With new opportunities for learning and an ongoing dialectic engagement, NPs may continue their journey, through being pulled to be more to live the experience of being more. In being more, NPs undergo another inner transformation, in which they gradually unify the various advanced nursing practice role competencies such that increasing the level of participation in any one competency does not dispense with any of the others; on the contrary, the requirement to participate in the other competencies is increased. Why do some NPs experience this transformation while others do not?

Wenger (1998, p. 176) told the story of two stonecutters who are asked what they are doing. One responds, “I am cutting this stone in a perfectly square shape.” The other responds, “I am building a cathedral.” As Wenger pointed out, “Both answers are correct and meaningful, but they reflect different relations to the world.” The difference does not imply that one person is a better stonecutter than the other, as far as holding the chisel is concerned. At the level of enactment, both may be doing exactly
the same thing, but each stonecutter’s experience of what he is doing and his sense of self in doing it is different. This difference is a function of imagination.

If NPs’ journeys are viewed from the perspective of this analogy, they differ as a function of the imagined vision of the perfect fit for which each initiated his or her respective journey. Given that each journey and way of being is different — not better or worse — each NP may learn and understand very different things from the same activities, and journey to very different places, both personally and professionally.

Wenger (1998, p. 176) viewed imagination as “a process of expanding our self by transcending our time and space and creating new images of the world and ourselves.” In this sense, imagination is looking at the NP role and seeing the possibility of the perfect fit. It is an NP envisioning quality of care for her patients as “one-stop care for individuals . . . that includes health promotion as well as tertiary-level care . . . and being provided outside the walls of a large tertiary-care centre because not all clients necessarily like coming to hospitals for their care.” It is an NP hearing about a health care issue in his or her own setting, knowing that issue is experienced by thousands of patients or nurses around the world, and then partnering with other professionals from around the world to find creative solutions through the sharing of expertise. It is an NP envisioning the use of her artistic talents to research and establish an art therapy program to help ease her patients’ suffering. It is NPs seeing themselves as “being able to work with patients and staff in the same moment.”

Wenger (1998, p. 177) said that imagination, used in this context, “emphasizes the creative process of producing new images and of generating new relations through time and space that become constitutive of the self.” It involves a different kind of work of the self — one that concerns the production of images
of the self and of the world that transcend or reach beyond direct engagement. Rather than being a purely individual process, it is anchored in social interactions and communal experiences. “It is a mode of belonging that always involves the social world to expand the scope of reality and identity” (Wenger, 1998, p. 178). “Being able to be creative with a group of people,” noted one NP, “goes a long way in terms of feeling happy in my job and growth and satisfaction.” One NP used an example to explore the meaning of being creative in her role, what she described as problem-solving with others and identifying issues that are significant for patients and families that others have yet to recognize or explore. Unable to help families who turned to her for advice on how to best manage their loved ones’ fatigue during cancer treatment, and because there was little research on this health care issue, she presented to members of her interprofessional team the idea of engaging in research to address this problem. Over the course of several months, the group generated potential research questions and ideas for moving the project forward. The NP then used the national oncology organization to search for an opportunity to work with experienced nursing researchers: “I became a co-investigator on the project — and that’s fine because that’s how you learn — and I obtained a scholarship from the Oncology Nursing Society, a novice researcher mentor award. . . . So we’ve done two studies in relation to fatigue with this population. It’s gotten to the point where we’ve developed a brochure on healthy lifestyles in patients with cancer and I’ve included a section in there on how you manage fatigue.”

Imagination as anchored in social processes is evident when NPs identify the Athenas in their personal and professional lives, individuals who are the wings beneath their feet, or when they describe the joy, satisfaction, and sense of being empowered and enriched when working in open and receptive “can-do” and
“why not?” environments. Then again, imagination is stifled, disconnected, and ineffective when NPs work with naysayers and obstructionists or practice within “top-down” or “follow the rules” environments.

Imagining one’s practice as a continuing history is difficult if one lives with the fear of replacement. Conceiving new developments, exploring alternatives, or envisioning possible futures is problematic if one does not have a sense of belonging to one’s local community of practice or to the broader social system in which one operates. If NPs do not perceive that they have power over their own energies or the capacity to inspire self or others, their imaginations may become narrowed and diminished. However, the imagining of who one is, what one can become, and what one can do helps to prevent the NP from being only that which has been imagined by others.

In being more, NPs discover how they grow again in their understanding of what nursing practice is and what their practice can be. They even begin to have a fresh view of others in their roles, and this recognition brings about a new valuing. This is illustrated in a well-known quote from Marcel Proust (1999, p. 803): “The real voyage of discovery consists not in seeking new landscapes, but in seeing with new eyes.”

Part of the growth process and maturation of being in this new role was, by working with others in a new way, I learned about valuing. So, for example, I learned more about the respiratory therapists — who they are, what they come to the table with, and what attributes they bring to the situation that we’re working together in. It’s sort of that whole re-education about the value of other professions. . . . And so that first experience of working outside that [nursing] box . . . [I saw] that there are different ways of doing things, and that one way is not always the right way, and no one person has control, and you can’t have control over everyone else either. It was
just to see how much value we all have and that we all bring what we’re experts at to the game, and then we have a much better game.

In this time and place of being more, NPs continually experience new ways of “building on their nursing practice,” “always trying to get to a point to be ready to test new waters,” and “setting new directions and new horizons.” Being more is about imagining how to use all their accumulated knowledge and experiences gained through a lifetime of nursing to constantly further this nursing role. It is about imagining a role that is not just clinical but also an advanced practice role that sees “clinical nursing in a bigger, broader sense” and provides the “opportunity to integrate so many different aspects into one practice,” many of which have been developed during previous career paths.

But [being an NP] is also about being able to bring all of the experiences that I’ve had throughout my career, being able to work with a variety of people, being able to make a difference at the bedside, and also being able to do some of those other advanced practice roles — being able to go to conferences, present, publish, do research, mentor colleagues, being able to interact with different people, different organizations. I think all of those things are really critical, for me, to the NP role. Because you have to not just make a difference at the bedside, but you have to make a difference to the staff that you work with. I think you need to influence the physicians that you work with, and you need to influence the broader nursing community. Maybe you can’t do it all the time with other demands, but at some point you need to be able to say, Okay, I need to put energy into and contribute to moving nursing practice forward. And it’s neat because the NP role allows me to do everything, has the potential to do everything, if you want to go on that road.
In being more, NPs reconcile the dichotomy of being NPs and CNSs. They “blend the CNS component with the NP component . . . to make a true advanced practice role.” Undeniably, they struggle to juggle or balance their time, but time and workload create the tension, not the sense of being split. These NPs have one identity made up of many components, in a mixture that is unique to each of them, just as others’ identities are unique to them as individuals.

Perhaps the NP who has made this reconciliation is most similar to Janus, the Roman god of gates, doors, doorways, beginnings, and endings. Janus is most commonly depicted with two faces looking in opposite directions and has frequently been used to symbolize transitions such as the progression from past to future, one condition to another, one vision to another, one world to another, and adolescence and adulthood (Hamilton, 1940). Hence, this figure has been representative of the middle ground, or in-between time and place, reminiscent of Aoki’s (2005, p. 318) image of “crossing” between East and West, a “generative space of possibilities, a space wherein . . . newness emerges.” It may be that these NPs find themselves as part of “a story of unfinalized hybridity, of unceasing attempts to bring together disparate parts, respecting their otherness . . . but believing in a harmony among these parts” (Frank, 2004, p. 105). Perhaps, as Stuart Hall (1990, p. 223) stated, “there is the recognition of a necessary heterogeneity and diversity . . . a conception of ‘identity’ which lives with and through, not despite difference.” Perhaps NPs’ renewed identities, as Hall describes identity, “are those which are constantly producing and reproducing themselves anew, through transformation and difference.” (p. 223)
Being an Advanced Practitioner

Below are three NPs’ stories. These stories bring forth each NP’s unique practice and the work in which she is engaged, based on her imagination of what it means to be an advanced practitioner and thus who she is as an NP. What is illuminated through these three stories, both explicitly and implicitly, is that being more in being advanced practitioners gives meaning to these NPs’ practices and renews their sense of identity; they have discovered the perfect fit during the transformation to being more as experienced through being an advanced practitioner. All advanced nursing practice competencies are viewed as inseparable and mutually constitutive, and their complementarity gives the NP role its richness, dynamism, and uniqueness, all of which are also beautifully illustrated in the three representations of two hats by the illustrator Tom Phillips. Ultimately, NPs identify themselves as encompassing all of these competencies and are seen this way by others in their communities of practice.

The first story concerns “Jenny,” an NP working in a critical-care environment. Her designated title is NP and, despite numerous battles such as unemployment, workload demands — “in reality,
the clinical component is 99 percent of my job, but part of the difficulty is that nobody knows that there’s another 25 percent of my job, even though I keep telling them over and over again” — bedside nursing resistance, and lack of administrative support, she believes that she has finally found the perfect fit in being more. For her, an NP is part of the big umbrella of advanced practice nursing in which CNSs and NPs must work together, albeit with a different division of workload. Jenny and the program’s CNS identify day-to-day issues that frustrate them or which they see as problems that have global impact on the program. Having completed several research projects and having published and presented at national or international conferences at least once each year, Jenny has established that research, in partnership with the CNS, is now an integral part of her role.

For example, Jenny and her colleague perceived that there were unnecessary delays in endotracheal tube (ETT) extubations, which resulted in an increased incidence of ventilator-associated pneumonias, prolonged lengths of stay in the intensive care unit, and increased costs to the health care system. Jenny noted that, “an NP doesn’t have a zillion hours to develop proposals and go to Ethics, and so we worked together.” Both were involved in the literature review and research proposal development, but the CNS wrote the formal proposal and research ethics application. Jenny approached nurses in the clinical area to “to help out with data collection, to try to bring them into thinking about nursing research, maybe get them excited about it and want to be part of improving practice.” Both provided education to the unit staff on the benefits of early extubation based on scientific and local evidence.

Jenny and her partner subsequently undertook a post-extubation evaluation and found that they had made a significant improvement in timely ETT extubations. Early extubation also reduced the use of sedatives by half, thus saving the system $15,000 annually. As a result of the success of this clinically-driven research project,
Jenny and the CNS became involved in improving the unit’s pain assessment and documentation, and developed research proposals related to oral care and diabetic management, the latter project being an outcome of Jenny’s participation on a hospital quality assurance committee for the practices of insulin and diabetic management. As a result of embedding nursing research, education, and quality management activities into her practice, Jenny observed:

The nurses see me as a role model, and maybe I’ve even been a mentor to a few nurses — because we have had probably about 10 nurses in our ICU actually go back into the master’s program because they actually want to do this role. And they see me as somebody who has some knowledge who they can approach to ask questions or who they see as being able to facilitate their learning as well. I love to do one-on-one teaching at the bedside with them, and a lot of times it happens when things are happening with their patients and they’re getting orders for this and that and sometimes when they are new or less experienced, they don’t always feel comfortable asking physicians because they’re scared or it’s a power thing, but they feel comfortable saying to me, “Well why exactly are we doing this, what is the reason and what is the outcome hopefully going to be?” So it makes you feel good about yourself as a nurse and as a person to be able to do all these things, as well as have hands on all the time.

The second story is told by “Colleen,” an NP who became tired of being told by senior nursing administration that she “could not have or do everything” in nursing. She was pushed to make up her mind about whether she wanted to be a clinician, a researcher, an educator, or a manager. Having wrestled with the question What do you want to do? she finally decided that she was “just going to have it all.” For Colleen, being an advanced practitioner means doing everything, all the while being able to make more of a difference, one patient at a time.
In her clinical role as a gerontology NP, Colleen has a broad sphere of influence because she is called upon by every clinical area in the hospital. She is able to generate questions about practice that she then takes through the research process, using the findings to implement changes that improve the quality of patient care. Her clinical and academic teaching opportunities also allow her to continually share with and learn from others. For example, in her story of a project that involved the surgical service — a project she described as “some really fun work” — Colleen emphasized the partnerships she works hard to develop:

*We try really hard not to be the people that come and say, “Oh we’re from geriatrics and we know all about care for older people, and we’re going to tell you all the bad things that you do.” We really try to present it as a partnership with them because they know all about their specialty and we know squat about it, but we know about some of the issues that are happening and the de-conditioning issues and these medication issues and all of those things with the patients, so we’re just trying to help put this together.*
Having observed that the surgeons had a high usage of “less senior-friendly medications,” Colleen developed a partnership with a pharmacist in an attempt to alter the surgeons’ prescribing patterns. Although she had been a colleague with the pharmacist for a long time, she noted that their relationship began to build in a different way when she became an NP. As a result of using one-on-one teaching opportunities combined with team presentations at surgical grand rounds, they were successful in eliminating the use of Tylenol #3 and Gravol, the two targeted medications, enabling her to affect patient care in additional ways.

Subsequent to this successful educational initiative, Colleen and the nursing manager for the orthopedics program engaged in a retrospective cost analysis for the targeted drugs before and after the teaching intervention period using the computerized medication records and discovered significant cost-savings. Colleen was eager to begin her next research project, which concerned Foley catheter usage and related nosocomial infection rates; this involved partnerships with some clinical nurses and a few student nurses. Colleen was replete with stories of how she made a difference by calling on all the competencies required in this advanced nursing practice role.

And then as an NP, when I’m doing consults, they’ll ask me questions, whether it’s the nurses on the team or the social workers in discharge planning. . . . When I first started as an NP we really wanted our team to try and develop a geriatric assessment form that was more interdisciplinary so that I wasn’t going and doing a cognitive assessment and the occupational therapist was going and doing the same cognitive assessment. We wanted to make it with the understanding that it could be any of the team members contributing to that. So we worked on this and now we’ve taken it regionally and we’re going to standardize it so that we are not repeating work across institutions and we’re helping to build trust in each other as
colleagues. We also made a conscious choice to generate a problem list rather than the diagnosis list, which helps us to focus on the patient and their issues, and lets all the health care professionals create or add to the list. Now we need to work on the discharge planning based on the patient-centred list.

The third story is told by Grace, an NP with the designated job title of NP/CNS who worked within a cardiology program. Being more for Grace is about the ability to influence change on many levels by being actively involved in all domains of practice. The advanced-practice NP role offers her the opportunity to “do everything.” As a result, there are always new learning opportunities with new challenges “to mentally turn [her] on, to stimulate [her].” She is constantly stretched, but then observes ripple effects not only on patient care, but also on the nursing staff and even on the physicians. Being more is about “the whole package of advanced practice” and, as such, is “just the perfect nursing role.”

Grace’s practice is built on a belief “that most nurses have the knowledge to do a lot of things that NPs do; they can do a lot of things physicians do, but what prevents them is that the structure doesn’t allow them to practise to that level.” Therefore, she sees the NP role as a first step to expanding the role of the staff nurse. The reader might recall Grace’s story about learning to remove arterial sheaths after cardiac catheterization as described in chapter 3. Grace later recounted the evolution of the performance of this procedure. Once she became confident and comfortable removing arterial sheaths and managing any related complications, Grace noted that the patients were required to remain flat in bed for six hours after sheath removal, although homeostasis at the site takes only thirty to forty-five minutes. Believing this practice was a “sacred cow,” she initiated a randomized controlled trial that assigned patients to two, four, or six hours of bed rest and compared all vascular complications across the three groups.

I had physicians whose only conception of a nurse in research was the people who helped them with their research. Most of them in the group had never heard of a nurse being a principal investigator on a research study actually conducting independent research. . . . When I presented my research findings, every cardiologist in the department took time out of their schedule to come to my presentation and they all asked questions. And there were staff nurses who came in on their day off. Before I’d even started doing the research, I said, “I’m not going to go through all this as a paper exercise. If this shows that it’s safe to reduce bed rest, then we need to implement the change.” And we all agreed as an advisory group that we would implement that change. And the day after I presented the findings, the change of practice went into effect. We went from six hours to two hours, which is really cool. It was better for the patients and decreased the workload for the nurses.
At the time of the study’s implementation, Grace noted that there was a large core of expert, experienced nurses who were interested in learning to do the procedure. Grace felt that seeing her manage sheath removal made it easier for them to say, “Well, if she can do it, I can do it too.” Although she supported them, she requested they wait to lobby for the expansion of their practice until after the trial; she needed to hold constant the quality of sheath removal, so as not to bias the complication rates. In the interim, she encouraged them to be involved in the study and used this time to help them develop a proposal. The results of the study fuelled their enthusiasm, and they argued in the proposal that the time previously allocated to caring for patients on bed rest could now be allocated to the sheath removal procedure. Grace was physically present on the unit to support the nurses in the management of complications arising: “Occasionally, they’d pull the sheath and the groin clamp would come off and then the patient would re-bleed later. The experienced nurses would always put the groin clamp on and then call me and I’d come and say, ‘Oh, it’s fine. You’ve done a great job. Just carry on.’”

Recognizing that the dynamic of a change in nursing practice often rests with physicians, “because if the physicians aren’t convinced that it’s going to be safe then practice isn’t going to change,” Grace presented the research results and their program change at an international medical and nursing conference: “And so I had two very stats-related, safety-driven presentations for the medical audience and then two more patient-focused ones in the nursing sessions.” As a result of disseminating the findings at the conference, her colleagues in several hospitals across the country changed their practices. The ripple effects were exciting and personally satisfying:
The neat thing was not only changing practice on our unit but changing practice well outside that. And for a lot of physicians it was something completely new to them to realize that a nurse can do clinically relevant research that changes practice in a positive way. And it was wonderful to see the ripple effects of that on the staff. After that, when I was being introduced to the new staff on the floor by the senior staff, they introduced me as, “This is our nurse practitioner. She’s the one who’s responsible for all the bed rest research.” So it was the research that they were focusing on. One staff member sought me out at a professional nursing meeting and said, “I’ve heard all about your research and I’d really love to work with you on nursing research.” And he said “nursing research.” But when they can see that they can actually use this stuff and be involved in it, it’s great to see them turned on.

These three NPs’ stories reveal that this search to be more through being an advanced practitioner is associated with a personal moral imperative of exercising their strengths in the context of close relationships within and outside their communities of practice in a transformative or empowering way. Rather than focusing on the obstacles to their progress, they deftly go over, under, and around them. They are not concerned with what nurses and others should or should not be doing; instead, they are concerned with how nurses and others can do anything they want and need to do. They are transforming their own and others’ lives through their strengths and their intent to give others, particularly nurses, the tools to claim their strengths and use them to live their professional lives to the fullest. Thus, sharing and using power to strengthen others is a constitutive element of their role as advanced practitioners. NPs demonstrate this vividly when they make a public demonstration of recognition for the Other’s perspective, thus validating, honouring, and valuing the Other’s knowledge and skills. They challenge the power-over
perspective by asking, “Why would you not include those who have the knowledge and skills? Why would you not hold those who do the job accountable for looking for the gaps, identifying redundancies, and knowing how to find the solutions? Why is there a need to tell bright people what to do? Why do we not work together to solve problems?” They know their own limitations — “I am not super-duper,” “I am not a super nurse, because again that’s not being respectful of my nursing colleagues. We are all there to provide patient care and we all bring something vital and important to the care of the patient” — but imagine the possibilities in others. In this way, NPs identify themselves as nurses without any extraordinary power and work hard to help others find the power within. As a result, paradoxically, their power is amplified, as is their sense of the possible. They may be inspired to say as Morpheus does to Neo in the movie *The Matrix* (1999): “I’m going to show you a world without borders or boundaries — a world where anything is possible.”

Driven by a desire to always be more challenged and more connected with the nursing profession, NPs in being advanced practitioners continuously expand their communities of practice through multiple and varied partnerships. They strive to make more visible for nurses and others that which has heretofore been invisible and silent, and they work hard to involve others, particularly staff nurses, in every element of what they do. At this point in their journey, having the opportunity to be pioneers means that they can lead the process of creating a vision, the final appearance of which no one really knows, the diversity of which is limited only by their own imaginations and the imaginations of others. From this perspective, NPs acknowledge that the results are out of their hands, since they are involved in a mutual process they even invite and encourage. However, they are open to the options available and involve themselves in creating the changes they intend without having an attachment to the
outcomes. Barrett (2010) would refer to this way of engaging in the world as power, defined as knowing participation in change, and as such she would likely see these NPs as living power-as-freedom, leading the change process from the perspective that power is inclusive and unlimited, with outcomes frequently not predetermined. Being an advanced practitioner enables NPs to achieve levels of scale and complexity that give new dimensions to their belonging. Interestingly, the Old French word pio(u)ner carried the meanings “dig,” “excavate,” and “mine.” And pioneering NPs in fact unearth rich stores and abundant rewards inherent in being advanced practitioners. They find a greater sense of personal fulfillment as nurses through their opportunities to make a more diverse and broader difference to their patients, families, and the nursing profession, and they discover more of their own possibilities for being who they desire to be. Barrett (2010, p. 47) might describe NPs, in being advanced practitioners, as “quiet rebel[s] with a pioneering spirit,” a perspective that sees the pioneering journey continue to this day and beyond.

These last three NPs’ stories reveal that in being advanced practitioners, NPs do more than participate in each of the practice competencies. They engage in building and nurturing communities of practice that have the patient and families as the core focus, and they develop partnerships that foster the growth and development of others, particularly (but not only) nurses, to make the best delivery of care possible. They also conduct community-building conversations and negotiate new situations through partnerships in projects, research, and teaching centred on patient-care issues. Through their ongoing development of interpersonal relationships, they pursue common enterprises in concert with nurses, physicians, dieticians, pharmacists, social workers, and others. As a result of engaging in shared activities, they create a history of shared experiences. Through their efforts, they build and expand the level of competence within their communities of
practice, through these interacting trajectories. Consequently, their identities and those of others are continually being shaped in relationship to one another. As advanced practitioners, they expand the boundaries of nursing and open the peripheries to allow for engagement with all those who work within these communities.

These stories also reveal that NPs’ imaginations come from a place of stepping back and looking at their engagement “through the eyes of an outsider” (Wenger, 1998, p. 185). By reflecting on others’ experiences, they imagine the possibilities in the situation and in others; they see themselves in new ways and imagine the “multiple constellations” (p. 185) that could be contexts for their practices. They explore other ways of doing what they do, take risks, and create unlikely connections. In fact, there is some degree of “playfulness” (p. 185) in how they engage in their work. As several NPs observed, they are having fun in discovering being more. Moreover, they are able to make visible and bring voice to what they do through the day-to-day sharing of their stories and explanations. By involving others in the processes of research, project work, writing, presenting, and problem-solving, those others, like them, begin to imagine “the present as only one of many possibilities and the future as a number of possibilities” (p. 185).

Perhaps as a result of reaching out to their colleagues in understanding, NPs as advanced practitioners begin to feel understood (Dickson, 1991). Through reverent attention to nurturing engagements with their communities of practice, NPs create an opening and emerge with the perception of being transformed. As Nichols (2005, p. 10) noted, there is a strong connection between “reverent attention to nurturing engagements” and “feeling understood” that strengthens the sense of belonging and sense of self:

If listening strengthens our relationships by cementing our connection with another, it also fortifies our sense of self. In the presence of a receptive listener, we’re able to
clarify what we think and discover what we feel. Thus, in giving an account of our experience to someone who listens, we are better able to listen to ourselves. Our lives are co-authored in dialogue.

This way of engaging may be similar to what Reay and colleagues (Reay, Golden-Biddle, and GermAnn, 2006) referred to as “cultivating opportunities grounded in NPs’ embeddedness.” While embeddedness serves to constrain some NPs, it may also facilitate action because it serves as a “means of stratification by opening windows of opportunity” (Dacin, Ventresca, and Beal, 1999, p. 335). NPs use their embeddedness, or engagement with others in their community of practice, as a source of opportunity “to evaluate the potential success of specific strategies and choose particular times and places to act” (Reay, Golden-Biddle, and GermAnn, 2006, p. 979). In being advanced practitioners, NPs continue to develop and apply their deep knowledge of the system and its actors in order to select and frame arguments for making changes within clinical practice, and they use their understanding of their communities to recognize and take advantage of opportunities.

Now, NPs subtly remove system barriers and prove the value of the NP role in richer and deeper ways (Reay, Golden-Biddle, and GermAnn, 2006). In being advanced practitioners, they find they can make more of a difference and “secure small wins” (p. 990), working at the front line day by day and interaction by interaction. Gradually they are seen by others as being more. Paradoxically, in finding ways to fit the NP role into already established systems and structures, they also change the system to accommodate this new role and in doing so find the perfect fit for themselves. Once they create and strengthen their connections in new ways, they begin to recognize that the NP role will be relatively difficult to disconnect or eliminate.
Administration sees the ripple effect on patient care, the staff, and even the physicians. I mean, some practices have changed for the better because of the research we do on questions that arise from our own practice. Nurses feel better informed. We hear that the patients are happy with the care we provide. I think they know that they would lose a great deal if they got rid of this role now.

These NPs’ stories illuminate a life in a process of a multiplicity of assemblages, of connections, and of interactions. In being more as advanced practitioners, NPs are not attached to an official structure, a rigid pattern, or an imposed or straightforward stream of thought. They engage in what perhaps could be thought of as “rhizomatic thought” (Holmes and Gastaldo, 2004, p. 261) — that is, their lives emerge and grow in simultaneous, multiple ways, without a beginning or an ending, and are in a constant state of play, a process that may be fostered because they are pioneers. In this way, NPs become capable of promoting the creation of new concepts that allow for the emergence of alternative possibilities for themselves, others, and nursing. They demonstrate an ability to tolerate ambiguity and chaos, and do not rely on certitudes to progress or develop new ways of being for themselves or nursing. Their imaginations allow them to continuously become Other, and they are willing to take the risks and face the challenges associated with the metamorphosis. In this way of living their work, they discover being more and find the perfect fit.

A transmuting sea star
Caught on a watery coil
In uncharted waters.

— Mika Yoshimoto (2008, x)