Living with Grey: Role Understandings between Clinical Nurse Educators and Advanced Practice Nurses

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Abstract
Professionalization efforts in nursing have opened up new opportunities for nurses to develop the roles in which they work. One of these roles is advanced nursing practice. However, the development of the advanced roles, with their aims of making an advanced contribution in education, administration, research and practice, results in role overlap and confusion. This paper presents the findings of a qualitative study that explored the ways in which nursing educators understand, value, utilize and interact with nurses in the advanced practice role. Data were collected among nurse educators and advanced nurse practitioners in an urban, acute care setting. The findings demonstrate how nurses in potentially conflicting roles differentiate themselves and define their job duties. Organizational supports for implementing clear advanced roles are suggested, adding to the knowledge upon which nursing administrators can base their strategic human resources decisions.

A review of the history of nursing clearly demonstrates the movement to raise the status of the discipline through professionalization (Coburn 1988). Recently, changing organizational structures, emerging healthcare legislation, increasing shortages of qualified healthcare personnel and an expanding body of nursing

research evidence have necessitated changes in nurses' approaches to practice. These changes offer new opportunities for nurses to develop the roles in which they work. One of these roles is advanced nursing practice. Advanced nurse practitioners (ANPs) perform not only direct patient care but also administration, research and teaching relevant to nursing care delivery. Despite the potential contributions of this extended nursing role, its successful implementation is hindered by role confusion between existing educator roles and new advanced practice roles. With this in mind, the aim of this paper is to explore how ANP roles are understood and differentiated, with a particular emphasis on the relationship between nursing educators and advanced practice nurses.

Professionalization

In the sociological literature, nursing is described as a semi-profession (Freidson 1970; Turner 1987; Rossides 1998). A professional occupation has certain distinguishing features. Professions possess a body of specialized knowledge and seek to build that knowledge through research (Blane 1982). They are self-regulating and independent, and are guided by a code of ethics that describes their commitment to others. It has been argued that nursing already possesses these attributes (Keogh 1997), but debate about the status of nursing continues, centred around the concept of autonomy/independence in practice.

Identifying the independent nature of nursing and its unique contribution in healthcare delivery has been a key focus in the discipline of nursing. In the past, nurses had to move away from the bedside into management, teaching or research in order to progress professionally (Parkin 1995). Current efforts to build autonomy into nursing practice focus on relocating the practitioner back into the clinical area (Storch and Stinson 1988). Advanced nursing practice has been a key strategy for accomplishing this. The new advanced nursing practice roles are intended to function with increased clinical discretion, greater professional responsibility and broad involvement in direct care, research, management and policy making (Parkin 1995) while maintaining proximity to the clinical setting.

Understanding Advanced Nursing Practice

Advanced nursing practice is an umbrella term for various roles that incorporate highly developed knowledge and skill relevant to a particular clinical area. In Canada, the *clinical nurse specialist* (CNS) is the most common of the advanced roles, although the specialty *nurse practitioner* (NP) is on the rise (CNA 2002). It is generally differentiated from the role of the "expert nurse," which is characterized by many years of experience, as advanced nursing practice incorporates theoretical aspects of practice in addition to the experiential (CNA 2002). Usually, advanced nursing practice requires graduate education in nursing. While both the CNS and NP roles function within direct care, education, research and administration, they

may do so to differing degrees. Both ANP roles are said to function from a strong nursing perspective (Wright 1997), but NP roles are focused on providing an advanced level of direct care, while CNS roles typically include a greater emphasis on education, administration and research. The debate about what the label "advanced nursing practice" really means is ongoing (Colyer 2004).

Role Boundary and Acceptance Issues

Just as the distinction between the two ANP roles is unclear, the shared emphasis on education and research between ANPs and clinical nurse educators (CNEs) is a potential source of conflict. Traditionally, continuing education has been handled by clinical nurse educators, experienced nurses who usually have baccalaureate preparation in nursing. It is often associated with the repetition of basic skills and procedures to maintain currency in practice (Binger and Huntsman 1988). Puetz et al. (1988) envisioned a greater purpose for continuing education, moving beyond the maintenance of basic skills to using it as a means of ongoing professional growth. To move continuing education to a higher level, the advanced educational preparation of the ANP may better position the nurse to contribute to professional growth by facilitating the acquisition of new knowledge in a particular clinical setting. The involvement of the ANP within the domain traditionally belonging to the nurse educator serves to confuse the roles.

Solutions to enhance the professional status of nursing, such as advanced nursing roles, do not always incorporate the paradigms of nurses from different educational and experiential backgrounds (Keogh 1997). The emphasis on theory development and research in nursing has alienated many bedside nurses. "There has been an anti-academic bias within nursing which is now only beginning to be overthrown. … The bright, gifted and intelligent nurse is frequently the topic of criticisms by qualified clinical nursing staff and heeded as unlikely to be proficient in practice" (Rutty 1998: 248). As targets of this discrimination, ANPs must work in ambiguous positions, deal continually with resistance and define, negotiate and explain their roles, sometimes on a daily basis (Martin 1995; Brown and Draye 2003).

Nevertheless, it is still anticipated that advanced nursing practice will not only enhance the professional status of nursing but also improve the quality of healthcare (DeBourgh 2001). It may be that advanced practice nurses are the ones best positioned to bridge the theory–practice gap by mediating between the research-producing academic world and the practice world of frontline nurses (DeBourgh 2001). For these reasons, there is value in studying how advanced practice nurses are able to negotiate their roles vis-à-vis other nursing roles in order to make their contribution. There is a need to understand nursing workforce arrangements in order to "ensure greater coherence and clearer lines of nurses' roles and responsibilities" (Pearson 2003: 625).

Study Setting

The setting for this research was a 600-bed tertiary care hospital in Alberta. The hospital is a regional referral centre caring for high-acuity patients in a wide variety of specialty areas. At present, most inpatient units in the hospital have an associated clinical nurse educator. As well, the number of advanced practice nurses is rising, with ANPs now practising in women's health, cardiology, geriatrics and intensive care. Nurse practitioners are increasing in number, while clinical nurse specialists are declining. Senior hospital administrators have expressed interest in promoting professional nursing practice and, therefore, in clarifying, understanding and appropriately expanding the ANP role in the institution.

The researcher's interest in professionalization and advanced nursing practice, coupled with the practical information needs of senior hospital administration, gave rise to the opportunity for a collaborative research project. Collaborative academic/organizational research projects are becoming more common as a means of generating knowledge that is both methodologically sound and contextually relevant (Golden-Biddle et al. 2003).

Study Methods

This study can be defined as an exploratory qualitative study, the purpose of which is to examine a particular experience and discover the perspectives of the people involved. The methodological simplicity of this type of research makes it feasible for practitioners to pursue questions of immediate, practical importance (Caelli et al. 2003).

Ethical approval for the study was granted by the researcher's university as part of a course on qualitative research methods.

Potential study participants were identified by the hospital's chief nursing officer. Each received a memo from her explaining the study and inviting participation in an interview. Shortly after the memo was sent, the researcher (author) contacted prospective respondents to ascertain their willingness to be interviewed. A purposeful convenience sample of six nurses (a sample that included all knowledgeable, available professionals employed in these positions at the time of the study), including four CNEs and two ANPs, were interviewed. Of the educator group, three had baccalaureate degrees in nursing and one had a master's degree in nursing. Three of the four educators also held additional clinical certification. The length of experience of the educator group ranged from 2.5 to 13 years. One of the two ANPs functioned in a CNS role, while the other was a nurse practitioner. Both had long histories in the advanced practice role (>10 years), and both had experience in both the NP and CNS roles. The two ANPs held master's degrees, and although both had nurse practitioner experience, only the one

currently working in the NP role had advanced, post-master's degree preparation for that role. Both had administrative experience.

Data were collected using semi-structured interviews with respondents who currently function in either of the two role categories. Respondents were asked about their educational level, years of experience, current role responsibilities, reporting relationships, working relationships, role conflict between their role and the other (ANPs with CNEs and vice versa) and barriers to the implementation of clear roles. Flexibility in the interview structure allowed for the exploration of details unique to each respondent's experience. As well, an opportunity was provided for respondents to add additional pertinent comments at the end of the interview. The interviews, lasting between 25 and 50 minutes, were audiotaped and transcribed.

Interview data were analyzed by coding key words and phrases in the transcripts and collapsing these into general categories. Coding is "the process of identifying persistent words, phrases, themes, or concepts within the data so that the underlying patterns can be identified and analyzed" (Morse and Field 1995: 241). During coding, the researcher in this study became familiar with the interview data by reading and re-reading the transcripts and highlighting interesting words or sections of text to be dealt with in later analytic stages (Mayan 2001). Going through the data a second time, she then extracted the highlighted sections of text and grouped them into categories and subcategories. The analytical strength of each category was judged by determining how clearly the data excerpts fit together and described the category. Categories were then integrated to illustrate the "big picture" (Mayan 2001).

In keeping with convention for ensuring rigour in the qualitative research process, the quality of this study can be confirmed in a number of ways. Appropriate sampling, "consisting of participants who best represent or have knowledge of the research topic" was an important initial step taken to ensure rigour in this study (Mayan 2001: 27). As well, despite the small sample size, there was tremendous unity in the responses of the participants, indicating data saturation (sufficient data to support category construction). Finally, peer review was utilized to confirm the conclusions of the study. The findings were presented to the nursing leadership team at the study hospital and acknowledged by them as accurate. As well, although the data analysis was carried out by a single researcher, the results were reviewed by two of the researcher's university-based research mentors and deemed to be appropriate.

Findings

The goal of qualitative research is not generalizability across all settings but rather

illumination of a topic that allows the reader of the research report to relate to and transfer the findings to contexts outside the study situation. Transferability is possible when the research provides clear and detailed information and rich description about the issue (Mayan 2001). The interviews in this study yielded very rich and cohesive data, generated by nurses experienced in their roles and thoughtful about the issue of role differentiation. After establishing from the data that study participants acknowledged the existence of role confusion in their own experience, three main categories emerged, including how the informants differentiated their roles, what their job duties were and how the organization supported successful role implementation. These categories and their subcategories are described and illustrated below.

Ways that roles are differentiated

The respondents revealed a number of means that were used to differentiate their roles from others.

Prior experience

Tremendous emphasis was placed on prior work experience as a means of determining role duties. Skills and tasks associated with prior roles, such as management, research or clinical activity, became, by default, part of the incumbent's existing position.

> I do some of the more clinical aspects because I've been more recently in the clinical areas working as a staff nurse, whereas [our ANP] has been out of the clinical area for a long time. (CNE)

Negotiation and ongoing communication

For these respondents, roles were differentiated and established through negotiation when new roles were initiated or new people filled existing roles.

> The new CNE came to talk to me and … I said, you know, I've never done this, this and this. … I don't think we've ever really differentiated the roles here. I just said, "Here's what we're doing." She just didn't want to step on my toes, either, in case there was something I saw as my territory. (ANP)

After initial negotiations launched the role, ongoing discussion and communication was mentioned by many of the respondents as vital to continuing in conflict-free roles.

Workload

To some extent, the high volume of work to be done mitigated any potential role conflict. One ANP suggested that "there's enough work, in all my experiences in

the past, there's more than enough." One CNE mentioned that she was glad to hand over certain responsibilities, such as establishing best practices, "… because I don't have time to look it up. … we just don't have that kind of time." Duties were negotiated on a daily basis, depending on workload issues. An educator said that she and the ANP in her program

> work as a team so that if we get triple booked, so there's two of us and three things to be taught that day, so we divide out that one will go to the committee meeting. … so maybe I'll go to the [clinical] committee and she'll teach and then I'll come back and maybe pick something up so we work well as a team to make sure that we get it all done.

Visibility

The extent to which CNEs and ANPs were visible to staff nurses or each other was a role-defining feature. In addition to being a defining feature, visibility was sought because of its association with credibility.

> Because our CNS is so busy, she's not seen very much on the wards and she's not doing hands-on care so she's not as visible unless I bring her into orientation and introduce her. I think in terms of credibility, the staff nurses wouldn't really go to [her]. (CNE)

Because of its importance, visibility became a key factor in how role responsibilities were practically established.

> I think it's [visibility] very important … to be recognized as having clinical expertise and how are you going to demonstrate that unless you are being asked a question or being involved in a situation that offers the opportunity to be able to demonstrate your expertise. … If I had a goal it would be to increase the interactions, visibility. (ANP)

Professional philosophy

Maintaining a professional nursing profile was important in role delineation. When discussing opportunities for nurses to create enhanced roles because of declining numbers of residents, a clinical educator said:

> On [one service] you know we lost most of our residents, so [a physician] started asking us if we'd start doing more … and the unit manager we had at the time thought, "OK," so I had to stop her and tell her, "Doctors do not decide nursing practice, nurses decide that and we don't do things because there's a doctor shortage."

Two educators, with experience working in an area with nurse practitioners, have noticed a professional division between the nurse practitioners and other nurses:

> Our NP we don't often refer to. She sticks with the doctors. Like, nursing-wise, none of the nurses would ever ask her to help with any nursing thing and she keeps herself totally separated from that. She's not here to help the nurses that way. [Interviewer: Do people see her as a nurse?] I don't think so. She's in a different role.

One ANP acknowledged the medical nature of her work but found a way to balance enhanced clinical duties with professional nursing. In describing her role, she said, "I am a nurse first; some of the things I bring into that practice are looking at … continuity and coordination, … those things that I think are really nursing purviews."

Hierarchy

All participants were asked whether a hierarchy existed that influenced the way in which roles were understood. Interestingly, all but one respondent indicated that there was no hierarchy. However, many responses demonstrated that a hierarchy was indeed in place and that the nurses differentiated themselves on the basis of education, knowledge, specialty practice, reporting relationships, union affiliation and even attire.

> I would say that my colleagues and I did see it as a hierarchy. We were master's prepared and we saw what we did, we perceived what we did was different from that of the CNEs. And of course, most of us were also in specialty practice. (ANP)

As well, more educated respondents considered themselves in a superior position and noted education to be a factor in how capably work was approached.

> I'm trying to come up with something that people are going to be compliant with and are going to use and make it in a language they can understand. … We have a lot of nurses who don't really have a handle on evidence-based practice, research, statistics, best practice.

It seems intuitive that reporting relationships would be strongly related to perceptions of hierarchy. In most areas, both CNEs and ANPs reported to managers. These nurses were content with the existing reporting structure because it fostered cooperative teamwork. Educators described situations in which they resisted attempts to put ANPs in supervisory positions, while ANPs indicated an openness to exploring the possibility at some point.

In situations where CNEs reported to ANPs, the supervised attempted to downplay the status of the supervisor by talking about teamwork, emphasizing accountability to a manager and drawing attention to the superior clinical expertise of the CNE.

Union affiliation was mentioned as a determinant of role responsibilities and status:

> I think the biggest difference is union vs. non-union. I seem to be privy to information that they're [the CNEs] not, so I guess that does give me a bit of a, there's a difference between the roles. (ANP)

As well, the fear of further unionization contributed to role manipulation. ANP incumbents spoke of being given specific duties in order to demonstrate their involvement in administration and thereby qualify for a union-exempt position.

Finally, educators and advanced practice nurses seemed to be differentiated by their attire. Wearing street clothes, a lab coat or a uniform identified certain roles and was symbolic of proximity to the clinical setting. Attire was, therefore, indicative of hierarchical position based on clinical involvement.

Unit/Program needs

The staff and patient needs in a given care area were important factors in shaping nurse educator and advanced nursing practice roles. Respondents emphasized the importance of clarifying the contribution that an ANP should make in fulfilling the unique goals of each program. In turn, the different expectations of each program led to idiosyncrasies in role duties across care areas.

Job descriptions

Surprisingly, job descriptions were the least-used strategy for distinguishing roles. Lack of communication about the role descriptions, lack of role differentiation within the job descriptions and unrealistic role expectations were cited as reasons for their lack of helpfulness in distinguishing roles.

> I think that there has been a lot of good work done in the region, looking at position descriptions, but I think we've been stymied in the roll-out of those things. It's fine to have these things on paper but unless you've really brought them out, … (ANP)

> I just gave some feedback on the CNS role description and I still think it's a walk-on-water job. (ANP)

Role responsibilities

Despite the role confusion, the strategies employed by these nurses to differentiate roles seem to be somewhat effective in clarifying role boundaries. The nurses interviewed presented a fairly consistent understanding of the job duties that have been informally allocated to the different roles.

Nurse practitioners were described, or described themselves, as having a mainly physician-oriented patient care component. Daily consultations, medication and treatment reviews and updates and follow-up care are the main functions of the role.

> We also do a consultation service here at the hospital and that's probably where I'm more involved now in my NP role, so either inpatient consultations [or emergency], so then I do the full consultation. I hate when people say "like a resident," but I guess, though, it is. I do a history, a physical, I put together an issue list, usually review them with the attending physician. (ANP)

The clinical nurse specialists had, and were expected to have, a less clinical role, taking instead responsibility for the development of nursing practice in their specific clinical areas, including program planning, policy, procedure and practice guideline development and research utilization. From their perspectives, "the clinical needs of the unit led more towards [making changes to] practice, guidelines, structure."

In contrast, CNEs concurred that they dealt with issues of daily practice, including routine problem solving and basic staff education. Product use and skills certification (e.g., CPR, fire response, IV insertion) were key role responsibilities. Their interest in the "day-to-day" was central to how they understood their roles.

Interestingly, although the roles seemed to be understood as quite distinct, the interdependent nature of the CNE and CNS roles emerged from the interview data. Working together, the roles formed a two-layer model for translating new knowledge from the external environment to the frontline staff. The CNS's work in reviewing the literature, establishing best practices and acquiring new research knowledge was implemented in the clinical area through the practical efforts of the CNE.

Organizational supports for effective role implementation

The positive and negative effects of organizational characteristics played a part in the implementation and definition of roles. Based on the comments of the nurses in this study, leadership, organizational structure and stability, policy and regulatory frameworks and resource use were key influencing factors in role delineation.

Leadership

Successful role relationships were associated with clear leadership and vision. Leaders who dealt with role issues proactively or who were able to respond to role-related questions enabled role clarity and cooperation. The significant responsibility of the program director or unit manager to "set the tone" and keep the roles "on track" was emphasized.

Organizational structure and stability

For longer-term employees, changes in leadership and organizational approaches to care delivery over time had a direct impact on the clarity of the roles in which they functioned.

> And that varied [my role] depending on how the program was organized. … for a while there, we used to switch [directors] quite regularly, so depending on what emphasis the patient care director saw, the emphasis would change. (ANP)

> We've gone from a decentralized program structure, where all of the interdisciplinary team was decentralized to a program, back into a centralized departmental structure, except there's one group that doesn't have a department – nursing. Nursing has been lost again. That's where these ANP roles have been lost again. (ANP)

Policy and regulatory frameworks

In addition to stating the need for adequate job descriptions, participants expressed hope that future national and provincial guidelines would set standards and contribute to role clarity for ANPs and CNEs.

Resources

Several respondents mentioned the importance of both financial and human resources to the successful implementation of advanced practice roles. Ongoing budgetary constraints and the associated shortage of nursing personnel were cited as fundamental barriers to the creation, clarification and use of various nursing roles. Existing personnel with global responsibilities, who were intended to be supports to developing advanced practice in the hospital, were viewed positively but were seen as destined to be ineffective because of overwork. For example, the nursing professional practice leader for the institution was highly valued, although her role was not seen as ideally structured:

> There is another walk-on-water role – one person for a few thousand nurses. But there needs to be something there that is more structured.

> Our professional practice leader doesn't have line authority to put things into place. (ANP)

Generally, although the CNEs and ANPs in the study were able to negotiate and manage role boundaries creatively in their own clinical areas, they also looked to organizational supports for role implementation and definition.

Discussion and Implications

The growing attention given to the advanced nursing practice role reflects the goal of nursing to enhance its professional status. However, the development of the advanced roles, with their aim of making an advanced contribution in education, administration, research and practice, can result in role confusion and overlap. The research presented here reveals that there is indeed role confusion in this practice setting and demonstrates how nurses in potentially conflicting roles differentiate their job duties.

CNEs and ANPs in this study utilized an elaborate, informal system of role differentiation, based on prior experience, role negotiation, workload sharing, program needs and hierarchical distinctions. Roles were often designed according to the unique backgrounds and skills of role incumbents, although specific program needs also influenced role delineation. However, the ad hoc nature of role delineation based on individual experience and unique program goals contributed to inconsistencies in role responsibilities across care areas. Interestingly, the strategy of determining roles based on workload was effective in allocating duties between the parties, but also had the effect of blurring the role boundaries further. Almost all the respondents denied the absence of a hierarchy between the CNE and ANP roles but subtly conveyed an elaborate system of hierarchical differentiation based on education, knowledge, specialization, clinical involvement, reporting relationships, union affiliation and attire. It is perhaps not surprising to find that advanced practice nurses see themselves as hierarchically superior, given their advanced level of education and their more strategic responsibilities. Conversely, some CNEs did not always understand the role of the ANP and maintained their self-perceived clinical superiority by being critical of ANPs' non-visible contributions to care. Interestingly, it was important to both ANPs and CNEs in the study to be respected and seen as clinically knowledgeable; attempts were made to demonstrate this, sometimes at the expense of work more suited to their role. The way in which roles are structured – for example, union affiliation and reporting relationships – can have significant ramifica-

tions for the way in which the roles are differentiated. As well, as the participants in this study revealed, even seemingly insignificant role requirements, such as the dress code, can be important in how the different roles are viewed.

table 1 **Main categories and subcategories**

1. Ways That Roles are Differentiated
   - Prior Experience
   - Negotiation and Ongoing Communication
   - Workload
   - Visibility
   - Professional Philosophy
   - Hierarchy
     - Education and Specialization
     - Knowledge
     - Reporting Relationships
     - Union Affiliation
     - Attire
   - Unit/Program Needs
   - Job Descriptions
2. Role Responsibilities
   - Nurse Practitioners
   - Clinical Nurse Specialists
   - Clinical Nurse Educators
   - Interdependent
3. Organizational Supports for Effective Role Implementation
   - Leadership
   - Organizational Structure and Stability
   - Policy and Regulatory Frameworks
   - Resources

Professional advancement through continuing education was noted to be a strong feature in the responses of the nurses in this study. Clinical nurse educators took on the responsibility of basic skill maintenance and dealt with daily practice issues, while advanced practice nurses saw their role as fostering ongoing professional growth and enhancement through the sharing of specialized knowledge. Clearly, the respondents in this study felt that one benefit to having the ANP role in the clinical setting was the ability to bridge the theory–practice gap by retrieving, understanding and translating research and best practice knowledge for adaptation to the practice setting. This is a key function in raising the professional status of nursing, as it demonstrates the existence of unique nursing knowledge and its usefulness at the bedside.

The nurses in this study demonstrated a remarkable ability to negotiate the grey areas in their roles and, to a large extent, develop functional relationships that advance nursing and patient care. They did, however, call for greater clarity and enhanced organizational support for role implementation, such as visionary leadership, adequate resources, organizational stability and strengthened policy frameworks. The successful role negotiation shown in this study is a testament to nurses' well-developed resourcefulness and accountability. However, nurses are required to interact with complex systems as they accomplish their work and rely on strong organizational supports to enable their practice. For these reasons, it is critical that health services administrators know how these roles are understood and what potential there is for more effectively structuring and utilizing them.

There is a need to understand the ANP role more clearly, and the ongoing work of professional associations and employer organizations will assist in clarifying these roles in the future. The findings of this small-scale exploratory study may assist in motivating and focusing this work further. As well, because ANPs function within administrative and direct care domains in addition to the educational domain, it would be useful to investigate role understandings between ANPs and administrators and ANPs and physicians.

Ultimately, the value in the professionalization agenda is its potential to highlight the contribution that nursing makes to patient care. The findings of this study suggest that there is a unique role for advanced nursing practitioners and that further role definition would allow them to make their contribution more effectively.

> I really think that it's important for the CNEs, the CNSs and for the nursing staff to have a clear idea of what everybody's role is. It would be something that would help organize care and the direction for change in care if we had a clear idea of everybody's role.

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