is, however, a paradox inherently associated with being confident: as NPs gain mastery of the clinical management component, they also enter new and uncharted waters as clinical experts. Tensions arise when they begin to surpass the expertise of their physician colleagues while at the same time they need their assistance when they find themselves outside their scope of practice. Struggling to do what is right for the patient and for one’s self in the situation is clearly evident in the following account told by “Gordon,” who encountered difficulties during
the performance of a bone-marrow aspiration involving a very obese patient on whom he had performed a number of aspirations in the past.

I did him with an eight-inch bone-marrow needle the first time. This time I couldn’t reach him with an eight-inch bone-marrow needle. I was blind. And I called [the attending physician] and he was busy and he also said, “You’re the most skilled of the group. You’ve done him all the way through.” And as I was doing it, I thought, Yeah, I am. I agree with him. But I know the least about anatomy of them all. . . . I did it, but I thought, I am out of my league. . . . And I thought: What do you do? I mean, we’re just not trained. And can we say, “No I will not do this procedure. I refuse?” Of course you can, but when someone says you’re the most skilled of the lot, can I still say no? Of course I could have still said no but what I actually asked then was if they would mind me going to a different site, which they agreed that I could switch sites, just to do anterior, which they don’t like me doing, but again they deferred to me as I was the most skilled, which is true. I’ve been doing the most in the last seven years. But it was an interesting position to be in. . . . And just as [the attending physician] was walking in the door, I got the specimen and it was good and everything was great. But the fact that he came down refreshed my faith in him.

As this example illustrates, being confident means that NPs acknowledge that they have a strong clinical grasp of the situation. They both recognize the familiar and individual patterns of responses and have a clear sense of when they are outside their scope of practice, based on the unfamiliarity of the clinical territory in which they find themselves. There is marked congruence between the confidence they express about themselves and others’ expressions of confidence in their competence. In fact, both are even able to readily acknowledge when the expertise of
the NP exceeds that of the physician in a particular clinical situation. Uncertainty arises when they know that they are outside familiar territory without the requisite knowledge required to legally engage in the activity. But the uncertainty experienced is different now than what they experienced in being adrift. Being confident results in an appreciation that they may have capabilities that others do not have, even when the demands of the patient situation may exceed their capabilities, and even when their capabilities may not be legitimately recognized in a court of law. Gordon acknowledged, “My insurance crossed my mind, and would they back me up?” NPs’ recognition of the others’ level of competence as compared to their own is then linked to the sense of timing required of the action for the sake of the patient and is quickly examined in light of other available options in the particular situation. All this information then culminates in a clinical judgment that is based clearly on a risk-benefit analysis.

While most nurses are able to turn to the cumulative and collective wisdom of their group for advice, the lack of a well-established homogeneous community of practice is strongly evident in Gordon’s story. He described being so shaken that he approached a student in the NP program to talk about the event. However, the student herself was so overwhelmed with her own confusion that she actually asked Gordon not to discuss it with her. He contemplated discussing the experience with the nursing faculty where he had trained and with members of his professional association. Unfortunately, his previous experiences with these potential support systems had led him to believe that they were as much in the dark as he was when it came to NPs’ scope of practice as it was actually lived in the practice setting. There were also no other NPs with his particular subspecialty in Canada whom he could contact at that time. “What do you do?” he said. “I didn’t know who I was going to call.” Two questions that are brought into consciousness by being confident and competent are
held in the balance for pioneer NPs: Who bears the responsibility for the risk-taking associated with the decisions made at this level? Who is best to take the risk in each particular situation?

Confident NPs also begin to make the decision when not to act, that is, when not to over-treat. Being confident helps them “to do what is in the best interest of the patient, not what is safest for the nurse practitioner.” They gradually find the fine line between being cautious and overly cautious, and see the patient that needs to be tended within a health care system. Confidence involves “not ordering fifteen tests when three would do because you have to consider the cost to health care.” NPs recognize that they cannot always play it safe by doing everything all the time.

And I don’t think that people can take care of patients just by doing everything. And I tell people the hardest thing is not to do septic work on every baby. That’s very easy. Every time they have a whimper or whatever I can send all the cultures off and start them on antibiotics. A much harder thing is to try and take all the information and say, “No, I don’t really think it’s an infection, this is something else.” It’s harder not to do everything. . . . There isn’t a lot of good reason to do this except to make you feel good, or to think I’m doing something. . . . But if you stop feedings and start antibiotics all the time they just never make any progress. . . . You have to get to these points and you have to kind of make that jump: “No it isn’t that and we’re just going to progress and stay on with this course.”

Being confident is also characterized by NPs intentionally holding off or delaying discussion of clinical management decisions with the staff physicians. Even when a clinical situation is outside their scope of practice, they believe that they can manage the event until the physician is able to assist them. In fact, they differentiate between keeping the attending physician informed
(because the physician is ultimately responsible) and consulting a medical expert who can better deal with the issue or provide affirmation. “Donna,” a neonatal NP, recalled how she had been summoned to the delivery room to assist the team with the resuscitation and stabilization of an apparently normal newborn after an elective Caesarean section. On arrival, she discovered that the baby’s breathing was abnormal and the team was experiencing difficulty with intubation.

When I went to intubate him it just made it worse . . . [and] just all this stuff is going through your head — Well I know I’m going in the right spot, it’s passed through his cords — but as soon as I do this it actually makes it worse, not better. I can give this baby CPAP and give him hand ventilation and it works much better than it does when I intubate him, so what is the problem? And so going through that and saying, “Okay, if this baby has a TE fistula then it can be that sometimes, once you pass the endotracheal tube, that you can go into the fistula and so that you have problems ventilating them or that you’re hiding the fistula and all of your pressure actually goes to the stomach instead of where you want it to; it just depends on where it is”. . . So, I’ll just continue with what is making him better, which is the positive pressure ventilation and maybe just the CPAP and let him do the work himself. He needs some help but I can’t do it. So, I got the lines in quickly so we could monitor his blood gas and how he was doing, and I also phoned the neonatologist and said, “There’s something really strange and you have to come in.” And he wasn’t really happy. He said, “Well, if you don’t know, how am I supposed to know? Look, I’m not coming.” I think I said, “You’re probably right; we might need to call ENT for this; there’s something wrong with this patient’s airway; but I’m not sure that it’s not just me.”
Donna had a clear understanding of the normal patterns of response to an intervention and, as a result, readily acknowledged that she was no longer in familiar territory. Her confidence was demonstrated by her ability to use her knowledge and critical thinking skills in such a way that she calmly and quickly thought through potential diagnoses and possible actions. At the same time, she observed the infant’s responses to the actions she employed in a trial-and-error format in this time-pressured situation. She continued to respond quickly and fluidly while managing multiple tasks. Even though she wanted to be able to do more for the patient and family, her skilled performance was linked with her ability to honestly assess her own capabilities. She called for assistance in a way that showed she now worked with the physician in a collaborative partnership rather than a hierarchal relationship. In this way, control of and responsibility for the clinical management of the patient was shared with the physician rather than relinquished. Even when she was unsure of one aspect of clinical management, she remained in the centre, directing what she could, complementing the work of others. Expressing a sense of failure was not about having failed as an NP because of ineptitude. Through the creation of a caring space for the distraught family, this information was even honestly shared with the parents:

The family was up in the unit while we were trying to intubate and I described the procedure to them and then I had to admit failure and I said, “I’ve tried and it actually seems to make it worse, so, I’ll just leave it as is, give him the help that he needs in another fashion, and I’m calling in these people. And what it says to me is that there’s a very serious problem with the airway and your baby; we know that your baby’s going to need surgery but I don’t know what else to say beyond that.”
Being confident also creates the possibility for advocacy and taking an ethical stance. If NPs are to be trusted to do the right thing, they need to perform in a way that is true to the intersubjective, social, cultural, and ethical concerns of the situation, rather than merely acting within a set of behavioural protocols or skills. It can be assumed, then, that the more thoughtful and reflective NPs are regarding a particular situation — calling upon all the ways of knowing that they have available to them — the more likely they will be able to act confidently in situations marked by contingency and uncertainty. Max van Manen (2002) regarded this as a quality of tact. For example, there is a moral imperative demonstrated in the act of acknowledging one’s limitations in the situation and then insisting upon the involvement of medical colleagues, even when those colleagues argue against the need to be involved because of their trust in those very abilities.

NPs recognize the limitations of the abilities of medical partners in particular situations and take the risk to be independent thinkers despite the strong dependent relationship that exists. Donna described how, after she had verified her impressions of the case once the physician made his initial attempt at intubation, she was able to protect the baby from further ineffectual intervention and possible harm by physically intercepting and definitively stating the need for surgical intervention. She expressed a combination of anger and disbelief that he would not recognize or acknowledge his own limitations in the circumstance:

But unlike me he didn’t stop. And I put my hand on his wrist and said, “He’s actually better when you’re not doing this. I think it’s time to quit and then just make the referral. . . . We need to transfer him.” So, he called the appropriate people and did whatever was necessary and it ended up the baby did have the most totally weird airway in the world; it was really non-operable. . . . So, the challenge was the decision-making for the neonatologist:
“You’ve got to quit now because you’re just making him worse. This is exactly what I have done; I’m satisfied it wasn’t just me, but now we have to call in somebody else.”

In due course, NPs learn to create a façade of knowing so that even when they do not have a full understanding of the intricacies of the situation — the anatomy, physiology, or pathophysiological process — they are still able to exude a sense of confidence in their ability to safely handle it. They thus embody the medical aura, a phenomenon described in the medical literature as “a cloak of competence” (Haas and Shaffir, 1987; Merton, Reader, and Kendall, 1957). Ironically, this cloak is not developed or used by NPs until they have confidence. When confronted with uncertainty, they don the cloak in order to communicate the impression of competence and confidence, of being in control of the situation: “People tell me I know everything. I know I don’t know everything, but I must present this aura of confidence. I just don’t tell everybody I don’t know everything. I need to have some confidence so that people can trust what I’m going to do and they’ll listen to what I have to say.”

NPs accept that members of the team expect decisiveness and action, action that is taken in a calm and inclusive manner: “The nurses want you to be able to make a decision. In a crisis, they want somebody who knows what they’re doing and doesn’t fly apart. . . . They do say that some people just kind of fall apart in a crisis and that’s not very useful or that they just boss them around and they don’t really want that either.” The consequence of controlling and manipulating others’ impressions is that NPs increasingly identify with their role and become even more confident. It would seem that there is a quality of self-fulfilling prophecy in these authoritative performances that contributes to a changing self-perception. Dr. Glenn Colquhoun’s (2002) poem When I Am in Doubt expresses the power of this façade:
When I am in doubt
I talk to surgeons.
I know they will know what to do.
They seem so sure.

Once I talked to a surgeon.
He said that when he is in doubt
He talks to priests.
Priests will know what to do.
Priests seem so sure.

Once I talked to a priest.
He said that when he is in doubt
He talks to God.
God will know what to do.
God seems so sure.

Once I talked to God.
He said that when he is in doubt
He thinks of me.
He says I will know what to do.
I seem so sure. (p. 89)

Learning to project confidence is part of the medical mystique. How NPs present themselves to nurses, physicians, patients, and families is as important as the content of that presentation. In an occupation that demands such a great measure of trust from the health care team and their clients, NPs must convince audiences of their credibility. They quickly realize that the audience looks for cues and indications of personal confidence. In response, they orchestrate a carefully managed presentation of self intended to create an aura of self-confidence so they can affect the patient’s medical plan of care in a positive way:
You’ve got to have confidence. If you present your plan of care as, [slowly, softly, hesitantly] “I think and maybe perhaps”, then the person listening to you is not going to or might not trust you as much as, [boldly, loudly, and quickly] “Well, I think this and so my plan is to do this.” Take out all the perhapses and state your case and be prepared to defend it. Don’t defend it unnecessarily because then they’ll think — well, you’re not really sure. So, it’s a whole way that you present yourself to the world.

An aura of confidence is facilitated when NPs learn the routine ways of treating a particular problem or the acceptable patterns of therapeutic interventions, along with the likes and dislikes of the various physicians with whom they work. Nevertheless, even after years of experience, they still sometimes experience uncertainty about how a particular physician will think in a given situation. Yet, they are able to retain the illusion of confidence by speaking definitively about parts of the plan of care while being vague about others. They open up discussion in a way that allows them to discover the physician’s thinking during the debate, so they can maintain their input into and control over the final decision. As one NP shared, “Even though you make your plan out and you order the things that you’re sure of, the things you aren’t sure about you learn to keep your decisions nebulous and to keep those things for the general discussion on rounds and then you say yes or no to them.”

Accepting that they can never be completely right all the time, while realizing that they can always learn from each experience to make a better decision in future, is part of being confident. NPs accept that they live in a grey area in which they “could do this or that,” and have learned to make a choice without waffling while being confident that neither decision will cause harm to the patient. Making a decision is almost as important as being able to make the best decision each time, the latter gradually appreciated to be an impossible task in many situations.
NPs nonetheless experience times in which their confidence eludes them. For example, others may still intimidate them, particularly some physicians. Specific clinical situations may cause them to doubt their ability to perform. “Alex,” with more than a decade of experience as a neonatal NP, described how attending deliveries for newborns with meconium aspiration still fills her with self-doubt, making her uncomfortable and apprehensive:

It’s in situations where you think that’s a weakness of yourself perhaps, or somebody that can intimidate you. I never like going to resuscitations where there’s meconium because then you have to intubate their trachea in the case room. They’re all slimy; it’s [a] completely uncontrolled [situation]. And so I was called in the middle of the night to this delivery for this baby and everything that could go wrong went wrong. And I’m kind of that little — you know, if I had to evaluate myself I would think I was not so sure of my skills in that area — so when everything went wrong and the physician who was there said, “What’s your name?” And you’re there thinking, “Oh, you’re not happy with my performance! [aggressive tone] How long have you been doing this job?” [laughs] So yeah, I wasn’t very confident there. . . . It’s easier to feel non-confident.

Although these situations may not cause the same intensity or duration of doubt and apprehension as they did at first, NPs continue to work hard to reduce the gaps in their clinical knowledge and skills. Feelings of insecurity serve as the compass for more knowledge, which leads to continuous learning and growth:

I’m kind of that knowledge person and I try to erase the deficiencies so that I do know what I’m talking about and that I’m sure of it, so that I can be confident. It’s when I’m not exactly sure. But I think as you do the role more and more, then . . . if it’s something
that doesn’t require immediate decision-making, I’ll say, “Well, I’ll just read this because I can’t recall the exact details but I’m going to go look it up and then I’ll get back to you.”

To summarize, in feeling competent, NPs believe they know how to do something, have the power to make things happen, and that their efforts will be successful. They exhibit confidence when they complete the task at hand and “just know” that they have done well. They have little doubt about the outcome of their performance and need no external feedback. Ironically, being confident increases the likelihood of a task being performed well because it enables people to make the most of their abilities (Davidhizar, 1991, p. 105). The union of confidence and competence in the NP role now makes being comfortable possible.

**Being Comfortable**

[He] learned what it meant to leap into the void . . . [Plotting a meticulous route on the nautical chart] had been a source of satisfaction in a profession where accomplishing safe passage between two points situated at far-spread geographical latitudes and longitudes was essential. There were few pleasures comparable to deliberating over calculations of course, drift, and speed, or predicting that such and such a cape, or this or that lighthouse, would come into view two days later at six in the morning and at approximately thirty degrees off the port bow, then waiting at that hour by a gunnel slick with early-morning dew, binoculars to your eyes, until you see, at exactly the predicted place, the gray silhouette or the intermittent light that — once the frequency of flashes or occultations is measured by chronometer — confirms the precision of those assessments.
When that moment came, [he] always allowed himself an internal smile, serene and satisfied. Taking pleasure in the confirmation of the certainty achieved through mathematics, the on-board instruments, and his professional competence, he would prop himself in one corner of the bridge, near the mute shadow of the helmsman . . . content that he was on a good ship, rather than in that other, uncomfortable world, now reduced by good fortune to a faint radiance beyond the horizon. (Pérez-Reverte, 2001, pp. 33–34)

So for most things, I’m comfortable that I can make the right decision. And if I’m unsure, there’s always someone to call, always. You’re never a boat alone in the ocean. It’s somewhat like sailing around in a marina.

During this period of being comfortable, NPs feel like they have finally come home. The word comfortable means to be in a state of mental and physical ease, to be free from hardship, pain, and trouble (Barnhart, 1988). When “at home,” NPs are at ease, comfortable with themselves; they are able to be who they truly are. They experience feelings of relief, pleasure, enjoyment, gladness, and even transcendence in their work. Although a sense of awe, wonder, or incredulity with discovering what they are capable of is now rarely experienced in their clinical practice, smooth sailing in the harbour is a preferred place to be at this point in their journey. In the novel The Unbearable Lightness of Being, Milan Kundera (1984) examines the question — “Which shall we choose? Weight or lightness?” (p.5). While Kundera acknowledges that, although “the heaviest of burdens crushes us, we sink beneath it, it pins us to the ground” (p. 5); he suggests that “the heaviest of burdens is simultaneously an image of life’s most intense fulfillment. The heavier the burden, the closer our lives come to the
earth, the more real and truthful they become” (p. 5). Perhaps then, being comfortable is revealed as a weightiness of being that occurs when NPs believe their practices have meaningful substance despite the heavy burden of responsibility. Their clinical practice is no longer experienced as burdensome but rather as a source of deep satisfaction.

Initially, being comfortable is experienced as a bodily perception, indicating that NPs’s practice is becoming easier. The mental fatigue previously caused by moment-to-moment decision-making is no longer evident, and in its place there is a taken-for-granted feeling that their clinical work is second nature: “I can remember being just so mentally tired from making these decisions and then I can remember not being tired. I can remember a call shift and I wasn’t tired and it was just so easy to make decisions. . . . It was just a couple that were difficult, that you had to really think about. At that point I was [thinking], ‘I can do this.’”

As a result of renewed energy, the opportunity to enjoy learning resurfaces, and clinical problems are perceived as a series of opportunities for being stretched and challenges to be faced with a sense of excitement:

I think every day is [a good day because I actually learn something new] when I’m working in the unit . . . I don’t get bored with my job because there’s always something new . . . it’s always changing. . . . Even in the field of cardiac surgery in this new era of stenting and [performing] multiple procedures in the cath lab, it’s changing the environment of surgery, because now . . . we’re only getting the ones that they’ve tried everything else on for the last ten years. . . . It’s exciting now; it was scary then.

In fact, once knowledge and skills have been honed, some NPs hanker after more challenging clinical situations, wanting to continue to push the boundaries of their abilities. This sense of wanting
to be stretched re-emerges as an aspect of being comfortable. Feeling scared is no longer a state of being but rather is accepted as an integral part of the excitement of risk-taking. One NP, for instance, felt comfortable enough to recommend to her medical colleagues that she establish and manage an independent clinic of a particular subspecialty patient population within their larger practice. She derived great pleasure bearing that responsibility.

Because NPs have become more efficient and effective as individual practitioners, their teams become more efficient and effective too, and NPs and team members no longer think about the momentum of the day. This sense that a service or program runs itself implies that the team trusts each member to know how to do what is required of them, at the performance level expected, and they respond to each other in a synergistic manner; team members come together in the enactment of their practice only to be strengthened. Thus, team comfort serves to enhance NPs’ feelings of comfort:

> I think we’ve settled into a lull . . . settled into a good system. . . . It’s nice now; it’s just comfortable, to the point where, if I’m out of town, [the physician] will say people don’t know why he’s come to do the procedure instead of me, because they expect me to be there. . . . It’s now more taken for granted. . . . Now it feels like our team runs like a well-oiled machine and . . . nursing is very much a part of that running of the well-oiled machine, to the point where we don’t wonder why things run so well anymore, because they just do.

Settling into a routine helps NPs create boundaries or a comfort zone, an internal safety line, within their scope of practice. The comfort zone is the internal place where feeling at ease is experienced and results from engaging in work in a way that requires less effort and distress. In this zone, the earlier pervading feelings of uncertainty fade from the NP’s everyday awareness. Little by
little, uncertainty (and dealing with it) becomes integrated into NPs’ lives such that it no longer requires active management, nor is it experienced as solely distressing. Uncertainty has gradually evolved into a certainty in their strength and resilience. Kolcaba (2003) spoke to the ability to rise above the discomfort of uncertainty when it cannot be avoided or eradicated as transcendence, a type of comfort that speaks to comfort’s strengthening property. In fact the word comfort also means to strengthen: the words roots are cum which means “together,” and fortis means “to be strong” (Barnhart, 1988).

Certainty is encouraged by physicians; they are quick to admonish when uncertainty is displayed, indicating that doubt will impair their effectiveness with patients. In fact, Katz (1984, pp. 184–206) has suggested that medical socialization involves training for certainty, not uncertainty. In this state of being comfortable, even uncertainty takes on new meaning. NPs realize that many of the decisions they make are not white or black; there is a wide grey area, an area of differences of opinion and a variety of choices that may lead to similar outcomes. Some choices may be better than others, but not all choices are necessarily wrong or bad. Although this helps to diminish the fear associated with the responsibility of clinical decision-making, it creates a taken-for-granted tension between certainty and uncertainty: “I know the more I learn about making those decisions, I realize that there’s no right or wrong either . . . It’s not as exact a science as you think it is.” The reality of needing to initiate a plan of care before all the definitive information is available contributes to this understanding that choices made may be less than perfect or even wrong.

So much of what you do initially is based on scanty information. . . . Even in the end, you may not have enough information to say for certain . . . but you have to just take this limited amount of information and say, “I think it’s this, this, or this, and then this
is how we are going to manage each one.” Maybe there’s conflicting ways to treat them so you’re going to have to make a decision — “Well, I really think it’s this.” And I mean you’re going to be wrong sometimes but other times it’s kind of where the clinical and the laboratory and diagnostic information leads you and the patient, and it kind of changes, and I’m comfortable with that now.

Being comfortable means that NPs also accept the certainty of their own imperfections, yet they accept the responsibility of caring for fragile and vulnerable patients, knowing that the choices they make can cause harm and even death. They have learned to live with the internal struggle to be perfect in the direct clinical-practice component of their role: “I guess I recognize that you can’t be perfect. This job makes you realize that. You have to be humble because if you think that you know everything and that you are always right, you won’t survive, because we all make errors; we all may make not exactly the best decision at the time, and you have to deal with that.” NPs are the first to acknowledge that they do not have the same breadth and depth of knowledge as physicians; yet they are also quick to acknowledge that medical knowledge itself falls short — a lesson first learned as a bedside nurse and then reinforced as an NP. Being comfortable means that a balance is found between being sufficiently decisive, certain, and in control, and recognizing the uncertainty that abounds in what they do. It does not mean that they wear what Katz (1984, p. 198) has referred to as the medical “mask of infallibility” so often worn by physicians.

The tension between uncertainty and certainty leads NPs to continuously strive to provide the best possible quality of care by reflecting on their mistakes, never taking for granted the decisions they make, asking for help when necessary, knowing when they are outside their scope of practice, and reducing knowledge and skill gaps through constant learning. In spite of this tension, they
come to terms with their need to be perfect, for without doing so, they either stifle their own practice opportunities, preventing timely responses to patient care, or they live with a constant anxiety that not being perfect brings to bear.

And some of us deal with it very well; others of us get way too uptight about it, and it doesn’t benefit our families for us to be so constricted that really we’re not working at the NP level but we’re still at the bedside level. Or the other issue is to become so blasé about it that you just think, Oh well, it’ll all work out in the wash, and then something happens and it doesn’t.

Even the need to create an aura of effortless perfection, the mystique that is often associated with the medical profession, finally gives way. Obviously effortless perfection is an oxymoron; the illusion of perfection requires an enormous amount of work. This is one reason for the sense of exhaustion that new NPs feel when they are trying to prove to others and themselves that they can do this job. They are elevating medical perfection to a high art, but perfection, as Quindlen (2005) wrote, eventually becomes “like carrying a backpack filled with bricks every single day. . . . What is really hard, and really amazing, is giving up on being perfect and beginning the work of becoming yourself” (p. 11).

The NPs’ ability to do just this while performing in their new roles is truly difficult and amazing. It is difficult because it means others may see that NPs do not always know what to do in the clinical management of the patient and so may reject or replace them, both as individuals and as a practising group. But this ability is also amazing because letting go frees a person from having to work so hard, all the time, to pretend they can know everything concerning their clinical practice. Ironically, letting go of trying to be perfect frees NPs to accept more responsibility and undertake more risks. The tension NPs have learned to
live with is accentuated for two more reasons. First, there is no NP zeitgeist to guide them. Second, their previous grounding in a nursing moral imperative necessitates that they reject the mask of medical infallibility that they were compelled to put on as part of proving they were clinically competent:

[Responsibility] can be exhilarating at times and it can be almost disabling at times, because all it takes is one instance for you to second-guess yourself, to say, “Should I have done something different, would I have done something different if I had known this or that or the next thing?” Or [for] a physician to say to you, “Well, did you think about such and such?” and to think, Well, yeah, I did but I discounted it; but should I have thought about it more? To think, This is too much; I’m not a physician, I shouldn’t be doing this; this is way outside the scope of practice, when in actual fact it’s your own sense of well-being and perfection that’s getting in the way. And then to be able to say, “No, I did the best for this child and this is how it worked out and maybe it’s not what anybody else wanted but this is how it worked out.” And those moments make you think, Okay, I just want another job; I just want to be doing something else, I don’t want to be doing this. But then, all it takes is one of those families to turn around and say, “I’m so glad that you’re on the other end of the phone and that you could answer my question”. . . . And you learn from those areas where you had some doubt and where you think, Okay now I’m going to do such and such. . . . And then other times you just have to say, “Bad things happen” . . . and you didn’t, in all of your ego, have as big an impact upon the outcome as you thought you did.

Although being comfortable means that uncertainty is generally a taken-for-granted experience on a daily basis, various circumstances, such as managing a new clinical event or a change in the medical team — especially if it involves the loss of a trusted
physician or the addition of a new member — brings uncertainty into full awareness, with the full range of emotions that this evokes. One NP described the surfacing sense of unease that came with a change in medical directors in her service. She was once again faced with the awareness of uncertainty as to how she would acquire her patients, the population to whom she would be assigned, and the expectations regarding her role under the new medical management. However, she discovered that this sense of unease, resulting from uncertainty, was also embedded in being comfortable with her own clinical competence and confidence. She felt a sense of certainty that she would eventually be able to negotiate her way through this situation to the satisfaction of the patients and families, the physician, and herself. One can observe her sense of relaxation with the negotiation process and the timing it requires, as well her patience and adaptability to the clinical situation, in the following quote:

With our previous medical director, I was very comfortable with how I acquired my patients and whether I kept them or not. This current cardiologist is brand new to the system; he’s brand new to practice, and so he and I have a few bugs to work out. . . . With the previous medical director, if I said to him, “This family has these issues,” he would say, “Do you want to take them on and I’ll see them in your clinic time?” Whereas this particular cardiologist doesn’t necessarily like to be there during my clinic time, which is a bit difficult because then he would have been more comfortable with me keeping more of what he classifies as the complex patients. . . . And so he says, “Well, those patients need to get seen but I want your surgical patients and you take those routine non-surgical cases.” So, I think we’ll do a bit of negotiation over the next couple of months in order to get that worked out, because my background is surgery, that’s how I started as an NP was to do cardiovascular surgery. I don’t want the families to lose my expertise for them,
because they need the time and they need the expertise of somebody who’s been in the operating room, who knows what the repair looks like, who can tell them what the post-operative period is going to look like. They need those questions answered. They’re not going to get that from the cardiologist.

Uncertainty also arises when NPs are forced to acknowledge the tenuous nature of the medical safety line. As explored in chapter 2, “Being Adrift,” the presence of a safety line is integral to NPs’ clinical practice in an acute-care environment. A lack of confidence in this line brings about an awareness of uncertainty so powerful that it brings into question the entire foundation of NPs’ clinical practice. If they cannot trust their physician colleagues, they are unable to trust the decisions that they themselves make, and consequently they question the ethical nature of their practice. At one level, this crisis is not dissimilar to that described by Benner, Tanner, and Chesla (1996) at the stage when competent nurses learn experientially that seasoned health care providers make faulty assessments or treatment orders, which undermine their confidence about the authority of these colleagues: “In reality, these nurses are confronting both incompetence in some co-workers and a necessary correction of their inflated expectations of experienced staff” (Benner, Tanner, and Chesla, 1996, p. 101). But at another level, there is a significant difference relating to the degree of responsibility that NPs bear. They often do not make the initial primary admitting medical diagnosis in the acute-care setting, yet they are responsible for ordering the treatments associated with it. Their role in the patient’s outcome is therefore both more attributable and visible as they set into motion a set of prescribed activities that will either help or harm the patient. There is a sense not only of guilt by association but, even worse, a feeling of being an accessory to their medical colleagues’ poor performance. In other words, they are reliant on
the competence of their medical partners and the physician’s willingness to engage in self-reflective practice and make personal or systemic changes to decrease patient risk and promote safe practice. Physicians have repeatedly expressed their concerns about potentially being held liable for NP errors in practice. The question arises, Should this not be a reciprocal concern for NPs?

“Sheila” shared her experience of having discovered first-hand the fragile and illusory nature of her safety line. She was once again living daily with the dis-ease of uncertainty despite having developed a strong sense of confidence and competence in her clinical abilities. Because of her profound discomfort, the meanings that constituted and sustained her practice as an NP were crumbling. Sheila no longer experienced being clinically comfortable:

I verified with the doctor that day that this was in fact the right protocol that this [patient] should be on and reviewed the orders. . . . Well, lo and behold, the next day the [physician] who had picked that protocol realized that it was the wrong one, and in fact [this patient] could die if we continued to give him this treatment. . . . And you know, I almost died as well, because I had seen [the patient] that day and regardless of whether or not I had signed those orders — I hadn’t been the individual to sign the orders, although that was definitely a factor — I had a feeling like, What’s going on here? Can I not trust my physician colleagues to pick a proper protocol? I almost signed those orders. If that [patient] had died from this protocol, my name is on those orders. I don’t want to lose my nursing licence over a situation like this, and probably more importantly I feel that you have to be able to look a patient in the eye and have them feel that they can trust you. And that was starting to waver for me. I wasn’t sure of myself anymore, or my colleagues . . . and it just came to a crisis for me . . . in terms of the NP role and thinking that I’m not sure that I like this role anymore, and what I’m doing in it . . . What do I need to do
to feel comfortable going to work every day? What is my role in relation to all those protocols? . . . If I’m going to be signing orders and admitting [patients] under protocols, I have a responsibility to know those protocols, right? But I don’t pick the protocol either; that’s the physician’s point. And I’m just trying to sort through all of that in my own head right now. What I do in the NP role, I’m not sure about anymore . . . and right now I’m feeling overwhelmed with . . . the weight of that responsibility and feeling like, What if I can’t trust everybody on this team? What if there is one individual who I’m having some concerns about in terms of their practice and . . . the thoroughness of their work?

Sheila’s story demonstrates the profound tension felt when NPs are again confronted with the stark realities of their own vulnerability within their practice. It serves as a persistent awareness of existential uncertainty and the tenuousness of the NP role. It had taken her nearly five years to reach the point where she could say, “This is a bit routine; I am feeling comfortable with this aspect,” but only a split second to lose it. This supports Cohen’s (1995) theory that particular triggers can heighten the awareness of uncertainty, which in the case of NPs causes them to question whether the work demands are worth the personal cost. It also demonstrates how one’s identity is closely linked with a loss of being comfortable due to the resurfacing of the awareness of uncertainty, as experienced through engaging in action with one’s community of practice. Sheila explained her need to take a break from the clinical component of her role because the physicians had chosen to ignore this and other patient safety concerns. She acknowledged that there are no guarantees that mistakes will not happen, but she expected everyone to think about the issues and try to put into place the changes needed to diminish the risks. An internal battle involving the social and ethical nature of her work is revealed. At this point in her journey, she is experiencing
difficulty in reconciling the form of membership she has with her medical colleagues and struggling with who she is in this role.

In understanding what it means for NPs to lose their safety line, consider Pi Patel’s experience of surviving a storm at sea only to come face to face with the loss of his life raft in Martel’s (2002) *Life of Pi*:

> I noticed the loss of the raft at dawn. All that was left of it were two tied oars and the life jacket between them. They had the same effect on me as the last standing beam of a burnt-down house would have on a householder. I turned and scrutinized every quarter of the horizon. Nothing. My little marine town had vanished. That the sea anchors, miraculously, were not lost — they continued to tug at the lifeboat faithfully — was a consolation that had no effect. The loss of the raft was perhaps not fatal to my body, but it felt fatal to my spirits. (p. 253)

Recall Gordon, who found himself in new and uncharted territories as an expert in the performance of bone marrow aspirates. He experienced a crisis related to the uncertainty he felt when he realized that his skills had surpassed those of his medical colleague, while at the same time he still needed this colleague’s support. Gordon felt greatly relieved when he saw the physician’s face and realized that he was going to back him up. This relief reveals the uncertainty that he must have experienced, even if only momentarily, and illuminates the faith or confidence that NPs have in the presence of the safety line. Physicians’ presence helps NPs to overcome their dis-ease by providing a sense of being heard, a moment of being together, of not being alone in difficult situations. As a result, they re-experience a sense of well-being, or, as Buytendijk (1961, p. 21) eloquently wrote, “The stream of life within us seems renewed or strengthened.” In contrast, Sheila
is experiencing a crisis of faith in the foundations of the safety line; her uncertainty arises from the limits of the collegial relationship on which she is dependent.

The loss of being comfortable, experienced as a state of dis-ease, is the awareness of uncertainty that is attributable to outside forces, that is, to those who potentially or actually impact negatively on NPs’ work. This awareness results in a sense of responsibility for having caused actual or potential harm to patients, what Cassell (1992) has called “paranoia” in her study of surgeons. Is it possible that the more dis-ease some NPs feel as a result of a sudden awareness of uncertainty, the more likely they are to publicly project these feelings onto others in a disparaging way, not unlike surgeons? Is it possible that this is one outcome of becoming visible? Now, the outcome of a clinical event, whether positive or negative, occurs before an audience and is attributable to the NP; both the NP and patient know who is responsible. Certainly, Cassell attributed these two factors to why surgeons are so aggressive not only in what they do but also in how they interact with others, particularly when it involves actual or potential errors.

In the following passage, an NP describes her reaction to a near-miss encounter that occurred during an operative procedure she was performing. Although she recognized that her reaction to the nurse’s error may have been excessive and hurtful, she also revealed the fear and doubt she experienced when she was suddenly faced with the depth and magnitude of the responsibility she carries. She was made aware, in a particularly public venue, that she could possibly have perpetuated the mistake of another, which would have resulted in the patient’s death. Not negating the influence of individual temperaments, perhaps the need to make the incompetence of the nurse visible was also in part due to the performative aspects of NPs’ work. Now that the outcomes of their actions are both more attributable and visible, perhaps some feel a need to critically judge others publicly, or as Cassell
(1992, p. 181) suggests, “The public glory of victory is balanced by the fear — and shame — of public defeat.”

We had a new nurse who thought she was being helpful and delivered the drug that’s being given to the [procedure] room to me; and I was just about to start the procedure and she came running in the room and said, “You forgot the medication upstairs,” handed it to me, and I just glared at her. And I don’t think I’m really a mean person, but she just started to cry and cry, that’s how I looked at her, because that’s the drug that’s killed some patients, and she brought it down. I had one of the nurses in the room call upstairs to warn everybody that she was on her way back upstairs, because I didn’t even say anything. But however I looked at her was enough for her to just melt into tears and start crying because she was handing me a drug that I could have given that would have killed the patient. I mean hopefully I would have checked it and I would never have given it but just that, like that tells you how the fear and . . . [long pause]

In summary, NPs experience being comfortable when they are strengthened through ably doing, acting in association with a trustworthy safety line, and being recognized by others for their abilities. But NPs must also perceive a fit between their expectations for clinical practice and those of others, not just in terms of clinical competence, but also in terms of the type of practice in which they wish to engage. They convey being comfortable through such terms as being excited, having fun, being satisfied, feeling safe, being happy, and having found the perfect fit. How they embody their practice is as important as what they do in their practice. At home in their practice, feeling most like themselves, they are able to relate to others in the way that is most meaningful to them and that they experience as making a difference. What differences do NPs make in their clinical practice? This is revealed in being committed and being connected.
Being Committed

Acting skilfully, being present in the moment, listening, providing information, reassuring, explaining, and exploring the meaning of the illness event with the patient and family are integral to NPs’ practice and to their sense of identity in their role. They are committed to the personalized care of the patient and their families, which is enhanced by being competent, confident, and comfortable.

The word commit is derived from the Latin word committere, formed from the roots com, meaning “to join with,” and mittere, meaning “to send,” as on a mission, in the form of a function or service to humankind (Barnhart, 1988). In this light, being committed means NPs are entrusted or charged with the safekeeping of those they care for. They must connect themselves to Others and, by implication, dedicate themselves morally to their cause. Being committed and being connected become interrelated in their practice.

Being committed speaks to the NP’s desire to provide ethical care by being with others in the moment, in a context of doing for others within their clinical practice, and is an expression of their caring as nurses. It is strongly demonstrated in the intentionality of their actions, in the meaningful and purposeful personalized care of patients and their families from moment to moment. Indeed, throughout NPs’ narratives there is a strong sense of commitment, of responsibility and accountability to the Other. Commitment is an act of will, a desire to do what is believed to be right and good in each moment, in every situation, despite the risks or burdens. This is well expressed by the poet Rainer Maria Rilke (1975): “And if only we arrange our life according to that principle which counsels us that we must always hold to the difficult, then that which now still seems to us the most alien will become what we most trust and find most faithful” (p. 99).
Integral to being committed is being technologically competent. Nightingale wrote in 1899: “The artful nurse knows more than what is to be done; she knows 'how to do it’” (quoted in Johnson, 1994, p. 7). Being technically skilful is a matter of pride for many NPs, as well as an expectation of the role in acute-care institutions. “Well, I do like doing procedures. It sounds like I’m bragging but I’m extremely skilled,” said one NP. The ability to perform skilfully is primarily judged by self and others in terms of such criteria as proficiency, efficiency, and fluidity (Johnson, 1994). Yet many NPs respond in each situation with an intention to treat the patients holistically. Why has there been little or no appreciation in the discourse for this? Do we fail to see or reveal it because technology as care is not valued?

At one level, being skilful is about technical mastery and receiving immediate gratification for a job well done. Having achieved the desired outcome while making everything look easy and with a natural rhythm, speed, and flow is a source of great satisfaction. Positive feedback comes in a variety of forms, from being recognized by one’s colleagues as an expert to being sought after by patients and families to perform a procedure. For some, being technically proficient is about being in control, being able to take action (however risky) rather than standing by and waiting for others to act. For a few, there is also a “love for doing skills.” The thrill that comes from having successfully engaged in high-intensity technical procedures in which the high risks associated with failure are great is at once terrifying and addicting: “I love to do the initial resuscitation. Some people say it’s the adrenaline rush. . . . Yeah, you’re terrified a lot of the time. But when you get it, it’s like, ‘Oh, I did it, I accomplished it. This is such a great day.’”

In a profession in which external rewards are few and value for what nurses do is generally unacknowledged (or sometimes credited to the broader medical profession), the success of undertaking
technical aspects of the role is so satisfying because the rewards are immediate and the victory is rapid, definitive, and ascribable. One NP stated that the hope of using technical, advanced techniques was one factor that initially drew her to critical-care nursing and then to the NP role. When asked to talk more about this desire to perform procedures, she responded, “I think it’s a very concrete thing in nursing. . . . With technique, you go to put in an IV, you take that catheter, you put it in, it’s in; that’s the immediate reward. And I think in nursing we don’t have that many immediate rewards. . . . It’s challenging, it’s sometimes difficult, but yet it’s very rewarding.”

The significance of the instrumental nature of the role as a means to visibility is also revealed in the following NP’s thoughts. She described how satisfying it was for her to be able to perform percutaneous intravenous central catheter (PICC) insertions throughout the hospital. However, she felt equally frustrated at being blocked by physicians in performing other procedures in her practice — procedures she knew NPs did as well as or better than physicians, based on documented evidence.

Whenever there is a patient that needs a PICC line in the ICU, we will be involved in inserting it, plus anywhere else in the hospital, which is quite new here. And so it is nice developing some clinical skills that, in the NP role here, we’ve not been allowed to do, you know, inserting art-lines, inserting chest tubes; it’s really not part of our practice at all. In the unit, the docs are not open to that yet. . . . They say, because we’re in a teaching hospital, every resident and fellow that comes in wants to do technical stuff. So we’re never involved in any intubations. Never. It’s not even discussed.

Being able to engage in highly skilled functions is a gateway to professional advancement and autonomy, and to cultural authority and visibility. When NPs are obstructed from engaging in the
instrumental functions traditionally aligned with the medical realm and highly valued by society, the credibility of the NP role as one of independence and authority is undermined. This creates doubt and confusion in the public’s mind about the very nature of the role. Patients and their families have difficulty accepting the role or the person in it as valid or trustworthy.

Well, you meet with the family, you explain to them that you’re doing an important job, that yes, you’re a nurse but in an expanded role. And you’re with them and you develop a relationship and then whenever something happens, you’ve been pushed aside because somebody else is going to take over, so your credibility may be challenged in the face of the family. . . . Whenever something happens you’re not skilled enough to do it, so maybe what you expressed before wasn’t right, right? So we claim we’re doing continuity of care, and we make a claim in face of the family that we’re as knowledgeable as anybody else on the medical team, and then whenever something happens, you’re suddenly not skilled anymore. So we’re put in a difficult situation.

Since the emergence of NPs in the United States in the 1960s, the discourse has asserted that NPs are differentiated from other nurses, in large part, by having expanded “their use of medical instruments and the use of instruments in ways previously denied nurses” (Office of Technology Assessment, 1986). The personal autonomy, authority, and visibility this has afforded have been contentious and viewed unfavourably by many in the nursing profession (Harding, 1980; Purnell, 1998; Sandelowski, 1997, 2000). However, this discourse and the stagnant view of NPs as junior doctors who relieve physicians of medical procedures that they find boring has devalued the possibilities for caring to emerge in each patient encounter. As Locsin (1995, 1998) contended, when procedures are viewed merely as technique there is a degeneration
of what it means to practice. Rather, an encounter between the NP and patient holds the possibility for discovering new ways of caring as a result of NPs’ being in control of the performance of the medical procedure itself. NPs in this study did not deny that they often feel frustrated that a large part of their practice is spent performing medical procedures, under time constraints that limit their opportunities to engage in a patient or family encounter, which would allow them to get to know them on an individual basis in the way espoused by the philosophical tenets of nursing. Yet despite the challenges they face in this regard, they integrate a caring intentionality into their performance that improves the overall well-being of their patients and their families. Indeed, NPs’ stories challenge the assertion that they nurse the technique rather than the patient, as implied by Sandelowski’s statement (2000, p. 189) that the NP role “has reprised the one-nurse-to-one-technique, as opposed to one-nurse-to-one-patient, model of nursing care.”

Recall Donna’s story about the difficult intubation, presented in the section Being Confident; this NP’s narrative revealed the possibility for advocacy and taking an ethical stance different from that of medicine. Donna intervened when the physician was unable to admit that he could not successfully intubate the infant with the TE fistula. She protected the baby from further ineffectual intervention and possible harm by physically intercepting and definitively stating the need for surgical intervention. Thus, when the NPs’ instrumental function is viewed in a deeper way and within the full context of their practice, it is possible to elucidate their nursing identity and the moral imperative that they bring to bear on the procedural event itself. Indeed, the ultimate goal of their performing clinical procedures is a desire to improve practice for the good of the patients and their families. NPs recognize and accept that the use of technology is a reality of acute-care nursing in Western society. There is an undeniable
tension created among the NP, technology, and patient. Nor is it denied that some NPs may act simply as technicians, proficient but not authentically present with their patients. Because of its frequent association with providing cures, technological competence does not have to be polarized against competence in providing care. In responding to the patient’s call, NPs are in fact ethically required to be technologically proficient, while accepting the patient fully as a human being, not as an object (Locsin, 2001).

For many NPs, advocacy, as it relates to the instrumental nature of their practice, arises from a fundamental difference in the training of nurses and physicians. In nursing, one NP said, learning a procedure is all about the patient, while in medicine it is all about the skill. This is demonstrated in medicine’s philosophy of “see one, do one, teach one” (Merton, Reader, and Kendall, 1957), a mantra that causes many NPs a great deal of unease. However, this has less to do with being afraid of performing the technical aspects of the procedure and more to do with wanting to prevent negative outcomes that result from ineptness, and to appropriately manage any adverse events should they occur. It concerns doing what is both right and good for the patient while performing the skill. Hence NPs ensure that their medical colleagues are present or near at hand until they feel ready to accept the responsibility of performing the procedures on their own, even at the expense of being perceived as overly cautious. “Grace,” for example, shared her experience of learning to remove an arterial-venous sheath, a skill that she felt was not mechanically difficult but carried the potential for significantly adverse cardiovascular events in about 15 to 20 percent of people who have a sheath removal:

I think [physicians] were in the mindset of the medical student — see one, do one, and teach one — which is not my way of doing it. I wanted to be sure that I was doing these things really to the
best that I could do. . . . The harder piece is the assessment of the patient to be sure that they’re ready to have the sheaths out . . . and then managing . . . the cardiovascular complications. . . . Because of where the femoral nerve runs, when you’re compressing it, a lot of patients will have profound vasopressor syncope. Their pressures will fall to nothing; they’ll lose consciousness. Some of them will seize . . . which isn’t great when you’re holding an artery and this person’s seizing. . . . So you can get somebody with a heart rate of 70 or 80 go to a heart rate around 30 and their blood pressure will go from a 120 to 60 by palpation and they’re losing consciousness, and you’ve got one hand on their groin . . . I mean that sounds bad enough, but it’s even worse if they’ve had an interventional procedure because the perfusion pressure through the artery, if that drops, then the artery will collapse and then they’ll infarct because it’s a raw area. So it’s critical that that perfusion pressure doesn’t drop. So learning to manage that, being able to detect it quickly, being able to give the IV atropine, often multiple doses of pressors, tons of fluid, as well as monitoring them for vascular complications in the leg. . . . And each patient is different. . . . So when I was learning the procedure I did the usual — watched a few and did quite a few under supervision . . . and after a while they said, “Okay, we’ll just go and wait at the nursing station and if you need us we’re here.” So there was a gradual weaning and I was probably ready to do it long before I let them go. But it was just more my feeling that I wanted to be comfortable because when I was doing it on my own, they were scrubbed in the lab, so if there was a problem they weren’t able to come and help me. So I had to be able to manage anything that happened myself.

For NPs, technological competence as caring is not just about mastery of the skill; it concerns being constantly attentive, vigilant, and prepared to respond appropriately, swiftly, and deftly in the event of danger, distress, or deterioration in the physiological
functioning of the patient during the procedure. This means that they need to know what to look for. But as Hawley (2005) recognized, knowing what to look for is not as simple as it seems:

Vigilance requires a sound and integrated knowledge base composed of theoretical (scientific) knowledge learned through study (e.g., pathophysiology, clinical manifestations, diagnosis, treatment, and potential complications), practical knowledge gained from experience (e.g., typical clinical trajectories or “the normal course of events” and known risks or complications in specific patient populations and subpopulations), and particular knowledge of the patient, including the clinical facts (e.g., co-morbidity or co-existing disease and injuries) and knowledge of the patient as person. (p. 181)

The NP’s intention is to do good (Algase and Whall, 1993) and be fully present for the patient. It may be argued that technology can be rendered safe in the NPs’ hands only when they are adequately prepared. Entering the world of the Other is coming to know the Other as a person more fully through the competent use of technology (Locsin, 1998), which most likely does not result from the educational philosophy of “see one, do one, teach one.”

Being committed, as embedded in technological competence as caring, is also reflected in the NPs’ need to know the intimate details of the technical apparatus and to know the patient in relation to technology. More specifically, the patient can be considered safe only if NPs acknowledge the impact technology can have on the patients’ care, both positive and negative. This happens in the context of knowing a particular patient and family in the moment.
The other day, there was a bedside nurse who was busy with something else and she asked, “Can you take over?” and I said, “Yeah, I’m sitting here anyway so no problem.” So a few minutes after, [the physician] came and said we need to give this and this. . . . Now, where should I give it? No idea. I didn’t know the lines; this is really technical but I didn’t know where I should give that without taking any risk. So I said I wouldn’t do that. I didn’t know that patient; I also didn’t know why we needed to give that medication, because I was just coming in and I didn’t have the time to know the patient, and I didn’t know what was the family’s understanding of the situation. Is there anything else that I should know on this particular patient? And I felt really pushed because I didn’t get the background that justified that medication. I thought I was able to take over but I was missing information.

Knowing who the patient is in relation to what is required in the way of technical care is an essential element of NPs’ commitment. Knowing the patient’s and family’s wishes emerges within the NP–patient relationship, during which the Other’s world opens up to the NP (Boykin and Schoenhofer, 2001). In this view, the skill is not considered mechanistic but is revealed as humanistic and interconnected; care being provided by NPs is not based upon the evidence-and-cure process, in which their functions are narrowly described as the diagnosis and treatment of disease and the ordering and implementation of instrumental interventions. Rather, their use of technologies becomes an expression of caring and commitment. NPs have in fact, brought the Other into the right relation with technology.

The NPs’ capacity to make a humanizing difference in their patients’ experiences of technological events is what Hawley (2005, p. 130) has termed “combating the technological imperative.” NPs express moral discomfort in situations in which physicians get “swept away” (Tisdale, 1986, p. 429) by the use of technology in
the fight to cure at all costs. At the same time, they also experience discomfort when technology is withdrawn or withheld if little regard has been given to the patient’s voice. Either situation represents a “lapse of humanity” (Frank, 1991, p. 27) in the face of technology. But NPs view their role as an opportunity to better influence decision-making within the health care team by illuminating the human values that are embedded in each situation.

We have one patient right now who is terminally ill with multiple myeloma, and who has had quite a bit of pain, and whose family and just about everybody thinks he should stop dialysis. But I was pretty sure that the patient didn’t think he should stop dialysis then because I asked him about it on more than one occasion. He has a 90-year-old mother and he doesn’t want to die before his mother; he thinks that’s too hard. He’s a quiet man and you have to sort of pull it out of him, never married and has siblings who love him and are very good to him. But the family was really struggling with this, so we decided to have a family conference. . . . I think they saw this meeting as a chance to develop a plan to bring him home for palliative care to a little town outside of here. And I said, “Okay, but we have to have the patient here because I’m not certain what he wants.” So I started the meeting and I asked the patient what he wanted. And he didn’t say anything really because he’s this quiet 70-year-old bachelor. So, I said, “I’m going to push here because everybody’s here because they want to know whether or not you want to continue dialysis, and if you don’t, we want to begin to plan to get you home so that you can enjoy some time with your family in your old home.” And he was ambivalent; I know he was. . . . And he finally said, “Well, I guess maybe we should plan.” So we planned, but it was a Friday and we knew we weren’t actually going to be able to get the plan implemented and talk to [community services] until Monday. And by Monday he had changed his mind. And I actually feel badly about that. I hope we didn’t coerce him,
but the important thing was that everybody then realized that [he]
didn’t want to come off dialysis.

By establishing a relationship of intersubjectivity, NPs are in a key
class position to speak out on behalf of the patients. Because of their
involvement over time, they come to know the meaning of the
health care event in the context of the person’s experience as whole.
As a result, they develop an ability to sense from the patient’s
perspective where the boundary between harm and benefit lies
(Gadow, 1989). This engaged knowing enables NPs “to speak, not
with their own voices, but rather, to the extent possible, with the
voice of the patient and in so doing truly fulfill their moral respon-
sibility to foster patient autonomy” (Hawley, 2005, p. 133), what
Gadow (1989) has argued is the hallmark of true advocacy. Simi-
larly, NPs reveal their capacity to make a humanizing difference
in the experiences of their colleagues caring for people who are
suffering and dying. In taking the time to help others reflect on
patient choices, to respond in a manner that reflects attunement to
and genuine concern for the predicament of others who are shar-
ing the patient’s life as lived with the choices made (e.g., nurses),
NPs further demonstrate their commitment to Others.

Because he looked so awful, and because it’s such a big unit, even if
it’s in the chart, you have to retell the story over and over and over
again, and you have to help the family who are still struggling with
the same issue, which is he’s literally got skin over bones and the
pain has continued to be an issue that we’ve struggled with. So, just
helping everybody be clearer . . . that it’s time to stop asking this
man whether he wants to continue and just get on with his goal,
which is to continue dialysis and to have pain relief. So I’m often
sharing that, particularly with the staff nurses, because I mean
they struggle. You know, they’re spending four hours with him and
I’m spending fifteen minutes with him twice a week. But I talk
with his family about twice a week and I’ve talked with the social worker and I’ve talked with the community support people who were continuing to come back and check . . . so, just making certain the plan of care is clear and everyone is supported in supporting him.

For many NPs, the desire for more control over the instrumental aspects of practice is not driven by a personal need for external validation as an NP. Rather, it concerns the acquisition of control of the procedure to better enable nursing both to meet an individual patient need and to more positively impact the broader care delivery system. Being committed is demonstrated in seeking opportunities to provide holistic care in a more timely and effective manner. Much of patients’ and nurses’ time is spent waiting for physicians’ availability to perform a procedure, resulting in unnecessary discomfort, increased anxiety levels, and discharge delays. Frequently, patients wait all day until physicians are finished their surgical cases or clinic appointments to interpret an X-ray, insert or remove a chest tube, or administer an intrathecal medication.

“Grace,” the NP who undertook the removal of arterial-venous sheaths after angioplasty, emphatically expressed that an NP’s approach to practice should not be about what the physicians or nurses need; rather, the question driving NP practice should be What are the needs of the patient that are not being met that the NP can assist with? As Grace noted, timely removal of the sheath brings greater patient comfort and autonomy and reallocates nursing care to others: “It’s how you can best meet the needs of the patient, and if it means you take knowledge and skills from traditional medical functions, that’s okay.”

[Patients] can’t get out of bed with these sheaths in; so, they’d be ready in the morning to have the sheath pulled but the physicians didn’t pull them until four or five o’clock in the afternoon. Patients
were on bed rest all day when they could have been up walking around and be using the bathroom by themselves rather than the bedpan. . . . The work load for the nursing staff was huge because these patients are on bed rest and have to be monitored with these arterial sheaths. . . . So that was the first thing I said: “Okay, this is the need; that’s the first thing in terms of skilled focus that I’m going to work on.”

Commitment to patients and their families is also revealed in the tensions that some NPs experience when they assume some of the technical aspects of practice that have traditionally been held by physicians. The burden of the instrumental nature of their practice, in terms of either the responsibility carried or the belief that the goals and ideals of nursing are at odds with the increasing demands directly associated with technology (Locsin, 1998) is negatively experienced. However, their commitment to the provision of holistic, continuous care intercedes. This commitment grows stronger when they are in relationships that feel powerfully connected or when they are acknowledged and appreciated by the patient and family to be a trusted care provider.

I don’t really mind doing the procedures when I look at it from the perspective that the families really appreciate me doing them. Yeah, it’s a medical technical skill, but I mean everybody has that in terms of their job. Nurses have got to put in catheters and do all kinds of stuff. I mean, there’s that piece of our work, right, and that’s basically how I view the LPs, because it gives comfort to the families actually to know that I have an expertise in that area, I can do it quite well, and they know me very well and they trust me with their loved one and this particular painful procedure. So I don’t really have a major problem doing that. At first, I wondered: How will this go? I’m not sure I want to do this, that kind of thing. But when I looked at it from continuity of care, the families do really appreciate me doing it.
Being committed to technological competence as caring is an ethical dimension that NPs embrace; they are committed to use themselves in relation to instrumentation in such a way that they can physically or emotionally strengthen their patients and diminish patients’ and families’ anxieties or concerns.

I like kids not to hurt. . . . It’s been three years of hard work to get to the point where I am; that we’re not scrounging up screaming kids and hurting them. So that’s part of the joy is just that now we do them . . . with no pain. . . . We have a treat box and give them all sorts of things and a [child-life worker] works with me to get them into the room, and a team of anaesthesiologists that help me sedate them, and then the technicians who take the specimens. I love to get good specimens and get good slides. . . . I like the guys in the lab to report “excellent specimen” because then I feel like I’ve done the best possible job that I could and that the child doesn’t have to go back to sleep again for another one. And . . . doing the best possible needles to the least headaches that you could ever have. . . . So, just to be able to do it once, in just one shot, and no band-aids, just shoot it in. And I’m arrogant as all get out. I like to aim it in and never miss and to get clear fluid with no blood. Yeah, it’s pure joy to do a perfect procedure.

At first blush, the proud and audacious nature of this description is striking — the NP’s ability to identify her own strengths, the confidence she has in her own skill. It is reminiscent of surgeons’ arrogance and certitude and their surgical motto, “Sometimes in error, never in doubt” (Cassell, 1992, p. 175). There is also a sense of competitiveness vis-à-vis her performance, a striving to be perfect. But, on closer examination, there are other layers associated with being committed to a technological competence of caring. First, performing the diagnostic procedure well makes a repeat procedure unnecessary and the findings more reliable.
Second, being able to do the procedure perfectly also means that patients will experience less discomfort afterwards, and adverse effects will be minimized. But this NP has also embraced the performance of the skill from a holistic viewpoint. By embracing the procedure, she embraced the opportunity to change the philosophical approach to how patients were cared for, thus revealing the moral agency of her NP practice. Seeing an opportunity to change the way in which the children were sedated for the procedure, the NP seized the opportunity to work with a large interdisciplinary team to initiate a procedural program that took the developmental needs of the children into consideration along with the pain and sedation management issues. A choice of pharmacological approaches, enhanced with hypnosis and play therapy, was part of the program. Connecting with the children through demonstrations of tenderness and caring during the performance of the skill were also evident in unique ways: “I put nail polish on them when they’re asleep. . . . I learned how the boys appreciated it because they were bright silver and [one boy] even went out to [a] party with them silver.” As embodied in technological competence in the form of caring, being committed is revealed when NPs demonstrate compassion, conscience, competence, confidence, and comportment. The stories shared by NPs reflect their capacity to give beyond the practical significance of the act. A generosity is demonstrated in “the skilled touch, a seeking contact with the person as much as it seeks to effect the task” (Frank, 2004, p. 6).

Being committed, particularly as it relates to NPs’ involvement in the instrumental nature of their practice, is also revealed in their willingness to accept and reflect upon their failures and mistakes. The intent of their reflection is to modify their approach, in order to provide the best care they can to their patients during the procedures. Although being comfortable and confident means being at ease and experiencing a sense of routineness in
their work, NPs do not become unconcerned or blasé about the responsibility they bear. The mere fact that they have stories associated with past mistakes and then choose to recount and reflect upon them during the interviews demonstrates their need to express their concerns and anxieties. The retelling is a means of reaffirming that they continue to be caring persons in highly technical environments. These stories are ethical ones, and they are another means of revealing the commitment and existential caring embedded in NPs’ clinical practice. “Joseph” shared a story about an event involving a technical procedure in which he attempted to cannulate an umbilical artery even after several attempts by another colleague. This experience shaped who he was as an NP. It was a difficult story in the telling, even years later:

And so I should not have tried that one more time. Did that make the difference? Did I cause the complication because of my obsession to get this intervention done? So living with the consequences of that was tough. I mean the child did fine but . . . you know, I was the last person to have tried the line and I probably should have just respected my colleague’s call on it and let it go at that. . . . It’s tough to know when to stop, when to recognize your limitations, and then living with a decision that you made that had consequences. And it’s more than just personal self-reflection. What have I done with it? It’s made me a better nurse in terms of respecting when my colleagues say that . . . they’ve given it their best shot and, unless I’m invited to have a try at it, be respectful of their decisions. Knowing when enough is enough and not being afraid to say, “We can’t do this anymore to this child.” And then . . . going to the mom and saying that this was a side effect of an intervention that we were trying to do to your son was a humbling experience in itself. . . . So that affects how you give information to parents later on down the road too. So in many, many different venues it influenced my practice.
Joseph dwells on his story even many years later. This is in Heidegger’s (1971, p. 147) sense, “to cherish and protect, to preserve and care for.” This story implies value (Frank, 1995), and in sharing a story about a mistake he made, Joseph calls us back to what is ethically significant: it was not enough only to reflect upon the reasons for his failure to do no harm, he also had to take the lessons learned and enact them so as to protect and care for others in the best way possible in the future. His story reveals the vulnerability of patients and their families and the NPs’ responsibility toward patients during the performance of a procedure, the need to do things for the right reason, and the need to respect and extend the strengths of colleagues on behalf of their patients.

NPs respond to the call of the vulnerable who need them to act “responsively and responsibly” (van Manen, 1991, p. 97). Nightingale (1992, p. 11) wrote, “A careful nurse will keep a constant watch over her sick.” But to watch over, or be vigilant, requires that the caregiver demonstrate a commitment to knowing the Other. In an attempt to know the patient better, NPs intentionally acquire a greater depth and breadth of knowledge and skills, to have these at their command in the actions of caring not as a substitute for caring, but as an enhancement of caring. Activities such as interpreting data from laboratory and diagnostic tests, observing patient’s responses to the manipulation of various therapies, and then engaging in an ongoing interpretive quest (Leder, 1990) at an advanced level are legitimate ways to know the patient whose needs have intentionally called the NP to action.

Attentiveness to details (via knowing and sharing them), being familiar with routines, and continually scrutinising the broad spectrum of technology for pieces of information that helps them know the patients better are all ways by which NPs demonstrate their commitment to being vigilant:
One day a resident commented to me, “Oh that’s funny.” And I said, “What do you mean, that’s funny?” And I was doing fluid orders, so I went to the patient, looked at the pumps, looked at the different IV accesses. And he said “That’s funny” because the resident would sit at the desk and would try to do his best but without ever looking at the patient. I said, “Come on, it’s IVs, medications are going to the patient, I need to look at them.” And he said, “Yeah, yeah, yeah,” but he would look at the chart, and maybe ask the nurse, but he wouldn’t look at the patient. And I thought, Yeah, but maybe that’s a good difference [between being an NP and doctor]. We’ll look at the patient, we deal with families, and we sit with them, we spend time, which may be different than what the doctor will do. Yeah, that was funny. Just fluid orders, it’s nothing, but you know the patient is getting the fluids.

There has been an assumption that by knowing the patient biologically in a deeper and broader way, the NPs’ focus of care will be reductive and objectified, resulting in the traditional series of problem-solving actions that are embedded in a medical model of care. Yet NPs demonstrate that to know the patient’s physiological status in the moment, or which life-saving or life-enhancing treatment options to offer, based in a focus on commitment, is to be connected with the patient. They are then challenged to respond authentically and compassionately as an advocate for the patient in the moment and in the particular. This requires that they know each patient fully as a person.

“Mrs. Jones” was a woman living with an inoperable neuroendocrine tumour. Her husband had brought her to the oncology clinic because he had found her generally unwell, with intermittent fever and confusion. With the concern that her cancer had metastasized to the brain, she was admitted to the hospital for follow-up tests under the care of “Helen,” the NP.
The very afternoon she came in, I reviewed the orders they had written in the clinic, and they forgot about half of her meds, so I had to do that. Then I went to see her, and the nurse came to me and said, “By the way, her temp’s 39.4.” And this lady is usually very talkative, very vivacious. She’s 73; you’d never know it. She’s involved in all kinds of women’s things, the women’s institute, and she’s hardly ever home when you call her. But she was not well. She was curled up in the bed, very withdrawn and didn’t want to talk, and you could tell she just didn’t feel well. Anyway, I said, “Well, they’re saying that a lot of what you’re experiencing could be drug related” — she’s in a clinical study because her cancer’s progressed on every other therapy they’ve given her, so she’s in this trial and some of this could be related to the study drug itself — “however, let’s do blood cultures.”

Although the last thing anyone had expected was that Mrs. Jones would have an infection, because her white count was normal, Helen was able to call on all of what she knew personally about Mrs. Jones to make the decision to test for other possible reasons for her behaviour. In so doing, she avoided closure. She did not abandon the search for the cause of Mrs. Jones’s symptoms in favour of the logical and predetermined rationale. Being attentive to all details of the situation, including scientific, instrumental knowledge, Helen was able to discover that Mrs. Jones was septic. Knowing this particular patient in a qualitatively distinct way, combined with what she knew to be the normal presentation of patients with sepsis, Helen was able to intuit a problem that was incongruent with what one might typically expect in the situation. She immediately initiated the appropriate life-saving medical treatment of intravenous antibiotics. Within several days, Mrs. Jones was feeling better, and Helen began to initiate discharge planning. Her vigilance helped to keep Mrs. Jones safe from harm.

In addition, Helen observed during this admission that Mrs.
Jones’s husband was quite nervous about taking her home. He was concerned that no one was paying attention or doing the right things for his wife prior to her hospitalization. Acknowledging that much of what she did as an NP was to help her patients and their family members feel safe to return home, Helen felt charged with a duty to reduce Mr. Jones’s feelings of anxiety. First, she ensured that home visits for physiotherapy, occupational therapy, and nursing care were organized upon discharge. Then she worked with both husband and wife in such a way that she could assist them to cope with the emotional crisis they were experiencing:

What we were prepared to do was to LOA to discharge, which we don’t do very often. . . . I said, “What we can do is we can give you a leave of absence tonight, and you just call in tomorrow, and if the night goes well and there are no problems, then you just call the nurse’s desk and say I’m staying home and then you’ll be officially discharged.” . . . But in fact the husband wanted to leave it until Saturday. I said, “Well, let’s see how it is tomorrow morning” and the wife said the same thing. . . . So I went in the morning prepared to say, “Okay, we can be flexible. It’ll be either today with discharge tomorrow, or Saturday to Sunday,” and he said, “No, I think it’s fine. I can see that she’s a lot better and she’s getting better by the day, and why take up a bed when I’m sure you have other people who need this bed and with health care dollars being what they are.”

NPs embody being committed by being present for their patients and families, by hearing their concerns and responding to them in a way that is inclusive and egalitarian. They know and use the system in a way that offers patients creative options that help reduce the chaos they may experience during the illness event. They do not seek closure to the relationship simply because the physical problem has been solved, but take responsibility for all the issues to ensure that patients do not fall through the cracks.
Being Connected

Because of the nature of acute care in today’s health care system, many relationships with patients are intense and of short duration, yet NPs are committed to development of a relationship with patients and their families; it is about being connected.

The best part of my day is actually sitting down with the mom or dad and just hearing their stories and trying to understand this crisis that they’re in from their perspective. . . . For many of our families, it’s the first time that they’ve ever had to deal with a crisis of this magnitude, so, outside of all the other resources — the social worker and our CNS — as a nurse practitioner, what else can I do for this family to try and put all the pieces together and keep it together and identify what their needs are? That’s the best part of the day.

NPs often struggle to find the time to make connected relationships that they find satisfying and sustaining on a daily basis. The rapid turnover of patients, their responsibilities for providing clinical management for all of the patients, and the families’ preference to seek information directly from the physician may interfere with their ability to get to know the patients and their families such that they feel connected in deep and meaningful ways.

As an NP, when you talk to the families, it’s more an information-giving session, a question-answering session; it’s not as much of a one-on-one, get-to-know you kind of thing, unless the patient’s there for a significantly long time and then you get to develop that relationship over time. It’s just because you don’t have enough time at each patient’s bedside. Sometimes I struggle with that whole thing because if the patient’s family wants information, they often want it from the doctor. . . . And a lot of families don’t even know what an NP is, for starters. So you have to try to develop that relationship
and say, This is who I am, and This is what I do, and I’m always around, and If you have any questions or you want to talk about what’s going on with your family member, I’m here for you. And I like to get to know them on a one-on-one basis, but it’s not always possible, and that part I really, really still feel a significant need to try to improve.

Yet despite their struggles, NPs experience profound moments of connectedness that occur through showing respect and sensitivity to the patients’ and families’ needs; talking to, listening to, and being honest with them; being available by encouraging them to call if problems arise; and appreciating them as human beings. “And I always give them my business card and I say, ‘If anything happens, if you have any questions, or you start feeling unwell again, I’m on my pager. You just call me.’” One NP used spare moments in her week to contact four or five of her patients just to say, “Hey, how are you doing?” simply because they appreciated it. Another said that the most personally satisfying time in the day was when she was able to create even a few moments with a patient to “just sit there and chat about their garden.” Even such simple but respectful and generous acts as personalizing care by referring to the patient by name rather than by diagnosis and bed number, and the use of spatial arrangements, opens the opportunity to connect.

The cardiologist stands, the NP sits down. I say, “Well, come into the quiet room . . . come sit here and we’ll talk about this,” and that’s very different than what they’re used to. They’re used to a cardiologist coming in and standing over top of the echo bed and standing there while they’re sitting. They get to ask a few questions, he answers and then he says, “I need to see you in such and such a time,” and then he goes away.
Simply put, NPs believe that patients and families want to be heard and attended to. They embody the belief that “an important component of healing, apart from the effect of any technology applied, derives from the relationship between the healer and the patient” (Matthews, Suchman, and Branch, 1993, p. 973). Being connected with the Other begins in the welcome and the opening of self to the Other and is a form of generosity. As Frank (2004, p. 2) has noted, “Generosity begins in welcome: a hospitality that offers whatever the host has that would meet the need of the guest.”

NPs have a profound respect for the value of connectedness and the comfort that it provides. Being connected is their promise not to abandon the Other. It is a struggle for them to sustain their moral commitment to the patients and their families when they are continuously challenged to battle the physicians’ commitment to medical education, fraternity, and an orientation of disease. One NP spoke about the time that she arrived for medical rounds only to be informed by the attending physician that she would not be needed in the clinical area because of a surplus of residents scheduled for the month. Although her initial reaction was one of shock and disbelief, she immediately connected with the patients and families for whom she had been caring to explain the situation. She was concerned that they would feel abandoned by her and believe that she had not valued their relationship. But in attempting to smooth the transfer of the patient’s care from herself to a new medical care provider, she recognized that the change was going to cause unnecessary suffering:

And I went to the family and said, “As a team we’re . . . giving your care to a good resident who will be really good with your son, really good with you, and . . . who will continue what we’ve been doing with you.” And it might have been my mistake to accept the staff physician’s decision, but she started to cry and said, “No, you cannot leave that way and leave me alone with all my problems, and
it’s not going well, and at least one thing is that we’ve got continuity and we’ve been really happy to see you on a daily basis. No, you cannot leave that like that.”

In response to the this implicit question What am I to do? — what Frank (2004) described as a microethical moment — the NP subsequently chose to follow through with her commitment to the patient and family by successfully defending her need and right to remain a part of the clinical management of the patients and families with whom she had been previously involved. This story is not about the NP arguing that she provides better care than the physicians or her fight for a de-marginalized position in clinical management because she had been blatantly declared superfluous; rather, the mother’s reaction to being “handed over” crystallized for the NP the essential moral commitment that she carries in that role. “Holding to the difficult” (Frank, 2004) in the interpersonal, locally contextualized, moment-to-moment, she chose to fight for the right to remain connected because she understood its therapeutic value.

NPs’ effectiveness is based on relationship-centred caring with the patient, their families, and sometimes even the community (Watson, 2008). For many NPs, their patient and family relationships involve much more than treatment of disease. They attempt to establish relationships that respect patients’ and families’ values, knowledge, and skills, and give their voices as much authority as their own. Being connected in this way is the difference between speaking about and speaking with; it invites patients to be open and honest about their health concerns and struggles. This in turn provides a fuller picture of the patients’ situations and allows NPs to make accurate diagnoses and fashion individualized management plans. By collecting data about various aspects of the patients’ lives, NPs are able to understand health and illness concerns from a wider perspective than that of a list of medical
diagnoses. This understanding allows them to be more effective in meeting the patients’ true concerns.

A few physicians have said to me, “Oh you’re thinking like a nurse again,” as if it’s a bad thing. And I don’t take it as a bad thing. They’re thinking more — what’s this person’s immediate health problem? Let’s solve it, and then off you go on your way. And they don’t really take into account the rest of the patients’ lives and what’s going on with them. . . . Whereas now I like to know more about the people and more of the social aspects than just the actual medical base . . . because I think it all plays in. I mean oftentimes when we have patients — the very sickest ones that have to have a continuous intravenous infusion of Flolan, which is a pulmonary vasodilator — all they can do is walk around with this little cassette with this infusing constantly. And quite often a couple of them will come in with headaches and say, “Something’s wrong with my Flolan.” Well no, they’ve had a fight with their son. So it’s the other things in their lives that are going on that [you learn] if you just sit there and talk to them. And I don’t need to change anything medically because there’s really nothing medically wrong. So I think it’s just as valid as dealing with their medical condition.

By encouraging patients and families to discuss the biographical and social contexts of their lives, NPs empower them by maximizing their voices. As an outcome, the asymmetry so common in the medical relationship is minimized. According to Fisher (1995), “It is this combination of medical and psychosocial skills that differentiates nursing from medical practice and that grounds nurse practitioners’ claim for professional autonomy” (p. 9). Many NPs understand that patients balance a unique set of commitments and obligations, such as work and child care, which determine the amount of energy they can bring to caring for themselves or their loved ones. Each individual has a personal history of
successes, failures, hopes, dreams, and fears that shape how he or she responds to the illness event. Each patient presents with varying cognitive and reasoning skills he or she uses in self-management of his or her condition. Each patient has unique values, beliefs, and goals regarding how he or she chooses to live. NPs know how important it is to understand each patient’s strengths and weaknesses, values and beliefs, fears and goals, when negotiating a treatment plan that will optimize his or her health.

There’s one individual who’s had HIV for quite a number of years and he’s Muslim. . . . He used to come in and we would figure out from the lab tests that he hasn’t been taking his meds even though he says he was. . . . And for some reason we developed a bond. I spent about two hours with him one day and we talked a lot about religion and spirituality. . . . He was interested in kind of where I was coming from and I was interested about where he was coming from. And through just talking a lot, he said basically that even though we were trying to do our best for him . . . it wasn’t us who were going to decide what was going to happen to him, it was Allah. And we talked a lot about that. And once we got to that point where it was out in the open, the pressure was off to try to improve his compliance or adherence or whatever word you want to use. So, every time I see him, we always talk a little bit about spirituality . . . and he asks me to pray for him. . . . And we talk about things like not being able to talk to anybody about his infection because it’s not something you discuss openly in a Muslim community, and the fact that there’s a lot of pressure being placed on him to get married, but he knew that he couldn’t get married because he had an infection, and he wouldn’t be able to disclose this to a potential partner. And the expectation is that they would have children. . . . So we had long discussions about this and I don’t think that if he’d been seen by a physician that that would have come out. . . . And so I don’t pressure him about his medications, and we just kind of understand where we’re each coming from.
This story reveals the emergence of what Mishler (1984) referred to as the voice of the patient’s lifeworld, which is different from the voice of medicine, which Mishler acknowledged is overwhelmingly characteristic of the medical worldview. In an attempt to provide care, this NP nursed the patient’s physical, emotional, and spiritual wounds. Through the creation of a bond with the patient, she tried to diminish the asymmetry in the provider–patient relationship and maximize his input into the encounter. There is no sense of blame or judgment evident in this NP’s story or a need to coerce the patient to become compliant with his medication regimen. She does not “medicalize” him. Thus, she avoids closure in each encounter and over time. Instead, she makes herself available and accessible by sharing a piece of herself. The NP lets the patient get to know her, and in doing so, she legitimizes his feelings about his life and illness.

By sharing her own cultural and religious beliefs, this NP identifies herself as both similar to and different from her patient, legitimizing her patient’s experiences and opening up the opportunity to reflect on these differences in new ways. She knows her patient as someone whom she affects, and she knows herself as affected by the patient who has become part of who she is as an NP. In doing so, the NP resists dominant cultural assumptions. Mikhail Bakhtin (quoted by Frank 2004, p. 20) calls this deepest communion: “To be means to be for another, and through the other.” This communion is what makes this moment moral. In being connected through dialogue, the NP and the patient are within a relation in which they hear, recognize, and remember each other. This is the premise underlying Gadow’s (1980) proposal that to regard “the patient as a ‘whole’ would seem to require nothing less than the nurse acting as a whole person. Therefore, the person who withdraws parts of the self is unlikely to allow the patient to emerge as a whole, or to comprehend that wholeness if it does emerge” (p. 87). By being open, receptive, and available, the NP
was present to the Other. Gabriel Marcel (1948) put it his way: “The person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seems merely to offer me a temporary loan raised on his resources. For the one I am a presence; for the other I am an object” (p. 26).

Connecting with patients by opening oneself also demonstrates that the NP–patient relationship is not built on a foundation of patient incompetence. The patient is treated as the expert on his own life and as such is free to choose his own course. “Committing yourself to dialogue with people is more than recognizing their inherent dignity and defending their rights; it’s being willing to allow their voice to count as much as yours” (Frank, 2004, p. 44).

The NP in this story did not independently define what was medically relevant, or simply confine medical relevancy to the patient’s medical symptoms; rather, she repeatedly made attempts to create a genuine opportunity for connectedness by generously offering herself in terms of time, space, and person. She left the way open for psychosocial issues to structure the exchange and be part of the meaning of the illness event. By viewing NPs’ practice through the family therapy work of nurses Wright, Watson, and Bell (1996), we realize that, for NPs, the goal of being connected is to enable their patients to discover how they want to live and to find the resources to do so. They do not regard diagnostic labelling of the individual as a useful vocabulary with which to work.

It is not uncommon for communication among multiple consulting physicians, various team members, and family members, in addition to the patient, to increase the complexity of decision-making. This can be particularly difficult for NPs who are involved in developing and implementing the medical treatment plan of care but who still do not hold the ultimate authority. However, for NPs, the decision-making process involves being connected.
There was one family in particular that their daughter was quite unwell, and I was giving the results of the ultrasound of the kidneys to this mom and dad. And it was not the results they wanted to hear, but the kidneys just weren’t working anymore. And the question being: Was transplant an option? And they said, “If it was your baby, what would you do?” And it was such a hard question for me. Everybody else was: “No, transplant’s not an option, can’t even think about it.” But when they sat and asked me, “What would you do?” it was like, “If it was my kid, honestly,” I said, “I don’t know. I guess I’d have to just think how much they were suffering. If there was any hope that it would work, they could still be alive and have a life or the life they still had, I would be doing it. It’s just two ways of looking at it.” . . . It was a very emotional situation. They were very sad. We were all crying. But, they understood where I was coming from. They appreciated that, because they were getting so much of “Just stop now.” But it was very clear for me that this family couldn’t live with the guilt of not having given her every single option or opportunity, and in this mom’s mind she had to look at every opportunity or option, and as a mom I could see the same thing.

In this situation, “Gloria,” the NP, does not reproduce the hegemonic medical understanding of the case. She supports the parents and, in doing so, speaks an oppositional discourse. Rather than say as little as possible and retreat into silence, she opens herself to the parents. She reveals herself as human by openly expressing her emotions, acknowledging the parents’ suffering by sharing it with them, “demonstrating that she too is human (as in ‘fallible’),” which fundamentally changes any perceived power imbalance between them (Hawley, 2005, p. 119). Moreover, by not shying away from the mother’s question — “If it was your baby, what would you do?” Gloria experiences a microethical moment in her practice; and holding to the difficult, she lets the
mother know that she understands her dilemma and the guilt parents may experience. Gloria calls on her own position as a woman and a mother to be as empathetic as possible. Even while they remain provider and “patient” (an extension of the infant), they relate to each other as women and as parents. The sharing of tears was not a crossing of professional boundaries but rather an opening of self. The NP is in the situation with the parents, and for that moment she shares their burden.

Positioning herself in a community of parents, Gloria identifies herself as like the parents. On this basis of solidarity she legitimizes their experiences, their values and beliefs, their feelings, and their choices. She acknowledges that she recognizes them. These dialogues are examples of what Frank (2004) described as a practice of generosity, where forming relationships of connectedness helps to diminish feelings of isolation for both the patient and family, and even the care provider. NPs are able to witness patients’ and families’ attempts to understand themselves as morally responsible persons. Likewise, in being witnesses connected with others, NPs are able to recognize themselves as morally responsible.

This does not mean that NPs do not struggle with the choices that patients or their families make, particularly those which are self-destructive. They may repeatedly offer the same “medical” recommendations and even show their frustration. However, many NPs reveal that they attempt to avoid closure by neither imposing their medical expertise nor their impression of the definition of the situation. By remaining in a dialogue, NPs keep open the possibility that the patient, and even they, may “interrupt the monological pursuit of their own purposes and self-perceptions” (Frank, 2004, p. 45):

I can get extremely frustrated with a client but at the same time
I still think about where they’re coming from, and maybe
they’re coming from isn’t necessarily where I’m coming from. . . . A patient that I have been working with for a number of years — he has a substance abuse problem — he phoned me and said, “I won’t be in for my appointment tomorrow because I’ve checked myself into [drug recovery program].” So after five years of planting the seed, picking him up, picking up the pieces, having him come into the clinic drunk, and just being there all the time and never really judging him in any way, the fact that he called me . . . I just said to him, “That’s wonderful; that’s fantastic,” and I said, “When you’re finished, you have to come and see me and tell me all about it.” But that’s a really good day; that’s a really good day.

NPs strive to engage in relationships with their patients and families in a way that is collaborative, reciprocal, negotiated, and participatory. They do not tell their patients how they should deal with the problems in their lives; instead, they put forward some things for them to consider. They explain the importance of health-related interventions and treatment options, teach their patients how to care for themselves, make recommendations, and circle the issues in multiple ways, revisiting them from a variety of angles. They seek to guide their patients through the illness event, helping them to find the path that best fits with their personal goals and aspirations. However, they do so in ways that minimize the distance between themselves and their patients, such that even when the NPs’ treatment recommendations are not chosen, the connectedness is maintained and the possibilities for further negotiation for care remain open. Helen shared her attempts to help her patient with a lung tumour better manage her pain, which resulted from a severe cough and radiation therapy. Although her symptoms were relieved with cough and pain medications, the patient discontinued their use once her symptoms dissipated, only to have them reoccur shortly thereafter. Helen acknowledged that the patient was reluctant to take
them because they made her “feel sleepy and spacey,” but Helen also observed that if her cough and pain were bad, then she had difficulties coping. Despite her frustration, Helen still thought “about where she’s coming from” and used multiple opportunities to help her see the use and management of these medications in a different way:

I said, “Well you don’t have to take anything. . . . However, I do think if you take the injection of the pain-management drug we’ve ordered before you go for your radiation treatment you’ll probably get through it better, because what I’m not sure is if it’s just lying on that hard table that’s making your back sore. . . . If it’s flared up from this treatment then I think we may have our answer, and then the trick is to take something pretty strong before you go over. . . . But you time when you take your pain medication, you time when you take the cough medication, but I might suggest that if it makes you feel dozy during the day then take the bigger dose of cough medicine at bedtime, because you know you don’t care if you’re dozy at night; you’re sleeping right?” And she said, “Yeah, that makes sense to me.” Anyway, we’re working on that.

Even within the constraints of a busy practice, NPs struggle to give the time and personal attention that helps patients to feel that they are being heard and not rushed. As Mishler (1984), Fisher (1995), and others have argued, physicians all too often dismiss the social or biographical contexts of patients’ lives as not the “real stuff” of medicine. By treating the medical and the social as dualities and treating organic pathology as medical, physicians leave the way open for two separate but interrelated phenomena. But what has been revealed here is that many NPs are driven by the ideology to unify the two in their work.

However, not all NPs are able to connect with their patients in this way, nor do all NPs develop these types of relationships with
all of their patients, all of the time. As one NP realistically noted, not all patients need or want a close relationship with their care provider. A contrasting example of how NPs may sometimes engage with their patients is offered by “Jamie.” She shared her feelings about a patient with known cardiac disease who regularly visited the Emergency Department with chest pain. He had been enrolled in the service’s chest program on numerous occasions, but due to a phobia of particular diagnostic tests as a result of a past life event, he failed to make his appointments. “Well, I’m basically fed up with him because every time we go through the same thing. We spend all this time with him trying to explain. I mean, I feel for this man, but I’ve just been around it so many times. . . . He just doesn’t really listen to what I say.” Instead of being connected with her patient in a way that helps to unify the psychosocial and biographical context of his life with the medical diagnoses, Jamie separates them. Consequently, there is an underlying sense that she blames the patient for his inability to comply with the treatment plan. As though if he could only control his fears, the proper care could be provided. The patient’s inability to take the required diagnostic tests is somehow at odds with the NP’s expectations. Because of this, Jamie not only presents the medical system as having definitive authority, but she also prevents any opportunities for the patient to discover new possibilities for healing.

Thus, not all NPs practice in a patient-centred, holistic manner or with a spirit of generosity all of the time, even though it is espoused as their intention and alleged to be highly valued. Many struggle to maintain their commitment to being connected. A few talked about managing their patients and their families, discussing them in terms of cases or diagnoses. They listed the multiple barriers that prevented them from entering into relations of care, and the frustration that they experienced with feeling unconnected. The list included such reasons as the volume of patients to be seen, expedient transfers from one unit
to another, the location of offices relative to the practice settings, the actual time spent on-service given the number of NPs within the service, and the other parts of the job that result in less time for being accessible to the patients and families.

The serious question is whether any of the reasons for circumventing connectedness are good reasons. Some NPs need to care for the patient right from the time of admission in order to feel connected: “I feel bonded when they are admitted and that’s usually when they’re the sickest . . . whereas, if you get this patient whom you’ve never met them before, then you don’t have that bond and it’s much, much harder.” However, some NPs are able to create connectedness despite being off-service, challenging spatiotemporal factors, early transfers, or multiple care providers: “I make a point of meeting with the parents, even the week that I’m off-service, because I feel and want a certain connectedness with them. . . . I say hi, and check on them. . . . And if they have a few questions, I answer those to the best of my knowledge, and then refer them to my colleagues who are on-service for the details.”

The role external factors play as barriers to being connected should not be discounted in any way. All NPs are challenged by a variety of situational issues on a daily basis, challenges that hinder engagement with patients and families in meaningful ways. Yet while many NPs are able to be connected despite these challenges, some are unable to be connected because of them. Does this reflect personal choice or the tendency to be drawn into the vortex that is modern technology? Could this struggle reflect medicine’s treatment of patients in terms of what Heidegger (1977, p. 16) describes as “an object on call for inspection” and what Foucault (1994, p. 14) refers to as the “medical gaze”; that is, the patient’s body is viewed as an object of inquiry and the individual is a case? In a seminal critique of modern technology, Heidegger argued that technology imposes a particular sorting,
ordering, commanding, and disposing of nature and man (p. 16). For example, the hospital is not a building (tool) we use; it is not an object at all, but rather a flexible and efficient (or inefficient) cog in the health care system. Likewise, the patients are not persons who use the health care system, but rather are used by it to fill the hospitals, clinics, and doctors’ offices (Rashotte, 2005, p. 53) and, thereby, are transformed into objects for inspection, “subordinate to the orderability” (Heidegger, 1977, p. 18) of the system. Likewise, viewed from a Foucauldian perspective, the patient’s body is treated in a machine-like fashion with personal identity stripped away as daily routines, surroundings, and clothes are removed and the patient’s voice is silenced and medical interventions undertaken (Leder, 1992, p. 121). Does the augmented use of technology that occurs within NPs’ practice — combined with their enhanced engagement with medical practitioners who view the human body as a pathological object through which to clarify diagnosis — promote detachment and less meaningful relationships with their patients?

Certainly, several NPs described the seductive power of medical practice and how easy it is to emulate the medical worldview. Perhaps by viewing the instrumental nature of NP practice as an obstacle to be overcome, NPs are challenged to remake themselves and in the process modify their medical milieu. Heidegger argued that we do not have to be prisoners of technology; rather, the saving power of technology is its ability to demand us to think in another way. He called for a reflective kind of questioning and meditative thinking. Engaging in reflective or meditative thought — which many of the NPs stories heretofore have demonstrated — “grants us the possibility of dwelling in the world in a totally different way [and] promises a new ground and foundation upon which we can stand and endure in the world of technology without being imperilled by it” (Heidegger, 1966, p. 55). Reflection as ontology — that is, a critical analysis in which
one learns about oneself and one’s way of being — enables us to correct and improve our practices for the purpose of shaping a ‘good’ nursing model of care (Kim, 1999, p. 1206). This involves reflecting on the ways in which we wish to govern ourselves such that the use of power becomes a relational power (Foucault, 1980). Perhaps being committed to being connected both through the use and despite the power of modern technology facilitates meaningful NP-patient relationship and is the difference that NPs are able to make in their practice. Being committed to being connected enables NPs practice to arrive at a “medicine of the intertwining” (Leder, 1992, p. 125), which involves and promotes “a chiasmatic blending of biological and existential” (p. 125) dimensions of care.

NPs often extend the provision of information, support, and referrals as well as the promotion of coping strategies beyond individual patients to their families and support networks. NPs recognize that the latter also need comfort and information during their loved one’s acute illness. NPs strive to create moments with family members to foster connected relationships. For example, the simple acts of stopping to chat, touching base on a daily basis, phoning families who cannot visit to provide them with an update, or staying behind to discuss concerns that are just touched upon in rounds are all examples of being connected.

It’s very common during bedside rounds . . . for one of us to stay behind, even if it’s not a nurse practitioner’s patient, and I say, “Did you understand what he said, or do you have any questions about that?” . . . Even if it’s something that is minor to us, well sometimes the parents are just flabbergasted, and I’ve seen my [NP] colleagues stop and take the time and even put an arm around the mom or something. You never see a physician do that, not even a female physician . . . that’s a nursing thing.
NPs demonstrate their connectedness through their ability to be compassionate, a word derived from the Latin words cum and patior, which together mean “to suffer with” (Barnhart, 1988). Leder (1990) indicates that compassion refers to an experiencing-with another, and in the act of sharing another’s experience, one is able to recognize the experience of the Other as a possible experience of oneself (van Manen, 1991). Compassion is the NPs’ justification for putting their arms around the Other or stepping away from rounds to spend time explaining or answering families’ questions and concerns. If one recognizes the power of information to create anxiety, uncertainty, and a further loss of control in the situation, then can it not be perceived as abandonment in the moment to simply throw out information and turn away? Instead, NPs help patients and family members comprehend the information given to them by simplifying and adapting the medical language, thus empowering them to become partners in care. Although using medical jargon and the medical mode of speaking with physicians in front of families fosters the families’ confidence in NPs as caregivers, when NPs translate that same information with an intentionality of respect and partnership, the interconnectedness between the NP and the family is deepened and strengthened. These acts represent the ways in which NPs strive to draw the families into a relation of care; “because care can only be a relationship, a dialogue not only of words but of touch” (Frank, 2004, p. 27), either literal or metaphorical.

The clinical practice in the acute-care setting involves communication and coordination with multiple specialty physicians, various institutional services, and outside community agencies. A large part of NPs’ practices involves being connected with the patient and family across and through time and place through a process of coordinating this complex system. NPs create constancy, consistency, and continuity, with the intent to ease the burden that being within the health care system tends to cause,
and to ensure that patients and families do not fall through the cracks. They do what Hawley (2005) has referred to as making the inhumane humane. The experience of being in this system is one of dehumanization (Gadow, 1980; Foucault, 1994) — invasion of privacy, infringement of autonomy, being viewed as object and rendered invisible — and it is real and ever-present in health care as it is currently structured.

“Joan,” (who was introduced in an earlier section) was concerned for those groups of individuals who did not know how to negotiate the health care system, such as newly immigrated families, those with poor language skills, those living in and out of the correctional system, those with mental health issues, or people otherwise living with somewhat chaotic lives and with limited resources. Joan believed that all of these individuals needed someone to support them, provide them with education about their illness, assist them with illness-related problems or treatments, help them negotiate multiple care providers, and provide health promotion, such as dealing with smoking cessation, cardiovascular health, and substance abuse. She felt that these needs arise largely because physicians who are very specialized in their knowledge do not deal with these issues in their practice. As well, these patients either tend not to have a family physician, or the family physician refuses to see them once they repeatedly fail to show for appointments.

Joan recognized the chaotic nature of these patients’ lives, lives that do not necessarily fit into a time structure or appreciate the importance of showing up on time for prescheduled appointments. Thus she created a “one-stop-care” practice. Although she arranged appointments with them, if they did not show up, were an hour late, or decided to come at four o’clock on Friday though they were expected at nine o’clock, she would still welcome and see them. As a result, more and more of these patients called her directly because they saw her as their primary-care provider.
Eventually family physicians and other nurses in the community of public health recognized that she could see somebody quickly. She did not work in isolation but negotiated this philosophy of practice with the other members of the team. Eventually they were willing for her to create this alternative form of time embedded within the traditional time structure of appointments: “Everybody knows that I could be with somebody for a half hour or I could be there for two hours,” and “when people come at weird times when I’m not expecting them to show up, basically what I do is I put things on hold and just say, Okay, this is the most important thing to do right now, and so I spend time with the patient.”

Being connected through constancy, consistency, and continuity involves worrying about the Other and then acting upon that worry. NPs work the system through such actions as massaging egos, calling in favours, crossing professional boundaries, and negotiating with one’s colleagues for the chance to create time and space in order to better care for Others. Being connected is recognizing that care has to happen within a relationship, which is different for each patient and family. One NP commented that for many patients and families, the “relationship is a professional one, in which they don’t know much about you and you don’t know much about them, and that’s okay, and the care is outside of their own sense of well-being.” But for some, the care “happens inside a specific relationship, and, if it doesn’t happen inside that relationship, it isn’t going to happen.” NPs encourage the patients and their families to define the relationship across time and place, as long as it isn’t outside the boundaries of NP practice. Consistency and continuity within their practice allows for caring moment to moment. Opportunities are enhanced to know individuals more fully as human beings with hopes, dreams, and aspirations, and for using every creative, imaginative, and innovative way possible to help them to live more fully and to grow as human beings.
Being Content

Both the world and beyond the world, free as a bird, the self searches for a third space, singing, dancing, nesting, and flying, sometimes with companions, sometimes alone, always already attending to the call of the stranger. (Wang, 2004, p. 138)

As an adjective, the word content, derived from the Latin word contentus, means to be satisfied, pleased, gratified, and even delighted. Being content with being an NP means experiencing a sense of satisfaction, and even joy, with what the NP does in his or her clinical practice. The word content also implies the sum of the constituent elements of something, such as the totality of the constituents of a person’s experience at any particular moment. The NPs’ experience of satisfaction is the sum of the constituent elements of being competent, confident, comfortable, committed, and connected, recognizing that the sum of the elements as co-experienced and interrelated is, as a whole, more than and different from the parts. Finally, the word content, means the allaying of doubt and the satisfying of the conscience. In being confident with their competence, and comfortable that they are able to embody their practice in a way that demonstrates being committed and connected, NPs find that their doubts about what they do and how they do it are allayed, such that they experience a strong sense of doing what is both right and good. Being content is about finding a fit in being an NP.

NPs want to do something manifestly practical in the clinical setting: stay close to the patients and their families. They find this in the direct clinical practice component of the NP role. “It’s about diagnosing and coming up with the solution,” about “the
actual doing of the procedure,” and “the sense of success when you have the line in the right place.” “It’s being able to complete the plan, the intervention, and then the re-evaluation of it, and being satisfied at the end of it that the patient is in the best outcome that can possibly be.” They no longer feel constrained. They have ample independence, autonomy, and added responsibility and accountability. They are able to work collaboratively and build partnerships with their medical colleagues, in a way that feels safe. They are able to be involved in every aspect of the patients’ and families’ care by developing relationships with them over time. They are continually challenged, recognized, and valued for what they do. In other words, they discover a niche in nursing. They are glad they have made the journey and believe they have made the right choice. They are happy with how it turned out and have no regrets. Being an NP suits them and they feel satisfied. Being content affects the dialogical engagement with self and Others and consequently they renegotiate how they understand who they are as NPs in their practice.

NPs recognize that some of their NP colleagues are entranced by the medical realm and seem to leave their nursing values behind, which potentially leaves the patient vulnerable. One NP observed, “That’s the danger of this role . . . opportunity and danger coexist on the same line.” NPs admit how easy it is to be “seduced by the dark side,” which does not mean medicine is “the bad side,” but that there is a great deal of power associated with prescriptive authority and the language associated with ordering. One NP noted, “You can choose to keep that [power] to yourself or you can choose to share it. It is a struggle and sometimes it’s just easier to be on the medical side.” For some NPs, being content only concerns the attainment of more autonomy, control, recognition, and power. To be seen as the captain of the ship, or at least a welcome sailor, is the desired fit. Being totally aligned with physicians is perceived as a reasonable means to a desirable
end, allowing NPs to “accomplish plans with others through access to traditional power sources” (Rafael, 1996, p. 13).

For many NPs, the natural state of complexity inherent in the process of being and becoming an NP exposes the contradictions in the experience of their practice, yet it also provides the opportunity to reconcile these contradictions. For example, many nurses drawn to the NP role have seen nurses working at the bedside as invisible, not valued, and “impotent in effecting the social and political changes necessary to transform their clients’ realities” (Rafael, 1996, p. 6). To acquire power, some NPs may distance themselves from other nurses by valuing knowledge and skills from other disciplines over nursing knowledge, or totally aligning themselves with medicine. Power, in what Rafael has called assimilated caring (p. 8), is acquired by aligning with medical characteristics, practice, and behaviours and by integrating medical norms. An NP who speaks with disdain about the physicians’ inability to see the patients “crumpled up at the bottom of the bed” while on rounds but subsequently “gets the nurse to reposition the patients so they’re more comfortable while we’re busy talking about their plan of care for the day” provides an example of distancing from nursing. NPs who echo the dominant medical discourse — which is that nurses’ key skills are those associated primarily with information gathering and the means by which they carry out medical orders — also exhibit this form of distancing. One NP said, “Nurses just usually follow orders. They’re there to gather the data that’s needed. It’s vital to have that information, but we’re the ones who put it together and try to find the solution.” Another observed, “There are a wide variety of nurses in the field and how they think, but many of them don’t think; they just do what the procedures are and they are not thinking about why they’re doing it.”

However, the cost of power obtained in this way may cause professional disunity, a lowering of professional self-esteem, and
a feeling of being marginalized. In fact, nurses’ caring remains devalued, thus fostering a lived contradiction. In addition, Bates (1990, p. 139) — a physician, the author of the classic physical examination text, and a strong proponent of the NP role — warned that “by expanding into medicine, nurse practitioners will need more than ever before to increase their consciousness of what nursing is all about. The values of nursing must not get lost in the dominant medical cultures. If they do, nurse practitioners justly risk the epithet of junior doctor.”

Many NPs resist the dominant discourse that associates medicine with independence, cognitive logic, and aggression, and nursing with dependence, nurturing, and emotive logic (Rafael, 1996, p. 3). These characteristics are no longer viewed as conflicting concepts or as superior and inferior ways of knowing and being. Instead, NPs demonstrate in their actions the power that comes from diversity, voice, nurturance, responsibility, knowledge sharing, and choice, deeply intertwined with autonomy, strength, mastery, and assertiveness. No one denies that traditional power over may be used as a means to an end, such as to influence action in a health care system that is in need of change. However, a strong emphasis on mutual power exists, such that NP, patient, and other care providers are transformed during the relationship, balancing out the power between. NPs who argue that the question should always be: What do the patients need? — and not What do the docs need? or What do the nurses need? — exemplify the move from power as being embedded in a division of labour that primarily serves the interests of those in power, to power as enabling, with opportunities for being equal in relations. Power as enabling is a relational way of being and becoming for these NPs. It is demonstrated in their heightened awareness of interrelatedness. It emerges as a sense of responsibility and generosity toward Others, in a practice informed by various forms of knowledge and skill, and it presupposes a growing knowledge base
and clinical competence. For these NPs, being content means practising within this ontological, epistemological, and ethical understanding of power in praxis.

NPs are frequently asked by patients, nurses, physicians, and their own friends and families if they feel more like a nurse or more like a physician in the administration of their practice. Do they live in the medical world or that of nursing? As they become competent, confident, and comfortable with the knowledge and skills required in the performance of their practice, embedded within being committed and connected, NPs begin to experience an inner transformation. They no longer resist the tasks traditionally associated with the medical world, nor do they dread the questions Who are you? and Where is your allegiance? They have endured the tumultuous seas of being adrift and overcome their fears by facing the most frightening places within themselves. Now, a new way of being in nursing is discovered within each encounter in the practice setting, and they discover all or part of the new dream or vision for their professional practice.

I’m a nurse. I think building those core relationships with the nursing staff and making sure you are aligned with nursing is important. And it’s very easy to slip into the physician’s world, to align too closely with the physicians. And the physicians will say, “You’re as good as a doctor,” and they mean that as a compliment, but I say, “Always remember I’m a nurse. I do not want to be seen as a mini-doctor.” But, I also mean that I’m part of the physician team too. And so, hopefully, I am the best of nursing and the best of medicine and I’m just broader, or rounder, but different. Is it a third mindset maybe? But it’s not necessarily separate, more of a joined mindset.

Amin Maalouf (2000), who was born and raised in Lebanon but lived and worked for 22 years in France, wrote that he always gave
the same answer to the question of whether he is more French or more Lebanese: “Both.” He explained, “What makes me myself rather than anyone else is the very fact that I am poised between two countries, two or three languages and several cultural traditions. It is precisely this that defines my identity” (p. 1). “Would I exist more authentically if I cut off a part of myself?” he asked. Similarly, would NPs exist more authentically if they cut off a part of themselves? Are NPs half-nurse and half-physician? Of course not. And despite the vast difference between identity considered in terms of ethnic origins and identity considered in terms of professional roles, identity in both cases cannot be compartmentalized. As Maalouf (p. 2) wrote, “You can’t divide it up into halves or thirds or any other separate segments.”

After giving a detailed account of why he lays claim to all his affiliations, Maalouf observed that someone always seeks to know what he truly feels “deep down inside.” This question seems to reflect the widespread view that deep down inside there is just one affiliation that really matters, a kind of fundamental truth about each individual, an essence determined once and for all when one belongs to a group or discipline. It is as “if the rest, all the rest — a person’s whole journey through time as a free agent; the beliefs he acquires in the course of that journey; his own individual tastes, sensibilities and affinities; in short, his life itself — counted for nothing” (Maalouf, 2000, p. 2). When NPs are asked who they are and where they belong, they are meant to seek within themselves such an alleged fundamental allegiance. Having located it, they are then supposed to flaunt it proudly in the face of others. Is this not what the current debate about the role of the NP is about? Does the current discourse expounding the lack of allegiance to nursing through their engagement in “physician tasks” not marginalize NPs for claiming a more complex identity?

NPs follow a quasi-Hegelian dialectical journey as they engage in the doing of clinical practice, during which internal contradictions
are transcended but give rise to new contradictions that require resolution. Thus, the journey shifts back and forth between an ongoing unmaking and remaking, shaping each NP’s particular experience. Frank (2004) observes, “Doing is what counts, and knowing what counts as worth doing depends on being a person who has become shaped through discipline” (p. 53). NPs continue to define who they are by where they have been in nursing as well as where they are going in their current role. By doing within a community of practice, NPs experience a change in their behaviour and performance. They know themselves no longer as people who only perform the tasks of taking histories, doing physicals, diagnosing, or prescribing, but as people who bring comfort to patients and families, always recognizing them as persons with whom their care is entrusted and with whom they are in partnership. They experience a new sense of belonging, and a sense of self is rediscovered in the act of experiencing their practice in a fuller way. In the words of Katerina Clark and Michael Holquist (quoted in Frank 2004, p. 46):

The way in which I create myself is by means of a quest: I go out to the other in order to come back with a self. I “live into” an other’s consciousness; I see the world through that other’s eyes. But I must never completely meld with that version of things, for the more successfully I do, the more I will fall prey to the limitation of the other’s horizon. A complete fusion . . . even if it were possible, would preclude the difference required by dialogue.

Over time, NPs are able to decide which judgments they choose to hold on to and which they will consider not conducive to becoming who they want to be (Frank, 2004, p. 53). New knowledge of self is revealed in the act of practising, and as result they no longer have to address questions about whether they are nurses
or physician replacements, or whether their focus is care or cure from a dichotomous position.

In the 2003 book Aidan’s Way: The Story of a Boy’s Life and a Father’s Journey, the author, Sam Crane, a professor of Asian studies, wrote of his struggles with his son’s rare birth defects and his transformation into the “Father of Disabled Child, a different status, [a role] that was harder to anticipate and freighted with dread and alienation” (p. 51). In “struggling to stay afloat, drifting at the mercy of the deluge” (p. 45), he found himself looking for answers and support in such ancient Chinese texts as the Book of Changes and Tao Te Ching “in search of a different, perhaps more positive, perspective” (p. 66) on how to live this new life. Frank (2004, p. 31) referred to this turn toward these passages as a way “to make a figurative raft” (p. 31). Through a dialectic engagement with passages from these texts, Crane (2003) grew in his understanding of how to live this new life by seeing his situation in a new way:

Water yields to its surroundings; it takes the shape and follows the course of the path it finds. Its adaptability gives it a certain resilience, its constancy a certain power — and it maintains these characteristics however precipitous its passage. . . .

The passage did not detail precisely how to adapt to danger, like the stream in the abyss, but it gave me a mental image of how to meet the challenge: take on the shape of the surroundings, fill up the spaces encountered, flow over and around the rocks and falls. (p. 54)

In much the same way, each experience of making a difference engages the NP in a personal dialectic, and those experiences serve as a raft on their journey. Each experience of making a difference in their ordinary, day-to-day practice adds resonance to their personal journey, connecting their struggles and discoveries.
to an understanding of how to live as NPs, how to understand who they are, and provides a measure of what counts as valuable and meaningful to them as NPs. These experiences, called upon in a dialectic engagement, have their “fulfilment not in definitive knowledge but in the openness to experience that is made possible by experience itself” (Gadamer, 1989, p. 355) and suggest which ways of understanding and acting they should cultivate and which they should avoid in their practice. Experience, from a Gadamerian perspective, is not concerned with the fact that someone already knows everything in the sense of information; rather, “the experienced person proves to be . . . someone . . . who, because of the many experiences he has had and the knowledge he has drawn from them, is particularly well equipped to have new experiences and to learn from them” (p. 355). In other words, experience relates to the emergence of insights that arise from the “many disappointments of one’s expectations” (Gadamer, 1989, p. 356) and the learning that occurs through suffering (p. 356). As a result of this type of experience, the values that NPs uphold become self-disclosed as well as evident to others. By using their new knowledge and skills competently, confidently, and comfortably, they affect their own representation of who they are as NPs through the way they do their work and relate to others. They reveal the moral framework within which they choose to live.

Being content means NPs realize that being an NP does not require them to abandon a nursing framework of care. NPs’ stories are replete with moments of both care and cure, as well as their performance in both the nursing and medical domains. The medical domain contains diagnosis and treatment of diseases. The nursing domain contains consideration of individual and family responses to actual or potential threats to health and involves helping patients cope with disease processes that might be occurring. NPs anticipate human distress and work on the level of what an illness experience means to the patient and family. They bring
together two traditions of thought that are intrinsic not only to the process of negotiating how to care for their patients, but also to the meaning of who they are as NPs. The complementarity of nursing and medicine reflects the fundamental inherent duality of who NPs are and what they do in clinical practice. This duality is a fundamental aspect of the identity of being an NP. Simply stated, medicine and nursing are two interacting dimensions embodied by the NP; they do not define a spectrum, for to regard them in this way is to still see a relationship between opposites, where “moving to one side implies leaving the other. More of one implies less of the other” (Wenger, 1998, pp. 66–67). As Wenger (1998) illustrated, with an interacting duality, both elements are always involved, and both can take different forms and degrees. In fact, the NPs’ practice can be construed as stemming from their ability to bring the two together.

This does not mean, however, that NPs want to, in Maalouf’s (2000, p. 21) terms, “dissolve” their identities “in a kind of undifferentiated and colourless soup.” Increasing the level of involvement in medicine or nursing does not dispense with the other. On the contrary, it will tend to increase and transform the requirement of the other. Wenger (1998, p. 68) posited that a binary or dichotomy “tends to suggest that there must be a process by which one can move from one to the other by translation into a different but equivalent state.” For example, when NPs prescribe, either their actions are ascribed to those of a physician substitute (and subsequently their identities would be translated as thus), or the prescriptive act is interpreted merely as a tool in the nurse’s hands, passed on by medicine. By contrast, a change in the relationship between nursing and medicine within a single role always transforms the possibilities for negotiating meaning. Participating in the medical world is not just a functional enactment of a set of prescribed tasks, but a renegotiation of what it means to be a nurse in this new context. In fact, engagement in
these medical activities creates the conditions for new meanings. Perhaps being an NP is like being in a frontier zone criss-crossed by knowledge, skills, language, and geography. But by virtue of this situation — peculiar rather than privileged — NPs have a special role to play in forging links, eliminating misunderstandings, smoothing out difficulties, seeking compromise. Being an NP means having the ability to act as a bridge, a mediator among the various communities and cultures.

And they say, “Are you more like a doctor or are you more like a nurse? And I say, “Well I’d say kind of somewhere in between.” But I’m still a nurse. I see a gap, I bridge it. So, sometimes I feel like a bridge builder.

Ted Aoki, a prominent Japanese-Canadian avant-garde pedagogical scholar, entreats us to stop and reflect on what it means to dwell in-between two worlds. In his essay, Imaginaries of “East and West”: Slippery Curricular Signifiers in Education, Aoki (2005) recalls the time he served as a university representative on a committee engaged in revising a humanities program and the discussion that ensued regarding the entitling of a course, which focused on enlarging students’ vision of the world. Suggestions such as “Western and non-Western Civilizations” or “Eastern and non-Eastern Civilizations” were generated; “Western and Eastern Civilizations” was the compromise. It was as a result of this experience that Aoki began a journey of philosophical reflection on the binary image of the terms “East” and “West” as compared to the term “East and West.” As Aoki (2005, p. 315) reflected: “The labels ‘East’ and ‘West’ suggest two distinct cultural wholes, ‘Eastern culture’ and ‘Western culture,’ each identifiable standing distinctly separate from each other” whereas “the term ‘East and West’ is rendered as a binary of two separate pre-existing entities, which can be bridged or brought together to conjoin in an ‘and.”’ Furthering his
reflections he played with the words bridge and bridging, appreciating the meaning of the words both as a link that enhances movement between places with greater efficiency and a structure that entices a person to linger and dwell, a place where “we are in no hurry to cross over” (Aoki, 2005, p. 317), such as those encountered in Oriental gardens.

Bringing Aoki’s reflections into play, we can place quotation marks around “nurse” and “physician” to remind us that both terms are rendered as a binary of two separate pro-existing entities. We can bridge these identities with an “and” when we think of “nurse/nursing and physician/medicine.” For an NP, “being a bridge / bridging” could be seen as acting in ways that expedite service, helping patients to move from one place to another in a speedier fashion, thus retaining an instrumental form of being. Such a perspective has implications for nursing, medicine, and administration at a variety of levels. An excessive emphasis on the formalization of the medical world (i.e., the knowledge, skill, and authorization) without corresponding levels of formalized acknowledgment of the nursing expression of the role would, in fact, result in an experience of meaninglessness for NPs. Conversely, a neglect of explanations and formal structures necessary to enable enactment of the medical components of the role would also result in this same experience.

For NPs, clinically managing patients always rests on participating in the medical world: what is said, represented, or otherwise brought into focus in clinical practice must now always assume a history of participation as a context for the interpretation of how they are seen by others, how they see themselves, and how they enact their role. In turn, how they enact the role and how their identity is shaped are always organized around nursing because they come to the role deeply rooted in their nursing history, in the artifacts, language, and concepts that shape nurses’ values and beliefs.
Thus, for NPs, nursing is not freed from medicine; in terms of meaningfulness in becoming and being an NP, the opposite is more likely. To be understood and to understand themselves meaningfully, NPs must maintain a close connection to the medical community while not obviating the enactment of the role from a nursing perspective. NPs who have been obstructed from participating in the medical world — that is, they are prevented from enacting the medical components of their role, such as prescribing or performing medical skills they have been trained and licensed to do, or have been asked to step aside when residents are available — find less meaning to their role, not more. Similarly, when they are unable to assimilate their nursing world into the medical one, as when they are adrift, they also experience less meaning to their role. Rather, as Aoki (2005, p. 316) wrote, we may view bridge/bridging in a Heideggerian sense, as “a site or clearing in which earth, sky, mortals and divine in their longing to be together belong together.” From this viewpoint, being an NP means that the bridge between nurse and physician is a dwelling place for NPs.

Dwelling on the bridge
In exile between kingdoms
With the stars at night

— Mika Yoshimoto (2008, p. xi)

And I’m always between nursing and medicine, always, always, always. But it’s not always a conflictual thing. . . . It is the place where I live. I am a nurse, yet I’ve got this medical training. I order tests, I read tests. That’s not a nursing task. Yet I do some of the parent comforting, I do some of the nursing teaching. So, I’m
always in between and it’s most often not an uncomfortable place. It’s an okay place to be. And sometimes you don’t feel you belong, but sometimes you do. . . . Where do I want to belong? I’d like to belong to both I guess. I like my attachment to nursing. I like the way nursing looks at patient care. I like the way nursing is holistic. Nursing is who I am. . . . I also feel that I have a privileged relationship with my attending physician and the fellows. Do I belong in either group fully? I don’t think so. But that’s okay.

When NPs state that they feel like they are “neither,” or “both,” or “in no man’s land,” and even for those who have found their existential place of being in nursing with the use of medicine, perhaps they are trying to articulate something akin to Aoki’s image of “crossing” between “East” and “West.” Aoki (2005) wrote that to loosen his attachment to East or West as “thing,” he called upon the Chinese character that “reads ‘nothing’ or ‘no-thing’”:

But I note that in “no-thing” there is already inscribed the word “thing,” as if to say “‘nothing’ cannot be without ‘thing’,” and “‘thing’ cannot be without ‘no thing’.” For me, such a reading is already a move away from the modernist binary discourse of “this and that,” or that imaginary grounded in an essence called “thing.” And now I am drawn into the fold of a discursive imaginary that can entertain “both this and that,” “neither this nor that” — a space of paradox, ambiguity and ambivalence. (p. 317)

If being an NP is reframed as belonging to both nursing and medicine, or to neither nursing nor medicine, and if “and” is re-understood as Aoki’s “both ‘and’ and ‘not-and’, that allows a space for both conjunction and disjunction” (Aoki 2005, p. 318), with bridges being both bridges and non-bridges. NPs’ ontological being can be rethought of as a third space between nursing
and medicine. Perhaps this is a new way to consider the meaning of the terms no man’s land, my own world, or the middle ground to which some NPs refer. And then, as suggested by Aoki, “identity” is “identification,’ a becoming in the space of difference,” “a generative space of possibilities, a space wherein in tensioned ambiguity newness emerges” (Aoki, 2005, p. 318).

Stuart Hall (1990, p. 223) wrote, “Cultural identities come from somewhere, have histories. . . . Far from being eternally fixed to some essentialized past, they are subject to the continuous play of histories, culture, and power.” Similarly Maalouf (2000, p. 13) observed that “while there is always a certain hierarchy among the elements that go to make up individual identities this hierarchy is not immutable; it changes over time, and in so doing brings about fundamental changes in behaviour.” In this light, NPs are viewed in a space of being content with being in their role, because within this space they share linguistic, geographical, and other cultural elements of both the nursing and medical worlds — “a hybrid of both individual identity and doubled identity” (Aoki, 2005, p. 318) — is created. Brykczyński (1985, p. 5) wrote that the NP is the true hybridization of nursing and medicine. And Ernesto Laclau (1995, quoted in Aoki, 2005, p. 319) noted, “Hybridization does not necessarily mean decline through a loss of identity; it can also mean empowering existing identities through the opening of new possibilities. Only a conservative identity, closed on itself, could experience hybridization as a loss.” Indeed, Aoki’s imagery allows envisaging of this meaning of a bridge as a third space between worlds. Similarly we can conceive of medicine and nursing as worlds to be bridged, between and among diverse segments of nursing, as spaces of generative possibilities, spaces where newness can flow.

Being an NP can be understood to mean building bridges between one discipline and another, between one part of the health care system and another, taking an active part on both sides, and
having an identity that is simultaneously “both” and “not-both.” This perspective demonstrates precisely why the unification of dualities is so significant, and possibly why NPs should not be pressed to take sides or ordered to stay totally within their own discipline. Anne Fadiman (1997) in her book The Spirit Catches You and You Fall Down, reflects these thoughts most eloquently:

I have always felt that the action most worth watching is not at the center of things but where edges meet. I like shorelines, weather fronts, international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one. This is especially true, I think, when the apposition is cultural. (viii)

An example from the NPs’ world brings to life the reality of being a bridge as an in-between or third space that creates new possibilities:

Nurses still perceive me as one of them. There are many situations in this unit where nursing and medicine see things differently. . . . Nurses tend to want to move more quickly towards palliative care or comfort care, and we’ll question more frequently why we keep going; and for medicine, as long as we haven’t exhausted all the avenues, then we’re not done. So I’m a bit between and that’s very demanding psychologically too. . . . So, for example, a very frequent issue is comfort. Nurses are very pro-comfort. Physicians are pro-comfort as long as they don’t want to extubate. . . . And physicians will say, “Well, turn off all the sedation and let the kid wake up,” and the nurses are the ones literally sitting on the kid and seeing this child cry and being uncomfortable. And sometimes they see me a bit as a traitor because I’m the one who actually writes the order — stop,
d/c sedation. . . . So I’m seen a bit as a traitor by the nursing team, but sometimes the medical team sees me a bit as a traitor too, as “Stop being a nurse now.” . . . But I can see that both parties need to be defended. So I go to my attending and I say, “Well, I don’t think we should stop sedation because this kid’s been on it for so many days,” and I try to negotiate. Usually I get part of what I want at least, and when I come back to the nurses I say, “Well, okay, we got them to halve the sedation rather than stop it.” And there’s times where it’s, “Stop the sedation,” and I can understand what the medical rationale is . . . and that comfort is not an issue at this point in time, and that we have to move on. And I think trying to explain to the bedside nurse why and to also say, “Well, if we get into trouble, I’ll be there and I’ll try to find a solution for you.” I think that my role with nursing, it’s trying to see if we can find another solution, and with medicine, it’s trying to negotiate.

Being an NP is an enriching and fertile experience when NPs feel free to live fully, when they are encouraged to accept their clinical practice in all of its diversity. But it can be hurtful if they are met with looks or words of incomprehension, mistrust, and even outright hostility whenever they claim to be nurses, or if every time they emphasize their ties to the medical world other nurses look on them as traitors or renegades. “[W]ho we are is produced by the effects of our movements among layers of differences” (Pinar and Irwin, 2005, p. 24). That is, the NP’s identity is a negotiated experience, a nexus of multiple memberships, and a relationship between the local and the global (Wenger, 1998, p. 149): others’ attitudes must allow for multiplicity to foster NPs’ acceptance of this composite identity with tranquillity.

Being content does not mean that the journey comes to an end, even for those NPs who have found the perfect fit. One only has to recall Homer’s Odysseus on the Isle of Circe to be reminded that a journey continues because the call for more beckons, there
is an external pull to pursue the search for more. After Odysseus had spent many years of bitter wanderings and woes suffered upon the seas, Circe urged him to stay on her island to rediscover the man he had been before he left Ithaca. He stayed with her for well over a year, forgetting to mark the passage of time, content with the fine food and honey-sweet wine, spellbinding songs, and enchanting women, until one day his men came to him to remind him that Ithaca called and that they needed to return to their homes. Then he, too, remembered his people and his obligation, and began to look for the opportunity to continue his journey.