Acute Care Pediatric Nurse Practitioners as Leaders: Perceptions, Self-Identity, and Role Congruity

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Acute Care Pediatric Nurse Practitioners as Leaders: Perceptions, Self-Identity, and Role Congruity

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Abstract
Introduction
This study aimed to gain an understanding of practicing acute care pediatric nurse practitioners’ (AC-PNPs’) perceptions of themselves as leaders in both clinical and professional contexts.

Method
This qualitative study was conducted at a midwestern quaternary care children's hospital. Cultural domain analysis, semistructured interviews, and free listing techniques were employed to identify areas of consensus and variation among a convenience sample of AC-PNPs.

Results
Findings demonstrated the AC-PNPs have a limited self-view of leadership.

Discussion
Nurse practitioners need additional leadership capacity and capability building during graduate education, the transition to practice, and throughout their careers.

Key Words
Advanced practice registered nurse, nurse practitioner, leadership, educational preparation, qualitative

INTRODUCTION
The pediatric nurse practitioner (PNP) movement began in 1964, with Loretta Ford pioneering the first PNP program in 1965. The original objective of the program was to train nurse practitioners (NPs) to meet the increasing demand of health care for children unable to be met by physicians in the primary care setting (Murphy, 1990). Since the inception of PNP practice, it has continued to grow with a nearly ubiquitous presence across all pediatric health care delivery settings, including acute, specialty, and critical care.

The care of children has evolved because of advancements in medical technology, changes in insurance and health care coverage models, and the mandatory limitation of duty hours for medical trainees. These changes, along with the establishment of the definition and certification for the acute care pediatric nurse practitioner (AC-PNP) distinction in 2005 by the Pediatric National Certification Board and the growing number of specialized AC-PNP graduate programs nationwide, have allowed for the exponential growth of roles and practice opportunities for AC-PNPs (Reuter-Rice, Madden, Gutknecht, & Foerster, 2016; Simone, McComiskey, & Anderson, 2016; Sorce, Simone, & Madden, 2010; Verger, Marcoux, Madden, Bojko, & Barnsteiner, 2005).

The National Organization of Nurse Practitioner Faculties is the leading organization for excellence in NP education in the United States and has developed a set of core competencies for NPs. These competencies are key drivers of the graduate program curriculum and include competency areas of scientific foundation, leadership, quality, technology, policy, health delivery system, ethics, and independent practice (National Organization of Nurse Practitioner Faculties, 2017). In the rapidly changing health care landscape, the ability to lead interprofessional teams to improve health care delivery and patient outcomes is more critical than ever. The Institute of Medicine’s (2011) call to action stated that nurses need to transform leadership by rising to the challenge of leading not only ourselves but rather the entire health care system. Despite the need for and focus on leadership as an expected competency for entry-level NPs, there is a paucity of intentional curriculum, assessments, and outcome measures of leadership skill acquisition across higher education institutions and entry into NP practice (Joyce, 2001; Judkins & Friedrich-Cuntz, 2007; Watson, 2008).
There is a lack of consensus regarding an encompassing definition of leadership, especially as it relates to NPs. Despite a plethora of leadership-centric literature describing a wide range of partial definitions, competencies, roles, and qualities of an NP leader, such as role model, mentor, change agent, and advocate, a lack of concordance persists of a mutually accepted definition of what leadership is in reference to an NP (Gardenier, 2016; McArthur, 2006). To complicate the matter further, NP practice is heterogeneous across settings and domains, including education, research, practice, organizational, regulatory, managerial, and so on (McArthur, 2006; Watson, 2008).

METHOD

This descriptive study aimed to understand practicing AC-PNPs’ perceptions of themselves as leaders, in both clinical and professional contexts, and to explore the multidimensional relations between these perceptions and their own leadership practices. The study used one-on-one interviews as the primary data source. The data collected focused on perceptions and experiential aspects of NP practice within their clinical and professional contexts. Institutional review board approval was obtained.

Setting, Recruitment, and Participant Sample

The study occurred at a large academic, quaternary children's hospital in the midwestern United States. The participants were a convenience sample of AC-PNPs who practice in the critical care setting, inclusive of a 72-bed critical care unit with medical, surgical, and cardiac patient populations with a 24-hr/day and 7-day/week AC-PNP coverage model. At the time of recruitment, there were 17 full-time critical care AC-PNPs (study's principal investigator excluded) and one AC-PNP postgraduate critical care fellow whose experience ranged from less than 1 to 18 years of NP practice. All participants identified as female and ranged from the ages of the late 20s to 60 years. Inclusion criteria were any credentialed AC-PNP actively practicing within the pediatric critical care setting at the institution. Subjects were recruited via an email invitation to participate in the study voluntarily. Consent was waived and implied by the voluntary nature of participation. A total of 7 of 17 (41%) AC-PNPs were successfully recruited and completed the interview process.

Data Collection

The primary data source was one-on-one interviews with the participating NPs led by a single investigator (T. P.). The interviews were semistructured and conducted using the free listing technique. The interviewer asked participants about clinical and professional situations in which the NP feels they are a leader and, alternatively, not a leader, and what contributed to their success as a leader (Box). Clinical leadership refers to clinical practice, inclusive of being part of an interprofessional team. Professional leadership refers to the other pillars of professional practice, including, but not limited to, education, research, quality improvement, administration, and participation in professional organizations. The interviews were audio-recorded and transcribed to produce textual data.

BOX

Interview prompts

1. Describe a situation when you are most comfortable or successful in the clinical domain.
2. Describe clinical situations in which you feel you are a leader.
3. Describe clinical situations in which you feel you are not a leader.
4. Describe professional situations in which you feel you are a leader.
5. Describe professional situations in which you feel you are not a leader.
6. Describe what contributes to your success as a leader.
Data Analysis

Data were analyzed to gain insight into the perception of NP leadership in both the clinical and professional contexts as described, experienced, and reported by the participating NPs. We conducted an inductive thematic analysis of all qualitative data using NVivo (version 11) software and analytic techniques recommended by Braun and Clarke (2006). First, general thematic codes were identified, followed by the addition of subcodes to each theme, and finally, codes were collapsed into the limited number of themes reflected here. An interactive reading of the texts for identification and interpretation of patterns of cognitive schema and thematic trends occurred, first independently and then collectively by four investigators, inclusive of one PhD-prepared AC-PNP (C. S.), one MSN-prepared AC-PNP (K. M.), one MSEd-prepared pediatric critical care physician (T. P.), and one PhD-prepared medical anthropologist (K. O.).

RESULTS

Leadership within the clinical realm was referenced more frequently and with more specific examples than leadership within the professional context. There was a strong group consensus that NPs provide significant leadership within the traditional understanding of nursing roles, specifically regarding communication with and education of staff registered nurses and graduate NP students. The NPs voiced a nuanced understanding of the nursing role, felt a sense of relatedness to nurses, and stated their ability to function as a “bridge” between the nursing and the medical providers.

Alternately, there were notable gaps identified in the NPs’ perception of their role as leaders within the broader interprofessional team. Numerous examples were described of conditional leadership in which the NP needs a certain set of conditions to be present to feel they could be a leader. One key condition repeatedly described was the need for psychological safety. Specifically cited was a setting where they can ask questions, advocate for themselves, have a collaborative discussion, and have a trusted individual to “bounce ideas off.” There was a pervasive sense described of waiting to be asked to provide an opinion in lieu of freely sharing their thought process. This sense may be related to what was coded thematically as the need for explicit invitation to participate rather than already feeling a sense of leadership belonging or “fitting in.” Finally, there was near-ubiquitous mention across all interviewees regarding the importance of familiarity, trust, and interpersonal relationships as positively correlated to team functioning and the ability to actualize one's leadership.

Within the frame of leadership readiness, NPs feel most prepared if they are “experienced,” especially in a time (i.e., years of experience) and repeated clinical exposure. Specific actions described positively correlated with the perception of readiness for clinical leadership include comfort and expertise with a specific disease process, adequate preparation time, and a patient’s course aligning with the expected trajectory.

After analysis, the themes were organized into frameworks of facilitators and barriers to the perception of leadership actualization (Table). Specific facilitators include clinical acumen, psychological safety, explicit sense of inclusion and belonging, and knowing one's value. In addition, the presence of balanced practice parameters inclusive of clear boundaries, support structure, and resources balanced with independence and autonomy, and an optimal environment inclusive of the components of team structure, team members, and practice setting dynamics.

TABLE. Barriers and facilitators of the perception of leadership actualization

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Facilitators</th>
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<tbody>
<tr>
<td>Inherent hierarchical imbalance</td>
<td>Clinical acumen</td>
</tr>
<tr>
<td>Overt displays of power/authority</td>
<td>Psychological safety</td>
</tr>
</tbody>
</table>
Clinical knowledge gaps | Sense of explicit belonging
---|---
Limited clinical experience | Balanced practice parameters (boundaries, support, resources, autonomy, independence)
Decreased years of experience | Increased years of experience
| Familiarity, trust, interpersonal relationships

Identified barriers to an NP’s perception of oneself as a leader include their perception of overt and/or inherent authority, power, and hierarchical imbalances. Additional barriers include clinical knowledge gaps, self-doubt, and limited experience in both years, and contextual clinical exposure. The NP-identified barriers were primarily within the clinical domain; however, there were several barriers related to professional leadership as well. The barriers to the enactment of leadership in the professional realm can be categorized into two main themes. The first is the perception of an overall deficiency in leadership opportunities available, and the second is a lack of awareness of the actual leadership opportunities that exist. Stated another way, the NPs interviewed do not think there are many leadership opportunities available, and even when there are opportunities, they are not recognized.

A final notable point requires some brief cultural context. At this children’s hospital, the institutionally assigned team leader of all rapid response team activations is a critical care PNP. Despite this universal clinical leadership role of all PNPs interviewed, not a single interviewee mentioned nor commented on this assigned clinical leadership role.

DISCUSSION
In alignment with existing literature regarding both adult and pediatric NPs, our findings reveal a lack of both appointed and self-recognized leadership roles (Elliott, Begley, Sheaf, & Higgins, 2016; Hurlock-Chorostecki, Forchuk, Orchard, van Soeren, & Reeves, 2014; Joyce, 2001). NPs in this study described their leadership experience as a siloed perspective of influence within the nursing profession by overwhelmingly referencing patient and bedside nursing interfacing experiences rather than interdisciplinary, organizational, or community perspectives. Verger et al. (2005) report the most frequently NP self-identified leadership activities are nursing education, nursing evaluation, discussion of care with patients and families, and alternatively the lowest frequency in initiating and participating in research and physician education. A second study by Watson (2008) describes NP leadership capability as functioning as a role model and mentor; however, solely referencing this role in relation to bedside registered nurses as opposed to other disciplines. In addition, NPs hold the skill set of “living” in both the medical and the nursing worlds, and thus specifically can uniquely identify and impact initiatives surrounding the cost of care as well as patient care models and outcomes (American Association of Colleges of Nursing, 2016). Finally, the sentiment was shared that nursing’s past is holding back potential nursing leaders, and there is a need to preserve the legacy of nursing balanced with embracing change to move the profession forward (Gardenier, 2016).

Hamric and Hanson (2003) describe the need and difficulty in educating NPs for practice reality, including role issues such as professionalism, regulation, and leadership, in addition to scientific foundational and clinical management content. There is a widespread perception that NP graduates go forth into a health care system that does not understand their value and provides little support in learning and assimilating to their new role; thus, NPs need to be armed with the knowledge and skills related to full enactment of their role to manage best and display their position and worth (Hamric & Hanson, 2003; Kelly & Mathews, 2001). Many nurse practitioner education programs focus on clinical preparation and underestimate the importance of leadership skills and role identity development (Hamric & Hanson, 2003; Judkins & Friedrich-Cuntz, 2007). As the American Association of Colleges of Nursing works toward disseminating the updated Essentials for Professional Practice, which
emphasizes the need for intentional education around the domain of personal, professional, and leadership development beginning in entry-level and progressing through advanced-level training (American Association of Colleges of Nursing, 2020).

In addition, there is often the pervasive organizational culture that supports a translation of the clinical hierarchy into the professional realm, thus limiting NP leadership potential both in and out of the clinical domain (Kelly & Mathews, 2001; McArthur, 2006). Finally, NPs perform a wide variety of “invisible work” often within a leadership capacity, such as the creation of trust, mentorship, and relationship building across teams and team members; however, when this work is left unrealized by team members, managers, and organizations, it devalues NP contribution, stagnates NP practice, and hinders the integration and use of NPs as full and equitable team members (Hurlock-Chorostecki et al., 2014).

The data from this study aligned with these global sentiments adds to the understanding of the complexity of NP perception of themselves as leaders and highlights a lack of role congruence with and self-identification of NP leadership. In the setting of the universally assigned clinical leadership role of a rapid response team leader to all study participants, our findings display the notable gap that the PNPs unanimously failed to reference, recognize, or report it as a leadership role. This understanding has numerous implications at educational levels, including higher education institutions and graduate program directors charged with curriculum and organizational levels, including institutions and departments of future NP employment.

A bulk of the barriers to NP leadership enactment are at the organizational level (Elliott et al., 2016); however, the universally assigned leadership role of this group of NPs interviewed stems from the organization suggesting the need to focus not only on leadership capacity but also leadership capability. Leadership capacity encompasses systems at an organizational level, whereas leadership capability refers to individual skills, abilities, attitudes, and competencies (Elliott et al., 2016). Steps toward building leadership capacity and capability, with an intentional balance between the two, are vital to ensure NPs are equipped with the skills to fulfill the demands of the profession, which include any number of leadership roles. These efforts may be limited by the direct competition for a time because of the high number and complexity of clinical loads for practicing NPs, and consideration of how to navigate this notable barrier, such as fostering organizational and managerial buy-in, will be essential (Elliott et al., 2016; Joyce, 2001). Experience portrays fewer opportunities for promotion and professional advancement exist in a primarily practice-based role, and so attention to more diverse ways of leadership demonstration, such as joint appointments, professional portfolios, clinical ladders, promotional pathways, and mentorship infrastructure, to name a few, should be considered (Chamblee, Dale, Drews, Spahis, & Hardin, 2015).

It is unclear as to what extent the PNPs primarily identify as clinicians, and relatedly, if and how much they view their leadership capacity extending beyond the clinical sphere. This siloed perspective of leadership existing only within the context of the nursing discipline appears to be related to the extension of the traditional clinical hierarchy into other domains of professional influence, which has also been suggested by the literature (McArthur, 2006).

Limitations
The primary limitation of this qualitative study is the convenience nature of the small sample size of seven PNPs, all arising from a single group of critical care AC-PNPs from a single institution. This limitation is balanced by the wide range of experience in years of experience represented in the sample, and one of the largest and longest-standing critical care PNP groups nationwide. In addition, the principal investigator is a member of this AC-PNP group participating in this study, which poses a theoretical risk of bias; however, this was explicitly addressed by the non-NP members of the research team.
CONCLUSION

Although this is a small study, it suggests that NPs need a broader conception of leadership, and there are opportunities to enhance leadership capacity and capability during graduate training programs, transition into practice, and throughout their careers. More pedagogical research is needed surrounding specific strategies to enhance leadership development. The data suggest that NPs associate leadership with years of experience in clinical practice; thus, educators should consider transitioning from a time-based to a competency-based understanding of leadership. American Association of Colleges of Nursing’s new draft Essentials is laying the groundwork to implement leveled leadership development across entry and advanced practice nursing programs (American Association of Colleges of Nursing, 2020).

Within clinical practice settings, there are many opportunities to aid in NPs development of leadership capacity. Flattening the hierarchy in academic health care centers has been touted as a way to improve patient safety (Appelbaum, N. P., Dow, Mazmanian, Jundt, & Appelbaum, E. N., 2016; Walton, 2006; Whitelaw, Kalra, & Van Spall, 2020), and our data suggest this may also be important in NP leadership development. It is important for NPs in clinical practice settings to have access to promotional pathways and professional advancement, and diverse opportunities to demonstrate leadership. These practice-based recommendations, in combination with proposed changes to graduate education, may yield a synergistic and positive impact on nursing leadership actualization.

Institute of Medicine’s (2011) call to action for nurses to transform leadership by rising to the challenge of leading not only ourselves but rather the entire health care system. NPs contain the skill set of “living” in both the medical and the nursing worlds and thus are uniquely positioned to impact the cost of care and patient care models and outcomes (American Association of Colleges of Nursing, 2016). NPs are ideally situated to influence positive changes in practice and to bridge the gap between nursing and medicine further; however, NPs may be lacking in leadership competencies necessary to successfully meet this challenge (American Association of Colleges of Nursing, 2016; Judkins & Friedrich-Cuntz, 2007). In addition, NPs often practice within nursing models that fail to pragmatically align with real-world NP practice leading to a wide theory-practice gap and further limit NP capacity for leadership (Elliott, Walden, Young, Symes, & Fredland, 2017). Failure to appropriately identify and maneuver through the barriers to the actualization of NP leadership risks limiting the extent to which NPs can become strategic leaders toward advancement, risk sustainability of the profession, and slows optimization of health care delivery.

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