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Metaphors of Interdisciplinary Collaboration to Overcome the Theory-Practice Gap when Transitioning from RN to Advanced Practice Nurses

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Abstract

A particularly pressing concern is how members of the nursing profession who have expanded their scope of practice from Registered Nurse to Advanced Practice roles of Nurse Practitioners (NP) and Clinical Nurse Specialists (CNS) experience their transition into the workforce. Available evidence suggests that new Advanced Practice Nurses struggle with "imposter phenomenon" (feeling not qualified for the job) and report difficulty in overcoming the theory-practice gap. To illuminate strategies for easing the passage of the role transition via interdisciplinary collaboration and support, graduate students completing a course in Theoretical Foundations of Nursing created metaphors of ferrying and gardening. These metaphors depict solution-focused approaches that reduce the anxiety and loss of self-confidence which accompany Phase One of the transition (initial process of acquiring the skills and knowledge needed for the advanced practice role) to ensure successful transitioning into Phase Two (period of adjusting to the new role that follows program evaluation).

Keywords: *Advanced nursing practice, Role transition, Interdisciplinary collaboration, Metaphorical inquiry, Transition theory*

1. Introduction

It is time to speak our truth, with passion, and as a collective. It is time to renew our commitment to care, and rise to a call to action … This is our time to go boldly forward with renewed vision, inspired by foundational nursing values and with absolute conviction of our place in the world [1].

The Nurses Association of New Brunswick uses Advanced Practice Nurse (APN) as an umbrella term that allows the graduate prepared nurse to perform advanced levels of critical thinking, data analysis, and synthesis as well as accessible primary health care and improved acute care outcomes [1]. The term APN can refer to Nurse Practitioners (NPs), Clinical Nurse Specialists, and Nurse Educators (NEs) prepared at the Master of Nursing level. Nurses new to the APN role often struggle with *imposter phenomenon*, a psychological pattern that according to Harvey and Katz [2] is based on intense, clandestine feelings of fraudulence in the face of success and achievement. Despite evidence of abilities, those experiencing imposter phenomenon believe they are less intelligent and competent than others perceive

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them to be [3][4]. Oriel et al. [5] found imposter syndrome present in one third of their sample of family medicine residents even though all study participants determined they were receiving the training needed to succeed in their careers. Henning et al. [6] had also found that among medical, dental, nursing, and pharmacy students, 30% identified as impostors.

Compounding imposter syndrome, APNs report workplace conflicts and limited recognition and understanding of the APN role. According to one APN, "they [physicians] are very happy to leave us to our own devices and I think they are sometimes a little bit unhappy…when we…ask them to look at things we are not happy about, and that can cause conflict [7]. Within the traditional workplace hierarchy in primary care, the physician (GP) leading the practice assumes ultimate accountability for decisions made by the nurse [8]. GPs were found to question if APNs have sufficient education to be autonomous and accountable [9]. Some GPs were reluctant to endorse referrals made by APNs to specialists outside the practice; some specialists refused to recognize these referrals, berating the GPs for bypassing the normal protocol [10]. Only once GPs are satisfied, they can relinquish certain duties and care activities to APNs can the APNs have freedom to operate within their scope of practice [11]. Such freedom enables continued skill building and competence as in the case of diabetic nurse educators whose skills in insulin initiation and titration are found superior to those of a GP [12].

Ambiguity concerning the APN role is a source of unease between nurses and GPs. Even when supervised by NPs in the initial stages of their training, GP residents were still unclear about the NP's scope of practice [13]; experienced GPs report the APN scope of practice as "ill-defined" [7][12][14]. This lack of a clear understanding of the role and responsibilities of the APN acts as a boundary between the two practice professions, with physicians losing interest in the position and becoming disconnected from the APN.

Medicalization of roles contributes to inter- and intra-personal conflict. For example, some physicians were uncomfortable with nurses making a diagnosis [15] and with losing control over treatment decisions [12]. Many NPs were found reluctant to fully utilise prescribing rights because they considered themselves to be nurses first and did not wish to be perceived as elitist and acting like a physician [14]. When practicing within environments micro-managed by a physician, nurses were found to doubt their care decisions and seek clarification for simple matters [7][8][11][12][13][14][15]. This unnecessary interplay between nurse and physician resulted in incidences of overt client requests being overlooked [16]. Other studies reported the development of protocols as a means of avoiding omissions and explicitly delimiting the APN's duties [7][8][10][11][12][13][14][15][16][17]. One nurse expressed that "it was tick the boxes, spit out the care plan, spit out the health assessment… We are not dealing with the patient as a holistic person" [16].

An uneasy tension developed when APNs wanted increased stature within the general practice [12][13][15][16][17][18] while GPs were the sole arbiters of what the nurse could or could not do. Disagreement on the place of the APN in the general practice milieu and how to best utilize this model of care was reported [12][13][15][17][21][22]. Whereas physicians may enjoy handing over what they perceive to be mundane duties, tensions regarding the cost of APNs and anxieties around recouping this expense were evident [10][16]. APNs reported being in a constant battle to be recognised professionally by their colleagues and clients [8][12][14][15][16][17][20][21][22] and also by other nursing staff [7]. To gain respect from GPs, APNs displayed skills that were more medically oriented; however, these skills were not accepted by their less qualified nursing colleagues who themselves felt undervalued and overworked. APNs have struggled to maintain a caseload commensurate with their training [12]. They have measured their worth to the practice in terms of the extra attention they could

give their clients [10][18][19]. According to one physician, APNs were "a waste of money" because they always asked for a second opinion [18]. Other GPs viewed APNs as effectively providing continuity of care to vulnerable clients and this view was supported by many chronically ill clients [8][11][12][14][15][16][20]. Yet, clients did not recognize the interactions between the APN and GP as professional cooperation. For instance, one client stated "she [APN] had to get permission from Dr. Ken to put me on insulin, but it was her that decided and he had to say yes" [10].

Amid the conflicts, there is evidence in the literature reviewed that APNs view interactions with GPs as opportunities for collaboration [8][14][15][17] and negotiation [7][8][14][15][16]. APNs report key components of collaborative relationships as mentoring and supportive networks [16] alongside shared knowledge, mutual respect, and acceptance [7]. APNs are socialized toward collaborative practice. In this article, we explore graduate students' perspectives of preparing to enter the healthcare workforce as APNs and their strategies to overcome imposter syndrome, perceived role ambiguity, conflict, and limited support for their role.

2. Transitioning the theory-practice gap

The term *theory-practice gap* was first used in the UK when nursing education moved out of the health service and into the higher education sector in the 1990s. Theory-practice gap bespoke a growing separation in ways of thinking about the relationship between theory, research, and practice between two groups of people geographically separated from one another and with different jobs and employers. The development of nursing practice was no longer the business of the health services workplace sector [23]. Rather, the research journal had become the primary means of communication between theory and practice; research-active academics published in these journals and evidence-based practitioners read them.

The restructuring of nursing education from hospital apprenticeship styled training to a university prepared professional practice discipline is an example of what Meleis [24] defines as a situational transition. The transition process involves passing from one life phase or status to another and is influenced by individuals' perceptions about the meaning of the transition experience. Individuals not properly prepared may suffer role insufficiency. To successfully transition, they integrate new knowledge, modify behaviours, and change their definition of self. Transitions involve internal processes that begin when an event is anticipated. The ending of old ways (of being, knowing, and doing) is accompanied by confusion and often distress as new ways of managing that lead to a new beginning are learned [25]. Outcomes of successful transitioning include mastery of the needed skills and behaviours and identity reformulation.

The transition from registered nurse to APN has been described as "moving from the side of the bed to the head of the bed" [26]. It is a two-phase process consisting of Phase 1 (acquisition) beginning upon entry to graduate school and continuing through program completion and graduation and Phase 2 (implementation) beginning after graduation when the new APN moves into the workplace until 6 months to 2 years post graduation [26]. Universities prepare nurses to qualify as APNs; the health services employ them. Universities have been criticized for not providing students with appropriate information to fully participate in client care and for producing nurses who do not know about mental illnesses. Criticism is also directed at healthcare settings for having unrealistic expectations of students or new graduates [26]. APNs starting out in practice who have not progressed through Phase 1 of role transition during graduate school may be at greater risk for disconnectedness,

isolation, and prolonged disequilibrium during Phase 2 of the transition process than those who began to transition during graduate school [27]. The challenge in reducing the theory-practice gap is to prepare nurses who can meet the needs of individuals, families, communities, and the nation within resources available and educational outcomes. Resolution of the gap requires mutual understanding of the goals and expectations and collaboration of all the key stakeholders.

3. Creating an artform to help transition the theory practice gap

Graduate nursing students enrolled in *Theoretical Foundations of Nursing* were asked to create a mandala (artform) or pitch (motivational speech) to illustrate their strategy to help transition the theory-practice gap in their work with a) nursing students, b) clients, or c) other clinical practitioners. The students, divided into two teams based on site (two participated in the course through teleconferencing [the distance team], three at the Fredericton campus [the home team]), presented their ideas as interdisciplinary gardening and ferrying metaphors.

3.1. From scraggly seedling to lush, thriving, and overflowing

The distance team pointed to a stunted, dishevelled plant [Figure 1] that did not look as if it would survive much longer in the arid soil of its clay pot. This seedling plant represented the new APN placed within the healthcare system. The plant needed to be watered by interdisciplinary team members who could offer nourishment (e.g., shared assessments, new perspectives) helpful for the plant to develop its roots and foliage for taking in and exchanging needed elements. While watering was vital, overwatering (e.g., too much information without opportunity to adjust) was a danger; the seedling must avoid drowning. Proper soil moisture and nutrients required monitoring. Ideally the seedling would self-monitor as well as be watched over until strong enough to stand unsupported and perform its task to positively influence the health of others. The plant's growth and expansion could be limited by a pot of restrictive health policies or governmental interference with role, lack of "Big Pharma" endorsement, and air pollution and/or deficiency in life sustaining fresh air and sunshine.

Figure 1. Gardening metaphor (Photo credit to Kimberly Chenier, August, 2017)

According to Kimberly, "*the seedling must be gently placed into rich, fertile soil. Nourished and protected from the harsh elements with room to grow, its lush leaves and blossoms will develop and thrive."* She added that

In the garden of healthcare, nurses require the same interdisciplinary supports as these plants, as they transition from nurses of skill to those of experience and confidence in their advanced practice roles. Nurses require comprehensive orientations, mentorship, and clarity regarding their roles and responsibilities. They struggle to be successful if they are not protected from the harsh elements of exclusion, negativity, bullying and incivility.

Kimberly believed her transition to an advanced practice role has been facilitated by the caring, kindness, and inclusion extended to her by her nursing and other healthcare colleagues. Mindful of the high rates of attrition, burnout, and compassion fatigue experienced by nurses, she implored further exploration of these potentially preventable outcomes within the Canadian context by drawing on the work of Drs. Wendy Austin and Heather Spence Laschinger. A deeper and more intimate understanding of the experiences of both graduate and APNs as they transition into practice provides the knowledge to ensure a more hopeful and positive future for these nurses. According to Austin, hope is an important resource for career engagement and personal resilience in challenging health care settings; *"professional caregiver hope can impact patient and client hope"* [28]. Laschinger and her colleagues identified the need for better orientations, appropriate workloads, and improved staffing to facilitate a successful transition into practice for Canadian graduate nurses. Teamwork, collaboration, positive mentorship and the development of safe, welcoming, and supportive work environments are critical [29].

3.2. From uncertainty of how to proceed to safe guided passage

The home team described the process of learning to transition from RN to NP as a journey of connection. They visualized themselves as primary care providers on one side of a deep river, while the client seeking their services was on the other side. Their task was to get either themselves and/or their client safely across the river to address the client's unique health needs [Figure 2]. Holli described this journey of connection as an exercise in reflection that begins with the mindset of the new APN. The connection then extends between the NP and the client by blending seasoned RN skills with newer knowledge such as diagnostics, interpretation, and prescribing. Depending on the needs of each individual client, as well as the knowledge and comfort level of the NP, multiple disciplines connect with advanced practice nursing to smoothly transition the client into enhanced well-being. Amy defined the transition from RN to NP as a turbulent expedition where new NPs no longer rely solely on the navigation of others but become independent and utilize their own internal compass to pilot patient or client care. Similar to a captain going to sea with navigation and safety plans while also recognizing that each journey is unique with unpredictable winds and shoals. the new NP makes informed decisions on how to navigate the waters based on unique patient or client needs and will seek assistance from the multidisciplinary team when required.

Boats with ferrying capacity represent knowledge and theory from multiple sources including personal beliefs and evidence-informed practices. The river waters, at times choppy, represent the many illnesses and challenges that face both NPs and clients. The need for client trust, therapeutic relationship, and NP role recognition need to be considered before the client or NP will willingly be ferried. The NPs need to utilize the assistance of a qualified ferry person to connect with their clients. This task is complicated because APN consults often differ from traditional requests (i.e., holistic vs pill remedies) and specialists who fail to recognize the NP designation prolong the referral process by waiting for co-signatures from collaborating physicians. The home team APNs deplored automaticity, defined by Logan [30] as performing tasks quickly, effortlessly, and relatively autonomously. They were aware that

their new place at the healthcare table was only partially accepted, and that their work would be scrutinized by others. They recognized that collaboration was required not only with the ferry person, but also with fellow APNs, physicians, specialists, and team members including physiotherapists, respiratory therapists, and dieticians. Such interdisciplinary collaboration would help ease their passage amid rough waters and the presence of fog that could obscure intentions.

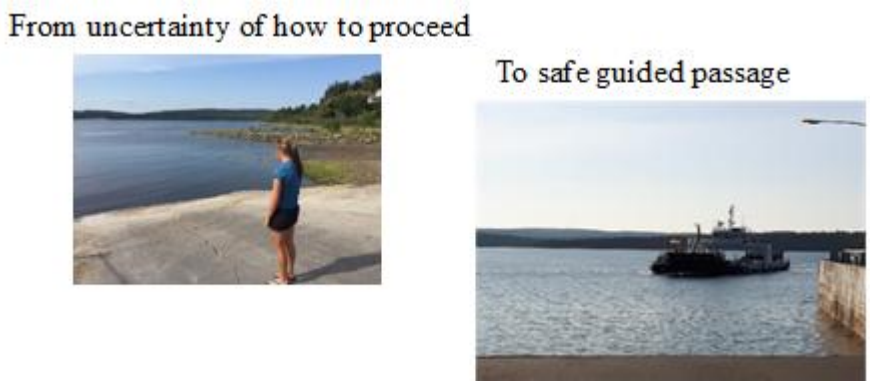

Figure 2. Ferrying metaphor (Photo credit to Kimberly Chenier, August, 2017)

3.3. Significance of the APN metaphors

Metaphors convey "feelings, moral practices, and spiritual awareness" [31], meeting a need for *"language close to experience, … affect, [and] morality"* [32]. According to Morgan [33], some metaphors are "fresh and must be calculated or figured out" while others are instantly recognized and understood. A newly invented metaphor assists thought by evoking a visual image [34] which helps provide a way to talk about experiences within ambiguous work settings and role confusion [35]. The graduate students' metaphors compared something not well understood (role transitioning) to something familiar (gardening, taking a ferry). Their creation of two different metaphors allowed seeing multiple perspectives of their role transition and its underlying layers in a new light.

The APN metaphors illuminate strategies for easing the passage of their role transition via collaboration with and support from teams of different disciplines and sectors. The metaphors convey that advanced practice nursing does not have a secure foothold in general practice. Despite APNs being able to articulate problems concerning their contribution and boundaries, there has been scant progress towards organizing and sustaining advanced nursing practice. The uncertainty surrounding the APN role in general practice is the result of a complex set of related factors that have sabotaged attempts to gain professional recognition for over a decade.

The metaphors of gardening and ferrying may be helpful in exploring elements of nurturing, anchoring, and guiding within and beyond graduate nursing education. Entry into advanced practice includes navigating the gap between educational preparation and the primary care setting. What is striking about the gardening metaphor is that people are nowhere to be found. This perhaps reveals how the plight of the APN is depersonalized by masking the human behaviours, relationships, and communications which make up practice. Resultantly, it is easier to get lost in the task of gardening without remembering the personal context. Once people are forgotten, it understandable how co-optation of their value happens. The ferrying metaphor depicts APNs as stranded but compelled to cross dangerous waters to

help their clients. It is clearly up to the APNs to take control, even in the presence of great risk. Although the ferry person received payment, safe passage could not be guaranteed. The APN passenger could drift with or paddle hard against the tide as the system lacked direction-guiding devices.

Using metaphors contributed new perspectives to an understanding of graduate nursing student role transitioning to advanced practice, and stimulated deep thinking and explication of underlying professional and personal values. Our findings demonstrate the vulnerability of the APN role (e.g., others must water the seedling or provide the river crossing). As suggested by the acridity of the soil in the seedling's pot and turbulent crossing conditions, attempts to reposition advanced practice nursing as a viable adjunct to medical care may be met with tension on the part of GPs. To illustrate, the American Medical Association strongly supports scope-of-practice laws to ensure client safety and prevent APNs from providing primary care without oversight by a physician [36]. The requirement for the practicing NP in New Brunswick to have a collaborating physician that began when the NP role was first introduced and had multiple ordering restrictions will soon be removed. Nursing advocates have taken strong exception to scope-of-practice restrictions, emphasizing an Institute of Medicine report [38] that recommended nurses be free to practice to the full extent of their education and training. The Canadian Medical Association has taken a similar stand as the Institute of Medicine, stating:

Ideally, every health care provider should have a scope of practice that is consistent with his or her education and training, and that the health care system should enable them to practice to the fullest extent of this scope ... providing high quality patient-centered care without compromising patient safety." [39]

Without imminent clarification, APNs in general practice may be unsupported to accept increasing responsibility as the healthcare burden increases over the next few decades. The thrill of bringing the scraggly seedling to rich bloom and solving the dilemma of crossing unknown waters underscores the power of teamwork, multi-tasking with others outside one's field, and solutions-focused planning.

4. Discussion

In discussing the understanding of role transitioning conveyed by their metaphors, the graduate students as NPs face *"an uncertain and terrifying near future where we will not feel prepared, we will second guess ourselves, and we will make mistakes."* They report relying heavily on guidelines, textbooks, and black-and-white decision making (e.g., picking or discontinuing a medication because it does or does not meet the guidelines and parameters in which their client falls). As novices, they constantly consult the literature to avoid errors by strictly following evidence-based practice guides. The NP graduate students agree they need to be responsible for their never-ending learning process. They have seen their preceptors who, although having practised as NPs for years, still "*look things up all the time*." The NP students consider the healthcare field as ever changing and thus requiring them toward continuous learning because if they are not committed to continuing to learn, their clients will suffer.

In identifying progression in navigating the theory-practice gap, the advanced practice thesis student described working with sophomore students to ensure:

They understand the rights of their clients and the rights of preparation. We discuss cold chain; anaphylaxis; the roles of Public Health and Health Canada; attenuated versus killed

vaccines; importance of educating the client on measles, mumps, rubella, diphtheria, tetanus and pertussis; signs and symptoms of these diseases; and the immunization schedule. This is only one aspect of care the students provide, however, I feel that I must provide them with a solid grounded foundation. A question came up regarding IM needles and Z-track injection process. I did not have the answer, and I was very open about this with the students. We collectively used critical thinking skills, discussed options, searched for the evidence, and looked at the current research. We spoke to the pharmacist, nurse educator, and eventually the company. I could easily have done this on my own; however, understanding Benner's theory, my experience, and knowledge allowed me within my scope of practice as an educator to ensure that my students understood how information is found and utilized. Their university education is only the first step, the foundation from which they begin their career.

APN students desire to practice to the full extent of their education and training. There appears to be greater resistance to the role in healthcare practice than in academic settings. The lack of community and professional awareness for the role of the NP has a huge impact on their ability to practice to their full scope. Based on clinical experience, there are many times when valuable time is wasted in clarifying provider information. It is astounding that, given the duration of time NPs have been positioned in Canada and the USA, there is still a misunderstanding of the role. When working with many physicians, the NP students observed GPs as often unsure of the NP role and surprised when they come to fully understand the scope and autonomy that encompasses the role.

4.1. Recommendations

This metaphorical analysis birthed new knowledge and further awareness of the theory-practice gap that exists when transitioning from RN to APN. To help propel the development of the nursing profession, recommendations must be developed and implemented. First and foremost, a clear role definition that informs both the public and health professionals of advanced nursing practice must be produced and disseminated by professional regulatory bodies. Self-reflection and scholarly assignments that require students to address their personal experience and insecurities are recommended to be completed early in their graduate studies. Once self-reflection has occurred, APN students must develop strategies to increase their confidence, even in the face of adversity. Unfortunately, the students in the Theoretical Foundations of Nursing course experienced this opportunity in their final semester. We would also recommend Universities ensure that clinical placements have staff and physicians who are well versed on the role and scope of the APN during this vulnerable period of the APN novice learner role. Finally, a mentorship program could be created where the new APN is paired with an experienced professional counterpart as a peer support for their initial transition. This will help ease role transition and reduce feelings of imposterism on the part of APNs.

5. Conclusion

We used metaphorical inquiry to call out some of the obstacles to APN role transition in New Brunswick, Canada. The resulting metaphors reveal the need for these nurses to be full partners with physicians and other healthcare professionals in redesigning the care delivery system. The APN students will need to continue to clarify and collaborate with those who stand to benefit from their advanced practice role within NB/Canadian healthcare systems. Such collaboration with physicians, APNs (especially NPs), and other health care

professionals as well as with those who are clients in their direct care can assist with overcoming the historical, regulatory, and policy barriers to their full-scope practice.

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