Wenger (1998) argued that the work of identity — in other words, being and becoming — is always ongoing, not in the sense of a fixed course or destination but a continuous motion “that has a momentum of its own in addition to a field of influences” (p. 154). NPs have become who they are — that is, Being a Nurse Practitioner — by learning certain ways of playing a part in action with the healthcare team that constitutes their community of practice in the clinical arena. They competently engage in the joint enterprise of caring for a select group of patients in the acute-care setting and participate in a shared repertoire of routines, languages, and genres within this community. But, being an NP is more complex than has been revealed thus far. As is our nature as human beings, the work of identity is always ongoing because it is constructed in multiple social contexts. Furthermore, “identities are defined with respect to the interaction of multiple convergent and divergent trajectories” (Wenger, 1998, p. 154). Finding the perfect fit is one such trajectory, and the dream of what that fit could be provides the context within which NPs
determine what learning and activities actually become significant within their role. This sense of trajectory, albeit a course that is not charted or even foreseen in all its variations and permutations, gives them a way of sorting out what matters most, what contributes to their being (and thus their identity), and what remains marginal. NPs are always simultaneously dealing with specific situations, participating in the histories of certain practices, and involved in becoming particular persons. Their journey incorporates their past and their future in the very process of negotiating their present. It is influenced by that which they wish to be and that which others want them to be. Sometimes there is congruence and at other times tension or conflict, but in either case they experience both internal and external struggles. Never is this struggle more evident than in the process of being pulled to be more.

The first and only priority for NPs when they start their journey is necessarily the clinical management of their patients. Keeping their focus entirely on “learning all [they] need to know in the clinical area and to become comfortable doing clinical” is a lengthy process. One NP in her fourth year of clinical practice expressed mixed feelings about her level of clinical expertise and her ongoing development as an NP. She described herself as barely at the point where she could engage in the reflective process of what it meant to be an NP and what had shaped her development. She said, “It’s not any one thing, just everything, and nothing” that influenced who she felt she was at this point as an NP, for the entire first two to three years were a blur, the time she was struggling to develop competence, confidence, and comfort with the clinical component of her role. Depending on the nature of their practice — the complexity and variability of patient care, years of experience with the patient population prior to becoming an NP, and relationship with the physician group — it is not unusual for NPs to have been three to five years into their role.
before they experience and admit to the routine, sometimes even mundane, nature of the direct clinical care they provide and begin to contemplate that they could do more within their practice.

You spend the first year trying to keep your head above water, trying not to kill anyone, and trying just to get comfortable. And to even suggest you could do education or research the first year is ludicrous in my opinion. The second year you kind of hone and refine your skills, and not just physical skills, but just your whole diagnostic reasoning skills. So you’re comfortable on call now by yourself . . . And then, it’s not until the third year that you can look outside of yourself for these defining moments because they actually can impact on you then. You can’t even take it in before then, really. And I think that that’s the point, too, where you have so much more to give and you’re ready to take on more in the role and you’re ready to mature. . . . So I’m just barely there; I’m just to the point where I can consider and maybe even do more.

Thus as NPs become more efficient and effective in the clinical management of their patients, time and energy become available for them to take on more and different responsibilities in their role. As one NP noted, “when managing patient care begins to run like a well-oiled machine, there is more time to be involved in committee work, education, and research.” But, like the initial call to be more, being pulled to be more arises from a variety of internal and external callings.

“They began to give me administrative roles initially,” said one NP. “Mostly, it was committee work that I had. I think, after about four years, they gave me responsibility for doing policies and procedures. And now I’m expected to do some element of staff education.” For some NPs, the pull arises externally. They find themselves being told about or given added responsibilities by nursing management. Despite acknowledging that the NP role
has been set up to include “a clinical portion and to be responsible for some education, some administration, and a small expectation for research,” life as an NP is experienced as being only so big, and many feel that they “can’t fit it all in.” For these NPs, engagement in other advanced nursing practice competencies transpires because of nursing management expectations: “Given that NP salaries are being paid from the nursing budget, NPs need to do things other than just the patient care and contribute back to nursing within the organization or to the program.” The concept of “owing the system” is embedded within this perception. However, for NPs who have already found the perfect fit in direct clinical practice, being pulled to be more is experienced as an irritant to be managed and contained, because these extra role functions interfere with the hands-on clinical work they love. As a consequence of “trying to fit in the other parts of the job,” noted one NP, there is “less hanging around time” in the unit to be available to meet with families.

There’s always this struggle. Most of the people who stay in this role, I think their primary interest is in patient management, and so if you try and get us too far away from that we’re not going to be very happy. How much time do you spend doing this and how much time do you spend doing that? Well, of course, your patient needs are paramount because you can’t just leave them be, so they probably take more of your time than what some of the managers would want; but from my point of view, I kind of like that because that’s why you’re here. You like to do the extra things on the side, but, then they [nursing management] say, “Well, we have this many people so this is how your role is going to be.”

Wenger (1998, p. 75) argued that work that is less visible than the more instrumental aspects of practice can easily be undervalued and even totally unrecognized. As a result, some NPs struggle
to become engaged in activities that, although desired by some within the more global institutional nursing community, are judged to be of less value by the local community of practice, and by themselves. In fact, for these NPs, being pushed or decreed to produce research or publish more violates their personal definition of a nurse practitioner. Concerned that the organization or nursing administration wants to make “a specialist” out of them, they perceive research, education, and leadership responsibilities to be domains of practice that belong to the CNS role.

As a result of the constant tension experienced between clinical practice and other advanced nursing practice responsibilities, resentment toward management surfaces, and NPs’ frustration at not being understood builds. Nursing management comes to be perceived as “they,” with power over NPs’ time management and energy focus: “If administration is putting out a lot of dollars into some position, then they want to see more nursing output and see that work highlighted throughout the world. It isn’t enough to give good patient care; you have to be publishing it.” Fear of replacement arises and is compounded by the perception that the physicians with whom they work have little power to intervene on their behalf. They are aware of the discourse about “foreign graduates who can’t get on as physicians but who could become physician assistants,” and the consequent negative impact this could have on the NP group if they do not meet the service component of the role.

The operating officer of this hospital believes in nurse practitioners, but not strictly as a patient management role, because then that could be seen as physician’s assistants or something like that. Somehow this has to be uniquely nursing, and I can buy that. But then what is the split? . . . So our manager is saying, “I think that you spend too much time on the patient management and I want to make sure that you have time for these other roles to make
it whatever.” But I’m just thinking, Well, make sure that you meet the program needs, because if you don’t then they will get physician’s assistants and then we’ll be unnecessary, and that’s not a good thing for us. . . . You can’t work that way. If you want the job and you say that you can provide this type of care and yet at the drop of the hat you just let everything go, can you see where people might perceive you as not that important? Like if you’re not there to provide the service then somebody else could do it because obviously you’re letting them do it.

A strong historical foundation for some NPs’ fear of replacement by other professionals undeniably exists. Memories are not so short as to forget that the first NP initiative ended in Ontario, just over 25 years ago, with the closing of the last primary health care NP education program at McMaster University. This occurred because of a perceived oversupply of physicians, lack of a remuneration mechanism, lack of public awareness regarding the NP role, and lack of support for the role from medicine and nursing (Nurse Practitioners Association of Ontario, 2005). Hundreds of newly trained NPs found themselves unemployed as a surplus of new medical graduates flooded the market. NPs, seen merely as physician replacements, were no longer needed or wanted. It is also a fact that some legitimately qualified NPs have replaced nurses who had been permitted to engage in advanced roles without adequate qualifications, and who subsequently lost their jobs. Many nurses seized the opportunity to become NPs because their CNS positions were declared redundant due to perceived lack of cost-effectiveness, only to find this role being replaced with case managers, clinical resource nurses, and others. Registered nurses working at the bedside have repeatedly been replaced by registered practical nurses and patient service workers. Current professional and public discourse is replete with controversy regarding the need for NPs, who are being encouraged to promote
themselves as a cheaper alternative to other health care providers (American Academy of Nurse Practitioners, 2010; CNA, 2002). The use of physician assistants as alternatives to NPs is another current discourse that has emerged on the Canadian scene; it is an appealing option for physicians, who retain control over their activities, and for institutions, as PAs are paid less. Therefore, is there a possibility that the fear of replacement connects with the discourse on owing something more to the organization? Owing not only implies that one has an obligation or duty to give back something of equal value in return for something received; inherently, the sense of obligation creates a sense of being owned or of belonging to another in an instrumental and economic way.

Why does the organization believe that NPs owe the system more than what they already do in the clinical domain of their practice? Does this reflect the overall devaluing of hands-on care that arises from the nursing role? Current NP discourses have resulted in the NP being constituted as an object of nature and therefore understood metaphorically as a tool or instrument within the health care system to be used efficiently and effectively. Charles Taylor (1991b, p. 5), in The Malaise of Modernity, argued that when a society is redesigned on the values and beliefs of individualism and autonomy, instrumental reason becomes the yardstick by which success is measured. Consequently, individuals become vulnerable “to being treated as raw materials or instruments for our projects.” Heidegger (1977, pp. 14–23) argued that technology imposes a particular sorting, ordering, commanding, and disposing of nature and humans. It seeks to unlock, transform, store up, and distribute concealed energy from nature and humans and order it into a “standing reserve.” The result of this stockpiling is that modern technology orders everything and everyone to stand by, to be always ready to be used and to be on call for further doing.
Heidegger (1977) further argued that the essence of modern technology is to seek to order everything so as to achieve more and more flexibility and efficiency: “Expediting is always itself directed toward furthering something else, i.e. toward driving on to the maximum yield at the minimum expense” (p.15). Heidegger concluded that whatever “stands by in the sense of standing-reserve no longer stands over against us as object” (p. 17).

Viewed from this perspective, NPs, for example, are not individuals who engage in meeting patients’ needs as worked through in the NP–patient relationship but are manipulated by the system to do its work. In essence, NPs become a resource to be not only used but also enhanced. “Man, who no longer conceals his character of being the most important raw material, is also drawn into this process” (Heidegger, quoted in Dreyfus, 1993, p. 306).

In contemporary times, NPs have come to be regarded as machines or tools to be scrutinized in terms of possible uses and efficiencies within the workplace. This discourse allows NPs to be thought of in terms of what their role is, but not in a way that provides a space for knowing who NPs are, what their interior life is, and what it means to be an NP. In becoming an object, the NP as a tool has been separated from the whole person. The full measure of what NPs have to offer their patients has failed to arise in the discourse and therefore remains invisible. This way of being may be interpreted as less valuable, and only activities that are identified in dialogue with others are perceived as having enough value to be retained in the system. The dominant discourse, for instance, has not made visible the time and skill that it takes to be physically, personally, and existentially available to the patient. In many cases, the NPs’ “hidden riches” (Dreyfus, 1992, p. 177) have failed to surface even at the institutional level.

There are “technological traps” (Bergum, 2003, p. 123) inherent in viewing and being viewed from an instrumental and economic viewpoint. One trap is the power of technology to
direct human action. Danger arises when individuals become mere objects, managed and controlled as the means to accomplish technological ends (Gadow, 1994), because they begin to view themselves from this perspective. No wonder some NPs feel like puppets whose movements are controlled by the whims and fancy of others. The puppeteers, or external force, such as nursing management and physicians, can force an adaptation and flexibility that results in an experience of being more controlled rather than being more in control.

The puppet analogy carries a significance that is deeper than may first appear and can be closely associated with the power of technology. The word *puppet* is derived from the Latin word *pupa*, meaning “girl” (Barnhart, 1988) or “doll.” Since the sixteenth century, *puppet* has been defined as a particular kind of doll that acts on a stage under human direction. Similarly, the word *pupil*, derived from the Latin word *pīpīlla*, meaning “minor,” was understood to be a person who could see herself reflected in miniature, like a doll, in the eye of the other. The Anglo-Norman word *pupille*, meaning an orphan child in the care of a guardian, also descended from this Latin word.

Through history, both women and orphans have often been perceived as chattel, property of others to be used as cheap and expendable labour, objects in service for instrumental and economic ends. Does this also apply to nursing, a predominantly female profession with a strong history of being dominated by others? If it does, some NPs may see themselves in others’ eyes as smaller, minor, and consequently of less significance, than those who gaze upon them. From this instrumental and economic viewpoint, it is unsurprising to discover that although many NPs acknowledge being good nurse practitioners, in being pulled to be more they often question themselves: Am I good enough? Am I doing a good enough job? If I’m not perceived as doing enough of the work, and I’m not doing the CNS or advanced nursing practice role, again am I not good
enough? So, as secure as NPs can sound in the clinical component of their role, they have many insecurities.

A second trap is the effect of technical language (Bergum and Dosseter, 2003). Labels such as “physician extenders” and “physician replacements” carry not only a sense of objectness but also a negative social connotation. Bergum and Dosseter found that moral language is lost when we engage in this form of discourse. These labels evoke no sense of nurse, the practice of nursing, or the commitment that NPs embody as a result of belonging to the nursing world. One NP made the following observation about being called a mini-physician and physician replacement:

I think it negates the whole nursing side of it, the whole nursing background piece that we all bring into the nurse practitioner role, and that encompasses all the human compassion aspect that we talked about. It all gets negated. Because when you use the descriptor “physician,” you’re automatically thinking more medical model than, “Oh, you take care of families as well as the patients.”

The third trap is the effect of the polarization of self that this view tends to foster (Bergum and Dosseter, 2003). For example, when nursing administrators engage in discourse that dichotomizes the domains of the NP role into direct clinical care (physician-replacement activities) and education, leadership, and research (nursing activities), NPs are once again encouraged to experience themselves as being a polarization of opposites.

But who “owns” the NPs? Certainly, NPs who have found the perfect fit observe that those who hold the purse strings have the power to determine the expectations for the role. For some, the salary is controlled entirely by nursing, while for others, medicine and nursing hold equal shares. For example, one NP shared that as a result of the clinical workload associated with managing the inpatient population, clinics, and all phone calls for the
service, she had negotiated with her nursing manager to “give up” one of the subspecialty clinics within the service. However she stated that, “The physicians said that since they pay part of my salary that I needed to go back there. I didn’t really have choice.”

As importantly, many NPs have also mentioned that they are indebted to the physicians with whom they work. Physicians determine both the nature of the safety line, with its inherent promise to keep both the patient and the NP from harm, and the nature of the clinical work in which NPs are allowed to engage. The degree of autonomy and the scope of clinical practice are contingent on the physicians with whom they work, for they approve the medical directives (or their equivalent) in the institution and then delegate the types of patients for whom NPs may care. This is the paradoxical nature of power. While NPs attain the power to belong, to be a certain person, to claim a place with the legitimacy of membership (if only on the margins), they also experience the vulnerability of belonging to, identifying with, and being members of some communities that contribute to defining who they are and thus have a hold on them (Wenger, 1998). The tension between the identification and negotiability inherent in power as well as its richness and complexity is thus revealed.

In contrast, some NPs experience the tension of being pulled to be more as a welcome opportunity that needs to be seized, despite warnings from other NPs that it will deflect them from the role’s essential work. For example, one NP recalled that it was her medical mentor who raised the idea that she consider her role in developing nurses professionally. She was both surprised that a physician would use those words and embarrassed that it took a physician to encourage her to become involved in what she envisioned to be part of her role. However, she interpreted his remark to mean that she was now competent in the clinical management of her patients and therefore was ready to take on other challenges. Knowing that she could not engage in additional
responsibilities without protected time, she seized this opportunity to negotiate with both the medical staff and the nursing manager for one day per week away from direct patient-care responsibilities. As she noted, although she felt blessed to work with such a supportive group, it was her responsibility to make it happen.

Some NPs become restless with the purely clinical nature of their role, a feeling that emerges at the time that their clinical acumen has become more honed. The paradox of their jobs is that the narrowness and tight focus of their specialty, although overwhelming during the early part of their career, eventually becomes a source of frustration. While the routine nature of their clinical work brings into being a sense of comfort and confidence, it also creates the need and desire for new challenges; they begin to re-experience the call to stretch themselves in new and different ways. Feeling bored, under-stimulated, or in a rut, some NPs hanker after new and different opportunities that will help them to be more challenged or to use some of their advanced skills, such as project work and research. Some are being pulled to be more because they believe that only in the enactment of other advanced nursing practice competencies will they be viewed as more than physician replacements, because the possibility of being more connected with nurses lies in making more of a difference to the nursing profession. For these NPs, the search for the perfect fit has still not been achieved.

Some NPs have a clear sense of direction about how they should proceed with their journey, and so being pulled to be more is not experienced as a turbulent period. Others, however, may struggle to identify where to explore next. All they can acknowledge is that the pull to be more exists.

I’d like to have some very specific interest or interests that I can work on besides the clinical, and whether it’s to be able to teach that portion of it or do research on it, I’m not sure. But I’m feeling a need to
try and find a focus, something that really interests me. And I do like some of the discharge stuff, and maybe I will pursue some of that discharge planning, but I really want something a little bit more concrete too, something maybe not quite physiological, but along those lines. So right now it’s mostly clinical, but I’m hoping that it’ll be a more well-rounded role at some point. But I’m floundering; I don’t know.

Some NPs feel an internal pull to be more, experienced as the need to expand more, to become more complete. They are ready to tackle more either clinically or in the other components of the advanced practice role. They want to develop and use new knowledge and skills, or embed the knowledge and skills that they possess from previous roles into their NP practice. If they encounter resistance to taking on these challenges, the pull to be more may cause tension that for some becomes a source of frustration to be circumnavigated.

The major barrier obstructing NPs’ attempts to move beyond the clinical component of their role is lack of administrative and medical support, a finding consistent with studies that have explored factors that hinder NP role performance (Kilpatrick et al., 2010; Reay, Golden-Biddle, and GermAnn, 2003; van Soeren and Micevski, 2001). Resistance from physicians presents itself in the form of refusal to grant time away from patient-care activities. Nursing management is perceived as silent on the issue, ineffective in lobbying on their behalf, or lacking in an appreciation of the potential for NP role development. One NP found herself constantly stalled by the “can’t do” philosophy of leadership within her organization. Physician priorities and lack of flexibility with how clinical practice could work take precedence over the vision of how NPs can contribute differently to the organization. These NPs struggle with their inability to negotiate their role description or enactment of the role as they desire it to be: “Clinical takes precedence, so whenever you’re at work you’re at the beck and
call of the unit. They can call me or page me anytime if there's a shortage of hands and that's where I'm expected to be. Everything else takes second place to clinical. And I just would like someday for it to be more than clinical.”

The yearning for more is heightened when NPs glimpse what this could mean for themselves and others. One described an opportunity she had had to provide a series of in-services to recovery-room nurses who had found that they lacked the knowledge needed to be confident about and comfortable with implementing a new pharmacological treatment. Despite having to fit the teaching sessions into the middle of a busy day, she really enjoyed knowing that the nurses now had a better appreciation of the medical condition as a whole and could safely manage the patients’ episodes. She acknowledged that the patients, nurses, and she would benefit highly if she could only be involved in more teaching, but she was unsure if she could get beyond the barriers imposed by the clinical challenges.

Unable to do what was originally envisioned for the role, another NP described her ongoing, albeit occasional, struggle with being an NP as “sometimes feeling like a go-fer” for the physicians, all the while hearing the managers say that the NPs should be doing research and they should be setting aside time to publish. Unable to accomplish either of these in her role, she admitted that sometimes she felt that she had not met the expectations of the role and wished she could do a better job. Under these circumstances, some NPs engage in other domains of practice on their own time, often working seventy- to eighty-hour workweeks, while others search for different employment opportunities or simply live with the tension. One NP found that the best way to compromise and fit in some of these other activities is by presenting at a yearly conference outside the hospital setting:

The role is called NP/CNS. So, of course, what I’ve described is mostly nurse practitioner stuff, and by rights, that’s only supposed
to take 80 percent of my time. We’re supposed to have 20 percent, or equivalent to one day a week, doing the CNS part. Unfortunately there isn’t time for that. Management recognizes that they would like us to do more in the CNS part. They’re the ones who pay our salary and they’re not getting the added nursing value, as I’ve heard some upper-management people say. But, by the same token, the surgeons have become quite accustomed to looking on us as being their assistants, so it’s hard to explain to them why you’re not going to attend to that patient issue because you want to work on something else. So the something else doesn’t happen, at least with my role. I just have to sneak it in in other ways. . . . It would be nice to be able to wear both hats, but unless I can negotiate one non-clinical day a week, it just won’t happen. I’m already working ten-hour days. I just can’t fit the time in. So I miss out on it.

Lack of support can also come in the form of missing mentorship opportunities for advanced practice nursing competencies for which many NPs have limited to no knowledge and skill. As a result, these NPs re-experience feelings of incompetence, non-confidence, and discomfort with being an educator, researcher, leader, or change agent. They acknowledge that they flounder and shy away from some or all of these activities:

I think it’s because our programs, although they have research in them, they don’t really; and even subsequent to getting the job and going through your orientation, it isn’t on how to do research. It’s on how to take care of the patients, and that was where your skill set was developed. . . . Even though I have the theory, it’s a whole different ball of wax to implement it, and I believe that one of the reasons that we don’t do research is that we don’t know that much about research, we’re not really skilled in it. . . . If we had somebody who had met with us regularly and helped us develop our ideas, not just say, “Well go off with your idea and come back to me,” because . . . you don’t
feel skilled in that area, and so you just keep feeling really tentative, and you can’t really get going. . . . It’s not that I’m really averse to research but I feel like I don’t really know what I’m doing.

In fact, under these circumstances, some NPs revisit a number of the feelings associated with being adrift. Uncertain what they want to do, where they want to go, or how to get there, they say that not being quite the beginners anymore but not yet the experts is a frustrating place to be. As one NP observed, when one is a beginner, permission is granted to ask questions and be offered advice. When one is an expert, neither seems to be necessary. Having proven themselves in the clinical arena but not in the other advanced practice competencies, NPs may find themselves without anyone to foster their ongoing growth and development:

They are NP experts because they don’t have to put so much time and energy into the clinical every day; it doesn’t take as much out of them and they have the time and energy to do other things. . . . But I find that . . . some of the middle-grounders like me aren’t in a position to do that right now. . . . We need the office time or protected time off the unit to be able to pursue other things, other interests besides LPS and whatever, because, although we’re able to do the clinical, it still may take us more time than the experts, plus we don’t yet know how to do the other parts of the job. That takes a lot of time too. . . . And I think the director tends to lump us together probably more than she should . . . and then if you point that out to her, “Oh yes, you’re right,” and then it is beginners and experts. Well, there are not just beginners and experts; there’s the whole in-between.

Even when the pull to be more is internally motivated, NPs observe that it may be strongly opposed by the pull to stay entirely immersed in direct clinical practice. The allure that advanced clinical management of the patient may have for them, particularly
when most of them have been searching to be more in control, more visible, more challenged, and more connected with patients and families while performing hands-on care, is not difficult to understand. One NP articulated that the type of focus that results from prescribing, ordering diagnostic tests, and engaging in a more detailed level of physical assessment “is sexier, more powerful.” As she admitted there is authoritarian and implied hierarchical power in the term physician order, and although she recognized that power over is detrimental to nursing, she also readily acknowledged that when a nurse has that power, it is “very easy to get sucked into it.” This back-and-forth pull is a struggle. She noted that the power associated with these entitlements of the role may lead NPs away from that which has been intended or envisioned for the role: “Being in a position of the one that people go to puts the NP in a position of power and you can choose to use that to keep yourself up there or you can choose to share it. But it is somewhat of a personal choice.” This NP’s admission of temptation with power’s “dark side” reveals the psychological burden NPs may bear that is associated with the power to act in the clinical sphere as garnered in being an NP. But the desire that some NPs have to make more of a difference by bearing and sharing power, rather than wielding it, is also revealed: some NPs use their power as a matter of conscious choice to escape its constitutive danger.

Living with either/or is promoted when nursing management and others engage in discourse that presents patient-care activities as medical functions belonging solely to the NP role, while the other advanced practice competencies represent the nursing orientation to the role. NPs attempt to reconcile the ideals of their education and expectations that emerge from the discourse of others with the realities of the context of their practice and their personal desires for the perfect fit. How do NPs experience their professional selves as they live with or journey through the tension experienced in being pulled to be more?
Being a Wearer of Two Hats

This time in the NPs’ journey is, once again, experienced as a time of living with a polarization of opposites — or, what NPs referred to as the wearing of two hats, the “NP hat” of direct patient care and the “CNS hat” of leadership, research, and education.

Right now I mostly have my medical or NP hat on, but I guess I’d like to be able to do some research and be a principal investigator . . . and I think there’s room for expansion in leadership as far as being involved in more decision-making as far as nursing within the hospital. . . . I’d like to be able to wear the CNS hat too.

Actually, the CNS/NP title is an interesting one. . . . When I have the NP hat on, it’s basically very physically and psychosocially oriented. . . . I find the CNS hat allows me to have a little bit of time for research, which is something that I wish I could do more of.

Fig. 3. Hats 1. Courtesy Tom Phillips and The Folio Society.
Time is experienced as being diverted from one role to another; the direct-practice activities are sacrificed to the other advanced-practice competencies or vice versa. For some, this polarization results from a resistance to engage in all competencies of advanced practice when the search for more has ended and the perfect fit has been found. For others, the polarization results from a lack of knowledge or skill in how to perform in these components of the role, while the call to find the perfect fit, to experience more, remains only partially fulfilled. This dichotomy is further enhanced by job titles such as NP, NP/CNS, and CNS/NP. These titles are not designated provincially, regionally, or institutionally. In fact, it is not uncommon to find all three titles within a single institution. Some NPs carry all of them at different points in their careers, as a result of either a move to another institution or a change in expectation for their role within a single institution.

NP/CNS is the title here and it’s a bit of a misnomer because we’re certainly more NP than we are CNS although we keep trying... And I’m not sure who came up with the title NP/CNS. The title has gone through many evolutions in this organization. It used to be CNS/NP and then some time over the last four or five years it switched around. When you look at our job description... certain proportions are supposed to be devoted to clinical, education, research, and professional development of the nursing staff.

Titles have the capacity to either constrain or expand what NPs do by identifying expectations with regard to the boundaries of their scope of practice and sphere of influence. For example, the singular NP title has the tendency to limit the vision for the NP position, since the dominant discourse associated with this title recognizes or acknowledges only one aspect of the role and speaks to it in terms of medicine. The title eliminates and devalues the other aspects of advanced nursing practice, which are
either lost or buried within the title, thus making these aspects of the role invisible. It seems that an appreciation for the contributions that \textit{NPs} can make under the umbrella of “advanced nursing practice” has yet to be translated into the singular \textit{NP} title at the level where \textit{NPs} live their work. If barriers, such as time constraints and lack of resources, also exist which inhibit the expansion of those boundaries, \textit{NPs} are forced to enact the discourse, which serves only to reinforce the other’s hegemonic view of their role. Consequently, in a catch-22, the title defines the space in which \textit{NPs} live and practice. On the other hand, the titles \textit{NP/CNS} and \textit{CNS/NP} suggest that there are two different sets of role functions brought together to be carried out by one individual. The specific placement of the two roles within the title often signifies the dominant commitment of \textit{NPs}’ time and perhaps what is most valued by the organization or the \textit{NP}. The title is subsequently viewed as a dual job, with the proportion of time allocated to each adding up to a full-time job.

\begin{quote}
If we are to look at the role itself, because they put the \textit{NP} first, that’s the big clinical chunk. The academic and the research and the professional development come as part of the clinical nurse specialist role, and so that takes a much lesser role. So probably 75 to 80 percent of our time is clinical and only 20 to 25 percent is the \textit{CNS} hat we put on. Others have a 50–50 split, but it doesn’t work well when you’re by yourself and you have to do all the clinical work. So really I wear the \textit{NP} hat most of the time.
\end{quote}

Ironically, while some \textit{NPs} lobby to have their title changed from \textit{NP} to \textit{NP/CNS} in order to legitimize or justify the time they spend, or want to spend, involved in the other components of advanced nursing practice, other \textit{NPs} argue that the singular \textit{NP} title accurately reflects the focus of the role. Although these \textit{NPs} are being pulled to be more by nursing management, the singular \textit{NP} title
legitimizes their belief that research, education, and leadership activities belong to the CNS role. If they have found the perfect fit, the singular title allows them to justify living within the perceived boundaries that this title appears to imply.

Each title, with its succinctness, portability, potential persistence, and focusing effects, gives NPs certain experiences and informs their communities of practice about what they should pay attention to. In other words, the title becomes a form of reification. But the evocative power of these titles is also double-edged, because they do not capture the richness of the NPs’ lived experiences. Rather, the titles have, in some cases, appropriated what NPs do in very misleading ways. The titles have gained concreteness, which becomes something that both the NPs and others refer to, strive for, appeal to, and use or misuse in arguments. In fact, the focus on the title may become a substitute for what was never intended to be reflected in the first place. Becoming an NP, CNS/NP, or NP/CNS is both taking on the label and giving the label specific meanings through participation in practice.

Because they are pioneers, NPs have experienced fluidity in their role, which may have impeded coordination, created apprehension about potential misalignments, or resulted in confusion and misunderstandings. Yet this same fluidity has allowed for interactive negotiation, as well as improvisation and creativity, which is the very nature of advanced practice nursing roles: dynamic and continually evolving in response to the changing contexts and health care needs of patients, organizations, and health care systems (CNA, 2008). This fluidity permits NPs within their communities of practice to seize moments and see opportunities that would not have otherwise been revealed. Thus titles as a form of reification may reinforce or anchor the specificities or expectations of the NPs’ practice, but too much reliance may be placed on the anchoring, at the expense of the emergence of all the possibilities for being and becoming an NP.
The paradox of the current titling discourse is that it separates the CNS and NP roles, resulting in NPs seeing the various advanced practice competencies as diametrically opposed. Although they may participate in some or all of the competencies at this time in their journey, they perceive themselves as performing two jobs. At the same time, the split title legitimizes NPs’ engagement in all of the role competencies when there is external resistance to their doing so, thus opening the possibility for some to experience a transformational journey to unification of competencies. The allotment of proportions of time, even if only on paper, may also serve to marginalize aspects of the NPs’ work or their desire for more.

NPs’ stories reveal the relationship between the enactment of the role and their identity as NPs. Some, particularly if they have found a fit in being an NP, identify more with the dominant focus of the role, which is associated with direct patient care. They refer to themselves as NPs and are disconnected from the other competencies: “I think we are nurse practitioners and we may dabble in or do some of the clinical nurse specialist traditional role, but we’re predominantly a nurse practitioner.” Although they may participate in other activities, such as education, committee work, or research, these activities are experienced as pieces of the job to be added on to their NP responsibilities.

The titling creates an expectation of who we think we are based on the tasks, rather than how it is and the philosophy with which we come to the job. And I think some of that comes from the way we are viewed by other nurses. It’s quite often been viewed or seen that we’re physician assistants and we’re not fulfilling a nursing role, and that’s come from administration in the building. And I don’t think they have a good understanding of what we do or how we do it, and maybe we haven’t presented that well to them either. But they think that in being an NP we’re doing more the physician role
than the nurse role. . . . Even though we probably have more nurse practitioners in this building than any other hospital in the country, there is still misunderstanding by administration and nursing administration about what we do and who we are.

Staying clinically focused and clinically driven is identified as the heart of being a nurse practitioner; otherwise NPs “are not different from the clinical nurse specialist.” Yet tension exists when NPs are unable to add or combine the other role competencies to ensure that they will be set apart from “the physician assistant medical model.” As a result of these various discourses and the tension perceived, NPs may even experience the dichotomy of identities as being split and straddling two worlds. “Gretchen,” who held the title NP/CNS, described her role as spending 60 to 70 percent of [her] time as an acute-care nurse practitioner and the other 30 to 40 percent of her time as really wearing the CNS hat, a time allotment she deemed fair. She related multiple examples of her participation in informal and formal educational initiatives with nursing staff and students, the development and implementation of support programs focused on the spiritual and sexual needs of her patients within her subspecialty of practice, and the initiation of and participation in research projects prompted by questions arising from her clinical practice. Yet she acknowledged that she still feels schizophrenic.

Gretchen recognized that the advantage of having the NP hat attached to her name allows her to create opportunities not heretofore afforded. For example, she was able to initiate a joint paediatric-adult clinic for paediatric patients transitioning to the adult sector within her subspecialty, and the identification of research questions that “really came out of wearing [her] NP hat.” She acknowledged that she would not want to give up the ability to manage the patients’ symptoms in a timely manner or the procedures through which she can attend to the patients’ and
families’ issues and worries in a way that is different from the physicians. However, Gretchen worked with a team in which she perceived that members saw her only as an assistant to the physician, assisting with physical exams and performing procedures. As a result, she felt like an NP as opposed to a CNS, although she also acknowledged that being an NP had been a good fit for more than five years. In the following, Gretchen reveals the ongoing dialectic in which she is engaged and the unresolved turmoil:

But am I wearing my CNS hat or am I wearing my NP hat now? What is it that I’m doing in all of this? Part of me feels it’s more the CNS role. So if I get going with the [new] program, work with them one-on-one, is that the CNS role or the NP role? I’m just struggling with that right now actually at this point in my career. But in some ways I am always doing the medical piece too. . . . And where do I want to go? What do I need to do to feel comfortable going to work every day? . . . Maybe I’ll be able to really integrate the nursing piece, the CNS piece, with this other piece. I’ve struggled, no, really gone out of my way, to really maintain and develop some skills in terms of research and some other aspects of the CNS role. So I’ve really tried to wear two hats basically at the same time. But I think I’ve gotten to the point where I’m not sure that I want to continue in the acute-care nurse practitioner piece of it. Or, if I do want to continue, how should it look? . . . So I don’t know if it’s just me or if other people struggle with this too. Do I need to look at the role a little bit differently and see how I can be happier in that role?

Gretchen believes that when she finally chooses between the NP hat and the CNS hat, the tension with which she has been living will be released. However, there is a fallacy in this assumption. The tension experienced by all NPs in being pulled to be more is a central tension about the expression of numerous obligations
involving confrontations of disparate viewpoints. These differing expectations for practice give rise to clashes of intentions, in which NPs, nursing management, physicians, staff nurses, and others assign motivational aims to the other(s) from their own respective understandings. Gretchen is striving to reconcile disparities she cannot escape. Both individual and collective work must be done during this transitional and transformational journey.

Do NPs have to choose one or the other hat? Must they live with the tension forever if they choose not to give up either? Perhaps not. A title, and the understanding of what the title means, even a negotiated meaning, is transacted within the politics of relationships. NPs working within their various communities of practice are not self-contained entities. In any community, people grow and develop within larger contexts — historical, social, cultural, and institutional — with specific resources and constraints. However, geographical proximity to other NPs, the network through which information flows, the presence of a job description, and even belonging to a particular organization is not sufficient to relieve the tension of living with a polarity of opposites. Further, the NPs’ individual responses to their conditions hinder or facilitate the transition through the time of being pulled to be more. Just as NPs gradually experience an inner transformation as they journey from being adrift to being an NP, some NPs embrace the tension created by the two constitutive practices of the “CNS hat” and the “NP hat,” and learn the delicate balance of combining both to work toward the larger quest of being more.

This is not to say that communities of practice are exempt from creating supportive and nurturing environments that are sensitive to this transitional and transformative process. However, NPs need to continue the journey in order to find a way to reconcile the tension experienced at this time. Some NPs use this tension as an opportunity to continue their journey in search of the perfect fit.
If I had my choice I would love to be able to have time to develop in-services and then do a couple of teaching sessions on the floor to help keep the nurses current with what’s going on with their patients. Then I could satisfy needs of other staff members as well, and hopefully indirectly then provide better patient care. And although I mentioned before that research intimidates me because I’ve never done it, I would certainly like to work with somebody on their projects and maybe that would open some windows for me. They would be opportunities that I would like to see happen. So I dream, and if you don’t have a dream you’re not going to get anywhere. . . . You know, you learn so many things that you tend to go in one way or the other before you really decide what you want to do and who you are. And so I don’t think I’m at the end of the road in terms of expanding my role. There’s so much more to who I am as an NP that has yet to be explored.