

The Nurse Practitioner: Historical Perspectives on the Art and Science of Nurse Practitionering

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CHAPTER OBJECTIVES

1. Identify factors that contributed to the evolution of the nurse practitioner role in the United States.
2. Describe the key attributes that make the nurse practitioner role unique.
3. Identify the different educational pathways that are shaping the curriculum in nurse practitioner programs.

These are heady days to be a nurse. With a 2-year-old mandate from the Institute of Medicine calling for us to practice at the highest level of our profession, achieve independence from physician oversight as we diagnose, prescribe, treat sick patients, and care for patients with increasingly complex cases, nurses are poised like never before to continue their march toward the center of healthcare delivery.

It's high time. More and more of us are turning to nurse practitioners for our primary care. And it's not just because they're easier to get appointments with (they are),

spend dramatically more time with patients (they do), have much of the same prescriptive powers as physicians (though not, as yet, in Virginia). It's not even because they get excellent training as healthcare generalists or that advanced practice nurses, like NPs, are everywhere, with some 9,000 new ones graduating each year and joining the ranks of the nation's roughly 140,000.

It's because the care that advanced practice nurses give—at physician-led offices, minute clinics, rural healthcare centers, and bustling urban hospitals—is second to none.

—Dr. Dorrie Fontaine, Dean, University of Virginia School of Nursing (reprinted by permission)

Nurse practitioners (NPs) have reached a tipping point as a profession (Buerhaus, 2010). Malcolm Gladwell (2000) states that the “tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire” (p. 12). We are aware that we have reached a time in which nurse practitioners have been given the opportunity to shine and to experience growth professionally. Nurse practitioners provide a solution to some of the issues affecting health care in the United States today. In 2010, the Institute of Medicine (IOM) released a report that identified the need for nurses to be placed at the forefront of health care. The report strongly recommended that advanced practice registered nurses—including nurse practitioners—be allowed to practice to the full scope of their abilities, and that barriers be removed to enable moving forward. The need for NPs is growing as we consider the IOM’s recommendation and the large population of aging baby boomers, which is anticipated to increase the use of the healthcare system (Centers for Medicare and Medicaid Services [CMS], 2011; Van Leuven, 2012). In addition, the Patient Protection and Affordable Care Act signed in 2010 instituted comprehensive health insurance reform and has the potential to expand health-care insurance coverage to 48 million uninsured Americans (Kaiser Family Foundation, 2014). Researchers have validated the cost, quality, and competence of NPs who provide primary care, and patient care outcomes are similar to those of primary care physicians (Hamric, Spross, & Hanson, 2009; Laurant et al., 2005; Mundinger et al., 2000; Wilson et al., 2005). Medical economist and health futurist Jeffrey C. Bauer (2010) reviewed evidence-based data to illustrate how NPs functioning independently can meet the need for cost-effectiveness of healthcare reform while providing high-quality care for patients in multiple settings.

Many important research articles published over a span of 4 decades speak to the excellent quality of care nurse practitioners provide (American Association of Nurse Practitioners [AANP], 2010b). At least 89% of NPs are educated to provide primary care (AANP, n.d.); however, in some states, many NPs do not work in primary care, possibly because of the state’s requirements for collaborators and written agreements with physicians. Many states have recognized these barriers and have removed such requirements, and many insurance companies now include NPs in their provider networks. So, will we meet the near-future needs for healthcare providers? The answer appears to be a resounding yes. In an age-cohort regression-based model, RAND Health projected the future workforce of NPs will grow to 244,000 by the year 2025 (Auerbach, 2012). Clearly, there is a need to fully understand the role of the NP in order to advance professionalism and unity of the NP workforce. Pertinent issues must be discussed as part of the education of student NPs as well as among NPs already in practice.

HISTORICAL PERSPECTIVE

The role of the nurse practitioner was developed as a way to provide primary care for the underserved. The role is typically described as having emerged during the 1960s, yet Lillian Wald’s nurses of the late 1800s bear a striking resemblance to the NPs of today. The nurses of Wald’s Henry Street Settlement House in New York City provided primary care for poverty-stricken immigrants and treated common illnesses and emergencies that did not require referral (Hamric et al., 2009). In 1965 the role of nurse practitioner was formally developed by Loretta Ford, EdD (nurse educator), and Henry Silver, MD (professor of medicine), both of whom were teaching at the University of Colorado (Sullivan-Marx, McGivern, Fairman, & Greenberg, 2010). The nurse practitioner program was developed not only to advance the nursing profession

but also to respond to the need for providers in rural, underserved areas. The program was initially funded by a \$7,000 grant from the School of Medicine at the University of Colorado (Bruner, 2005; Weiland, 2008). The first program, a pediatric NP program, was based on the nursing model and advanced the clinical practice of students by teaching them how to provide primary care and how to make medical diagnoses.

Whereas NP pioneers focused on advancing the profession, “making a difference,” and gaining autonomy (Weiland, 2008, p. 346), in the socioeconomic and political climate of the times, the NP was viewed as a cost-effective way to provide health care to the underserved. During the 1970s, federal funding helped to establish many NP programs to address a shortage of primary care physicians, particularly in underserved areas. In 1971 Idaho was the first state to endorse nurse practitioners’ scope of practice to include diagnosis and treatment. The number of NP programs doubled between 1992 and 1997. By the year 2000, 321 institutions offered either a master’s-level or a post-master’s-level NP program (Health Resources and Services Administration, Bureau of Health Professions, 2004). By 2002, more than 30% of NPs were working with vulnerable populations, including homeless, indigent, chronically ill, and elderly patients (Jenning, 2002). Today there are more than 192,000 nurse practitioners in the United States, with approximately 87% of these professionals in clinical practice as NPs in primary care, acute care, and rural health care (AANP, 2014; Ortiz, Wan, Meemon, Paek, & Agiro, 2010; Pearson, 2011).

With the need for healthcare providers expanding, and the focus on the ability of NPs to fulfill that role, schools are accepting more applicants for the NP track than before. In 2011, more than 14,000 students graduated from approximately 360 NP programs in the United States (AANP, 2014; Pearson, 2011).

NURSE PRACTITIONER EDUCATION AND TITLE CLARIFICATION

In the 1960s, the role of the NP was not warmly welcomed by nurse educators; therefore, many of the educational programs to train nurses in the NP role were continuing education programs rather than university-housed programs (Pulcini, 2013). In the 1980s and 1990s, NP education moved into the university setting as master’s-level programs, although confusion arose when efforts were made to interchange the clinical nurse specialist (CNS) and NP roles. Today more than 330 graduate-level NP programs exist. Many offer a clinical doctorate—the Doctor of Nursing Practice (DNP)—for NP education in response to the American Association of Colleges of Nursing (AACN) recommendation that advanced practice nurses be educated at that level by 2015.

In 2008 the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education* was finalized through the collaborative efforts of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee (2008). To clarify who is an advanced practice registered nurse, the document included the following definition:

An advanced practice registered nurse (APRN) is a nurse:

1. Who has completed an accredited graduate-level education program preparing him or her for one of the four recognized APRN roles;
2. Who has passed a national certification examination that measures APRN, role and population-focused competencies, and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. Who has acquired advanced clinical knowledge and skills preparing him or her to provide direct care to patients, as well as a

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component of indirect care; however, the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;

4. Whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. Who is educationally prepared to assume responsibility and accountability for health promotion and maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. Who has clinical experience of sufficient depth and breadth to reflect the intended license; and
7. Who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Clearly, the NP role is included under the umbrella definition of APRN; however, the title APRN does not clearly define which role and what type of educational background a professional has. Each APRN role differs from the others, and state regulatory agency requirements for licensing vary in each state and, in many cases, for each APRN role.

THE MASTER'S ESSENTIALS

The American Association of Colleges of Nursing prepared the *Essentials for Master's Education in Nursing* (American Association of Colleges of Nursing [AACN], 2011). Nine essentials focus on outcomes for all master's-level programs. In addition, direct patient care provider (APRN) education must offer three separate courses on the "3 Ps": advanced pharmacology,

advanced pathophysiology, and advanced physical assessment. The nine essentials are as follows:

- I. Background for practice from sciences and humanities
- II. Organizational and systems leadership
- III. Quality improvement and safety
- IV. Translating and integrating scholarship into practice
- V. Informatics and healthcare technologies
- VI. Health policy and advocacy
- VII. Interprofessional collaboration for improving patient and population health outcomes
- VIII. Clinical prevention and population health for improving health
- IX. Master's-level nursing practice

Essential IX, master's-level nursing practice, recognizes that nursing practice at the master's level is broadly defined as any form of nursing intervention that influences health-care outcomes for individuals, populations, or systems. Master's-level nursing graduates must have an advanced level of understanding of nursing and relevant sciences as well as the ability to integrate this knowledge into practice. Nursing practice interventions include both direct and indirect care components (AACN, 2011).

NURSE PRACTITIONER CORE COMPETENCIES

In addition to the AACN, which strives to advance the education of nurses in general, the National Organization of Nurse Practitioner Faculties (NONPF) sets the standards for nurse practitioner programs. NONPF (2012) states that there are core competencies for nurse practitioners in all tracks and specialties. The core competencies are listed here to demonstrate how coursework reflects these competencies.

Scientific Foundation Competencies

1. Critically analyzes data and evidence for improving advanced nursing practice.
2. Integrates knowledge from the humanities and sciences within the context of nursing science.
3. Translates research and other forms of knowledge to improve practice processes and outcomes.
4. Develops new practice approaches based on the integration of research, theory, and practice knowledge.

Leadership Competencies

1. Assumes complex and advanced leadership roles to initiate and guide change.
2. Provides leadership to foster collaboration with multiple stakeholders (e.g., patients, community, integrated healthcare teams, and policy makers) to improve health care.
3. Demonstrates leadership that uses critical and reflective thinking.
4. Advocates for improved access, quality, and cost-effective health care.
5. Advances practice through the development and implementation of innovations incorporating principles of change.
6. Communicates practice knowledge effectively both orally and in writing.

QUALITY COMPETENCIES

1. Uses best available evidence to continuously improve quality of clinical practice.
2. Evaluates the relationships among access, cost, quality, and safety and their influence on health care.
3. Evaluates how organizational structure, care processes, financing, marketing, and policy decisions impact the quality of health care.
4. Applies skills in peer review to promote a culture of excellence.

5. Anticipates variations in practice and is proactive in implementing interventions to ensure quality.

Practice Inquiry Competencies

1. Provides leadership in the translation of new knowledge into practice.
2. Generates knowledge from clinical practice to improve practice and patient outcomes.
3. Applies clinical investigative skills to improve health outcomes.
4. Leads practice inquiry, individually or in partnership with others.
5. Disseminates evidence from inquiry to diverse audiences using multiple modalities.

TECHNOLOGY AND INFORMATION LITERACY COMPETENCIES

1. Integrates appropriate technologies for knowledge management to improve health care.
2. Translates technical and scientific health information appropriate for various users' needs.
 - a. Assesses the patient's and caregiver's educational needs to provide effective, personalized health care.
 - b. Coaches the patient and caregiver for positive behavioral change.
3. Demonstrates information literacy skills in complex decision making.
4. Contributes to the design of clinical information systems that promote safe, high-quality, and cost-effective care.
5. Uses technology systems that capture data on variables for the evaluation of nursing care.

POLICY COMPETENCIES

1. Demonstrates an understanding of the interdependence of policy and practice.
2. Advocates for ethical policies that promote access, equity, quality, and cost.

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3. Analyzes ethical, legal, and social factors influencing policy development.
4. Contributes in the development of health policy.
5. Analyzes the implications of health policy across disciplines.
6. Evaluates the impact of globalization on healthcare policy development.

Health Delivery System Competencies

1. Applies knowledge of organizational practices and complex systems to improve healthcare delivery.
2. Effects health care change using broad-based skills including negotiating, consensus building, and partnering.
3. Minimizes risk to patients and providers at the individual and systems level.
4. Facilitates the development of healthcare systems that address the needs of culturally diverse populations, providers, and other stakeholders.
5. Evaluates the impact of healthcare delivery on patients, providers, other stakeholders, and the environment.
6. Analyzes organizational structure, functions, and resources to improve the delivery of care.

Ethics Competencies

1. Integrates ethical principles in decision making.
2. Evaluates the ethical consequences of decisions.
3. Applies ethically sound solutions to complex issues related to individuals, populations, and systems of care.

Independent Practice Competencies

1. Functions as a licensed independent practitioner.
2. Demonstrates the highest level of accountability for professional practice.

3. Practices independently, managing previously diagnosed and undiagnosed patients.
 - a. Provides the full spectrum of healthcare services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative care, and end-of-life care.
 - b. Uses advanced health assessment skills to differentiate between normal, variations of normal, and abnormal findings.
 - c. Employs screening and diagnostic strategies in the development of diagnoses.
 - d. Prescribes medications within scope of practice.
 - e. Manages the health or illness status of patients and families over time.
4. Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision making.
 - a. Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration.
 - b. Creates a climate of patient-centered care to include confidentiality, privacy, comfort, emotional support, mutual trust, and respect.
 - c. Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care.
 - d. Preserves the patient's control over decision making by negotiating a mutually acceptable plan of care.

The comprehensive nature of the competencies for role development is necessary and useful for developing curricula, evaluating the NP student during the educational training period, and establishing standards to which the practicing NP can be held accountable.

DOCTOR OF NURSING PRACTICE

In 1999 the AACN developed a task force to address the confusion that had arisen around

the variety of doctoral degrees available to nurses (Zaccagnini & White, 2011). Until this point, nurses had obtained doctorates in education (EdD), in nursing (ND), in nursing science (DNS/DNSc), and in other disciplines. In 2004, the AACN formally approved the Doctor of Nursing Practice (DNP) degree, which focuses on clinical practice in contrast to the research focus of the PhD. The DNP degree is available as a clinical doctorate for all nurses—not only NPs—who seek to improve healthcare delivery systems and patient outcomes. Although an original goal was to require by 2015 that the DNP degree be an entry requirement for NP education, the complexities associated with the endeavor, particularly at the state licensure level, make this unlikely to occur in such a short time. However, AACN endorses achievement of the DNP degree as a goal for all APRNs (AACN, 2013). The DNP degree is recognized as the terminal practice degree (AACN, 2006).

Why the need for a DNP degree when numerous studies have validated the excellent and cost-effective care provided by MSN-level NPs (AANP, 2010a, 2010b)? Owing to the ever-increasing complexity of health care and healthcare delivery systems, it is optimal to have clinicians who are well educated in the areas of health policy, quality improvement, evidence-based practice, and outcomes evaluation. Currently, MSN-level programs for NPs require 42–50 credits—much more than other MSN tracks, which typically require approximately 30 credits for completion. In addition, most NP programs require at least 500–600 clinical hours to graduate and take certification examinations. The DNP degree offers the NP student additional education and preparation to meet the needs of the complex healthcare system of the near future. Also, NPs work collaboratively with numerous other doctorally prepared clinicians whose education was clinically focused, including pharmacists (PharmD), physical therapists (DPT), physicians (MD), doctors of osteopathy (DO), and naturopaths (ND). To achieve educational

parity, the clinical doctorate (DNP) is recommended for nurse practitioners.

Currently, 184 DNP programs in the United States enroll students, and at least another 101 DNP programs are being developed (AACN, 2013). In 2012 more than 8,900 nurses were enrolled in a DNP program (AACN, 2013). There are differences in the existing programs, particularly as they relate to the scholarship of the terminal project—the title of which in itself has sparked numerous, passionate debates among leaders in doctoral-level nursing education. Whether the final scholarly product is called a project, project dissertation, practice dissertation, practice project, or—perhaps more like an MSN terminal project—a capstone, it is crucial that the NP/DNP be fully educated on the various types of research and evidence-based practice approaches to health care on individual and aggregate levels. It is important not to further discredit the clinical practice doctorate by drawing any lines in the sand as to who may or may not conduct research. That being said, it is probably much more appropriate for nursing's PhD colleagues to focus on theory development and for NPs/DNPs to focus on knowledge vital to practice (Dahnke & Dreher, 2011).

The AACN published *The Essentials of Doctoral Education for Advanced Nursing Practice* to shape the education of the DNP student to meet quality indicator criteria. The essentials were developed to build on the baccalaureate and master's essentials. They align with recommendations from the Institute of Medicine (IOM) that emphasize quality in education and evidence-based practice and that advocate nurses practice to the full extent of their scope of practice (Zaccagnini & White, 2011). The DNP essentials are as follows:

DNP Essentials

- I. Scientific underpinnings for practice
- II. Organizational and systems leadership for quality improvement and systems thinking

- III. Clinical scholarship and analytical methods for evidence-based practice
- IV. Information systems/technology and patient care technology for the improvement and transformation of health care
- V. Healthcare policy for advocacy in health care
- VI. Interprofessional collaboration for improving patient and population health outcomes
- VII. Clinical prevention and population health for improving the nation's health
- VIII. Advanced nursing practice (AACN, 2006)

The DNP essentials also contain language that reflects the need for the 3 Ps and the expertise required of APNs, which is in the following paragraphs for ease of access during seminar discussions.

Advanced Practice Nursing Focus

The DNP graduate prepared for an APN role must demonstrate practice expertise, specialized knowledge, and expanded responsibility and accountability in the care and management of individuals and families. By virtue of this direct care focus, APNs develop additional competencies in direct practice and in the guidance and coaching of individuals and families through developmental, health-illness, and situational transitions (Hamric et al., 2009). The direct practice of APNs is characterized by the use of a holistic perspective; the formation of therapeutic partnerships to facilitate informed decision making, positive lifestyle change, and appropriate self-care; advanced practice thinking, judgment, and skillful performance; and use of diverse, evidence-based interventions in health and illness management (Brown, 2005).

APNs assess, manage, and evaluate patients at the most independent level of clinical nursing practice. They are expected to use advanced, highly refined assessment skills and employ a thorough understanding of pathophysiology and pharmacotherapeutics in making diagnostic and practice management decisions. To ensure sufficient depth and

focus, it is mandatory that a separate course be required for each of these three content areas: advanced health/physical assessment, advanced physiology/pathophysiology, and advanced pharmacology. In addition to direct care, DNP graduates emphasizing care of individuals should be able to use their understanding of the practice context to document practice trends, identify potential systemic changes, and make improvements in the care of their particular patient populations in the systems within which they practice. (AACN, 2006, p. 18)

To be clear, the DNP degree does not confer a change in scope of practice. What it does afford nurses is the opportunity to improve health outcomes for patients and populations by supplying the tools to do so. Opportunities abound for the DNP/NP: the ability to clinically practice anywhere; to act in leadership roles in community health centers, larger acute care facilities, solo practice sites, and nurse-managed health centers; to perform research and then apply it in practice; to have joint appointments with educational institutions and healthcare facilities; to be a leader in disease management; and much more. Most importantly, the DNP/NP has the credibility and skills to be outstanding in clinical excellence. So, why become an NP? What is it that makes this role unique?

NURSE PRACTITIONERS' APPROACH TO PATIENT CARE

Sometimes I am asked why I became an NP instead of a doctor. My response is that becoming a nurse practitioner gave me the best of both worlds, nursing and medicine. I support my answer by stating that nursing continues to be one of the top trusted professions in the United States (Gallup Politics, 2012). I also point out that NPs have extremely high patient satisfaction scores, and nurse practitioners have a unique approach to health care (Weiland, 2008). This is not to say that there are no doctors who are amazing, but a common theme I hear from my patient population

is that “nurses listen to what I have to say.” One study found that only 50% of the patients seen by physicians—compared to more than 80% of NP patients—reported that they felt that the healthcare provider “always” listened carefully (Creech, Filter, & Bowman, 2011). In a study of more than 1.5 million veterans, satisfaction levels were highest in primary care clinics when the healthcare provider was an NP (Budzi, Lurie, Singh, & Hooker, 2010). Budzi and colleagues state that NPs’ interpersonal skills in patient teaching, counseling, and patient-centered care contribute to positive health outcomes and

patient satisfaction. These researchers concluded their report by encouraging the largest healthcare system in the United States to hire more NPs to increase access to cost-effective, quality care.

Of course, it is important to review and analyze quantitative research that supports the cost-effectiveness and improved health outcomes when NPs provide primary care, but it is also as important (in many cases, more important) to listen to what patients have to say about their experiences with NPs as healthcare providers. See the boxed feature “Stephanie’s Story.”

CASE STUDY Stephanie’s Story

At the turn of my 25th birthday, life was going well for me. I had just completed my master’s degree in elementary education and secured my first job as a head teacher in a local private school. I enjoyed my time during the day with my students, excited to employ the learning strategies I had discovered in graduate school. After school hours and on the weekends, I spent my time exercising outside, traipsing around New York City, and socializing with my friends and family. All of this changed the day I visited my gynecologist seeking treatment for a yeast infection.

Having no relief from an over-the-counter antifungal medication, I turned to my gynecologist—a highly regarded physician who studied at the Chicago School of Medicine. I found Dr. X to be warm, attentive, and funny; she did her best to make me feel comfortable despite the lay-on-your-back-feet-up-in-stirrups position. After confirming my self-diagnosis with a culture, Dr. X prescribed an antifungal suppository cream and sent me on my way home.

At the end of treatment, I still had severe itching and called my gynecologist’s office.

After discussing my situation with the nurse, we both assumed that I was fighting off a tough strain. Dr. X prescribed a stronger medication for me, and although I was itchy throughout this course of treatment, I held hope that my symptoms would abate soon after.

Still plagued with itching, I visited Dr. X a week after I finished the latest medicine. She asked me to remind her if diabetes ran in my family. She asked me to have my primary care physician run some blood work to be certain that I had not developed type 2. Throughout this, Dr. X and I still kept our humor about my condition. Although we were puzzled about why it lasted so long, we both assumed that it would clear up shortly.

Unfortunately, we were wrong. For 3 more months, Dr. X examined me at least twice each month as I was still experiencing relentless itching and redness. At each visit, she swabbed my vagina, ran a culture, asked if I was certain that I was not diabetic, and then prescribed me a cream, suppository, or pills. Dr. X explained that I would always test positive for yeast, as it is normal for a small amount to live in the vagina.

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CASE STUDY Stephanie's Story (continued)

However, she was surprised that the small amount of cells that I had caused me to be so itchy and red, that I must be sensitive to yeast.

Throughout my treatment with Dr. X, she maintained her warm demeanor; however, her nursing staff grew irritated with me. They became curt with me; sighing on the phone upon hearing my voice and rushing me through procedures at office visits. Through their lack of professionalism, they made it clear that I was not an important patient and that they were skeptical of my condition.

I began to feel worn down, broken. A simple infection had turned into a chronic illness, causing my gregarious nature to fade. I no longer wished to go out with friends. I pushed prospective boyfriends away so I would not have to contend with intimacy. I stopped exercising as body heat and sweat further aggravated my symptoms. I was tired of being sick.

Understanding my discomfort, which seemed to intensify after each round of medication, Dr. X decided to try something that was not a typical course of treatment: gentian violet. This antifungal dye was "painted" onto the outside of my vagina as well as inside the first third of the canal. As with the previous medications, my symptoms worsened. My skin felt raw and burned. And although I thought it impossible at this stage, the incessant itching intensified. Dr. X was all out of ideas and sent me to see a *Candida* specialist located 90 minutes away.

Dr. Y was an older man who entered the exam room while laughing with his nurse. Immediately he acted as though we had known each other for years. He was overly familiar, touching my arm, and doing his best to assure me that there wasn't a patient yet who presented a medical condition he couldn't fix. I quickly regretted taking Dr. X's recommendation to see him.

After Dr. Y questioned me about my condition, he asked me to lie back and then made sure to point out the strategically placed artwork in the room. Above my head on the ceiling, was a painting by Georgia O'Keefe. O'Keefe is famous for her floral still lifes that strongly resemble parts of the female anatomy. Dr. Y not only thought this was comical, considering his line of work, but also believed the art helped distract his patients from why they were in the stirrups. Personally, I found this strange, and rather than diverting my attention away from the purpose of my visit, I was forced to stare at a visual reminder while lying down!

Dr. Y separately swabbed the inside of my mouth, vagina, and anus, all the while sharing double-entendre jokes with his nurse. Half-naked and vulnerable, I willed myself to go through with the exam thinking that if I could get through these lousy 10 minutes I could finally have an answer to my problem. Dr. Y sent the swabs off to a lab, and then wrote me a prescription for an antidepressant. He told me that sometimes when a person has an illness as long as I have, it really is no longer a medical condition as much as a psychological one. He told me to take the antidepressant for at least 6 weeks and that it should help get my mind off dwelling on my problem and that he wouldn't be surprised if my symptoms vanished by that time. The nurses at Dr. X's office made me feel as though they didn't believe that I had an actual medical issue, and now this "specialist" was saying the same thing.

Desperate for relief and willing to consider the possibility that my illness was "all in my head," I began the antidepressant. When Dr. X's office called to say that my tests were negative for *Candida*, I continued the antidepressant, now hoping that it was a psychological issue, meaning there would be an end

CASE STUDYStephanie's Story *(continued)*

eventually. Although my mood had improved a bit, the itching and redness did not. During this time, I had scheduled an appointment with my dermatologist to check a questionable mole. Prior to her exam, Dr. Z asked how I was doing, what was new with me. I opened my mouth to say "fine," but broke down in tears. I had been uncomfortable and frustrated for so long that I couldn't control my emotions. I explained my ordeal—which by this point had been going on for over 6 months—to Dr. Z, and she replied, "I think I know what you have."

Dr. Z. suspected that I had acquired eczema from being overmedicated. A biopsy of my labia proved her correct, and I started a course of steroid treatment that lasted for several months. The relief was immediate! While I was ecstatic that I was on my way back to normal, I was also very angry. Initially, yes, I had a yeast infection. But at some point, the infection cleared and the itching and redness was from the medications. So, having a small amount of yeast cells in the cultures should have been a clue to Dr. X that it was not an infection. Dr. Y could not correctly diagnose my condition either and could only focus on yeast. After my experiences with Drs. X and Y, I lost trust in their capabilities as diagnosticians. I stopped seeing Dr. X and missed a year between my annual exams.

Months after I ended my steroid treatment, I developed what I was certain was a yeast infection. Scared to return to a gynecologist, I called my neighbor, a nurse practitioner, for a recommendation. She referred me to a fellow nurse practitioner who was working at the local Planned Parenthood. The NP was a friendly woman and patiently listened as I told her my recent medical history. She examined me, found a high number of yeast cells in the culture, and then prescribed me an oral

antifungal so as not to cause the eczema to return. Because I had experienced recurring yeast infections, she asked if I was diabetic. Unlike Drs. X and Y, and the nurses at their offices, the NP didn't stop after my reply of no. She then asked if I had a lot of wheat and/or chocolate in my diet as some recent studies have shown a correlation between those foods and yeast infections. Not able to do a thorough evaluation of my diet on the spot, I told her that I didn't think so. She told me to think about it and to give her a call to let her know how I fared with the medication.

On my drive home from Planned Parenthood, I started thinking about what I ate that morning and noon for lunch and couldn't believe how unaware I had been earlier with the NP. My breakfast had consisted of fruit and almond butter on two wheat waffles. Lunch was ham and cheese on whole wheat bread. The more I thought about my eating habits, the more I realized that wheat was in heavy rotation in my daily diet, and chocolate did indeed play a role during my menstrual cycle. I drove past my house and directly to the supermarket to purchase both wheat-free waffles and bread.

In the 8 years since spending those enlightening 30 minutes with the NP, I have had only two yeast infections, both successfully treated with over-the-counter medications. The NP shared invaluable information with me, information that has changed my life. To this day, if one is available, I prefer to see an NP to a doctor. I have found that the NPs tend to think more outside the box to solve a problem. They seem to be more aware of current research and studies and are willing to share this with their patients.

Thanks to my NP, I no longer have a chronic illness.

WHAT NURSE PRACTITIONERS DO

To articulate what nurse practitioners actually do, it is easy to discuss NPs' daily tasks: reviewing laboratory tests, performing physical examinations, charting, writing prescriptions, and ordering radiological procedures. Yet this approach describes only the profession or duties of the NP, and not the actual art of nurse practitionering.

Nurse practitionering—a unique term—incorporates the vital elements of nursing as well as philosophical theories, communication skills, diagnostic skills, coaching and educating activities, and, most importantly, skills for developing reciprocal relationships with patients. The foundation of nursing forms the basis of a holistic approach to the interview, assessment, diagnosis, and collaboration on goals for patient care, which help NPs to engage patients as full partners in aspects of their health care.

Dr. Loretta Ford described what sets NPs apart from primary care physicians as holistically oriented goals for self-care (Weiland, 2008). Florence Nightingale recognized the main difference between nursing and medicine by writing that, whereas medicine focuses on disease, nursing focuses on illness and suffering with the goals of easing suffering and promoting disease prevention (Nightingale, 1859/2009). Physicians are trained in a framework that is different from the one used to educate NPs. In an interesting article titled “The Total Package: A Skillful, Compassionate Doctor,” the theme was stated thusly:

Traditionally, medical school curricula have focused on the pathophysiology of disease while neglecting the very real impact of disease on the patient's social and psychological experience, that is, their illness experience. It is in this intersection that humanism plays a profound role. (Indiana University, 2009)

NPs, with their comprehensive, humanistic nursing background, formulate nurse practitionering in that intersection.

The role of the nurse practitioner is based on a nursing foundation and has integrated segments of the medical model to become the unique profession of nurse practitioner; therefore, differences in the role and practice of nurses and nurse practitioners exist (Haugsdal & Scherb, 2003; Kleinman, 2004; Nicoteri & Andrews, 2003; Roberts, Tabloski, & Bova, 1997). However, there remains confusion among the public and other members of the healthcare professions, as well as among some NP students, as to what NP practice truly is.

It is not surprising that defining nurse practitionering is difficult when one considers that it has historically been difficult to define nursing (Chitty & Black, 2007). Certainly today we have comprehensive definitions of nursing as developed by the American Nurses Association, Royal College of Nursing, and International Council of Nurses; however, it seems that Florence Nightingale wrote the first definition of a holistic approach to patient-centered care that can apply to the concept of “nurse practitionering”:

I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power to the patient. (Nightingale, 1859/2009)

NURSING THEORIES FOR NURSE PRACTITIONERS

Many nursing philosophies, theories, and models exist today, and NPs can and should build their professional practice on these. For example, Henderson (1991) identified the 14 basic needs of the patient (**Box 2-1**), which are needs common to all humankind.

BOX 2-1

The 14 Components of Virginia Henderson's Need Theory

1. Breathe normally.
2. Eat and drink adequately.
3. Eliminate body wastes.
4. Move and maintain desirable postures.
5. Sleep and rest.
6. Select suitable clothes—dress and undress.
7. Maintain body temperature within normal range by adjusting clothing and modifying environment.
8. Keep the body clean and well groomed, and protect the integument.
9. Avoid dangers in the environment and avoid injuring others.
10. Communicate with others in expressing emotions, needs, fears, or opinions.
11. Worship according to one's faith.
12. Work in such a way that there is a sense of accomplishment.
13. Play or participate in various forms of recreation.
14. Learn, discover, or satisfy the curiosity that leads to normal development and health, and use the available health facilities.

Source: Henderson, V. A. (1991). *The nature of nursing: Reflections after 25 years*. New York, NY: National League for Nursing Press, pp. 22–43. Reprinted by permission of National League for Nursing.

Jean Watson's 10 Carative Processes (**Box 2-2**) exemplify the changing relationship between patient and nurse attending to the unification of body, mind, and soul to achieve optimal health. Watson has spent many years as director of the Center for Human Caring at the University of Colorado in Denver. Her Theory

of Human Caring was developed by utilizing Carper's four fundamental ways of knowing to conceptualize her theory (Carper, 1978). Reflecting on empirical, personal, ethical, and aesthetic domains, Watson used the metaparadigm of person, environment, nursing, and health to provide a foundation for her theory of caring.

BOX 2-2

Ten Carative Processes

1. Embrace altruistic values, and practice loving kindness with self and others.
2. Instill faith and hope, and honor others.
3. Be sensitive to self and others by nurturing individual beliefs and practices.
4. Develop helping, trusting, and caring relationships.
5. Promote and accept positive and negative feelings as you authentically listen to another's story.
6. Use creative scientific problem-solving methods for caring decision making.
7. Share teaching and learning that addresses the individual needs and comprehension styles.

(continues)

BOX 2-2 Ten Carative Processes (continued)

- | | |
|---|---|
| <p>8. Create a healing environment for the physical and spiritual self that respects human dignity.</p> <p>9. Assist with basic physical,</p> | <p>emotional, and spiritual human needs.</p> <p>10. Open to mystery, and allow miracles to enter.</p> |
|---|---|

Source: Ten Carative Processes, Jean Watson 2007, 2008; www.watsoncaringscience.org; Watson, J. (2008). Nursing: The philosophy and science of caring. New rev. ed. Boulder: University Press of Colorado. Reprinted by permission of Jean Watson.

Hildegard Peplau (1952) focused as well on the relationship between patient and nurse in which the nurse takes on the role of counselor, resource, teacher, technical expert, surrogate, and leader, as needed. Whether an NP practices professionally in the United States or elsewhere in the global arena, to be successful in clinical practice the NP must use transcultural nursing theory, which was founded by Leininger (1995). The NP must use culturally sensitive and aware skills to develop relationships and to assess, diagnose, and treat patients.

King's (1981) framework uses personal, interpersonal, and social interacting systems to form a theory of nursing. Interestingly, upon review one might notice many of the concepts are the same in the *Calgary-Cambridge Guide to the Medical Interview* for physicians in training (Kurtz, Silverman, & Draper, 1998; Silverman, Kurtz, & Draper, 1998). In both of these methods for interacting with patients, the focus is on the concerns of the patient. King's framework gives the NP the ability to see the patient holistically by including the family and community aspects. Both King's framework and the *Calgary-Cambridge Guide* focus on mutual goal setting—taking the time during each step of the interview, assessment, and planning stages to truly understand the patient's issues and perspectives. By eliciting the patient's input frequently, it is easier for the NP to develop mutual understanding and

design interventions and goals for the patient to reach a state of optimal health.

The idea of forming a partnership with the patient is hardly new. Whitlock, Orleans, Pender, and Allan (2002) wrote about this concept in a U.S. Preventive Services Task Force recommendation, "Evaluating Primary Care Behavioral Counseling Interventions: An Evidence-Based Approach." Developing mutually respectful relationships with patients is likely to prevent patients resisting advice on healthy living and behavior change. Also detailed in this recommendation is an approach the National Cancer Institute developed to guide physician intervention in smoking cessation known as the "5 As": assess, advise, agree, assist, and arrange.

- **Assess:** Ask about and assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
- **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms/benefits.
- **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
- **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change,

supplemented with adjunctive medical treatments when appropriate (e.g., pharmacotherapy for tobacco dependence, contraceptive drugs/devices).

- *Arrange*: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment (Whitlock et al., 2002).

All of the approaches mentioned in this chapter focus on the need for the healthcare provider to be open to patients' needs, to hear what patients really have to say, to understand what patients really believe is wrong or right, and to let patients collaborate in the development of goals. The NP's ability to be culturally sensitive, flexible, and willing to collaborate and compromise when needed and appropriate helps to form the framework for a successful patient-NP relationship and, most importantly, assists patients to reach a state of optimum health. This is not to say that becoming expert in these skills is easy, or that it can be accomplished in one course; the student NP should start practicing these skills as soon as the educational program begins.

NURSE PRACTITIONERS' UNIQUE ROLE

In a survey seeking to identify barriers to using standardized nursing language (SNL) for documenting nursing practice, researchers found that most NP survey participants—believing that their role was a blending of the nursing and medical models—were not aware of what SNL consisted of (Conrad, Hanson, Hasenau, & Stocker-Schneider, 2012). Jacqueline Fawcett (in Cody, 2013) exhorts nurses to sever our “romance” with medical science and nonnursing professions and, in particular, to stop comparing NPs with physicians providing primary care. Instead, she advises we integrate nursing science as nurse scholars. With this in mind, while clarifying the professional practice of nurse practitioners it is important to

distinguish the profession from that of physicians and physician assistants.

In a qualitative study, Carryer, Gardner, Dunn, and Gardner (2007) interviewed NPs in Australia and New Zealand to illustrate the core role of NPs. Three components were described: dynamic practice, professional efficacy, and clinical leadership. *Dynamic practice* represented the clinical skills and expertise the NPs used in direct patient care, including physical assessment and treatment. *Professional efficacy* was what the researchers called the aspects of NP practice that were highly autonomous and for which NPs were accountable. This level of practice does not exclude the need for collaboration; however, the NP acted as an integral member of the multidisciplinary team. The participants described the overlap in role boundaries of NPs and physicians. Another aspect of professional efficacy was described as part of the patient-NP relationship: integrating the complex components of psychosocial aspects and the concrete physical aspects by taking the time needed in a patient visit to do so, and thus developing the therapeutic link for a significant relationship. Finally, the researchers described the advanced education and clinical experience that the NP brought to the advanced professional role. NPs understood the vital place that nurses need to occupy in healthcare delivery systems and how important it is to be a part of designing and implementing systems that can improve patient access to quality care. Therefore, NP leadership occurred in both the direct practice environment and in the context of the larger healthcare system. This final theme was not recognized at the same level by all participants. Many were still developing in this portion of role identity.

Nicoteri and Andrews (2003) sought to uncover any theory that was unique to understanding the attributes associated with NPs. This integrative review of the literature found that the role of the NP is influenced by many disciplines, especially medicine. The authors posited that an emergence of theory that is unique to NPs and grounded in nursing, medicine, and social

science was discovered. They suggested developing the concept of “nurse practitionering” (p. 500). The concept of nurse practitionering as a unique phenomenon has been written about in only a few journal articles. The term itself is not one used in typical conversation between healthcare providers and patients or within the nursing community; thus, there may be confusion with the term. The researchers’ goal for this endeavor was not to elevate or denigrate one profession or another, but to better understand the components of nurse practitionering.

Hagedorn (2004) posited that the difference between nurse practitioners and “biomedical practitioners” is related to nurse practitioners’ humanistic approach to patient care. According to many theorists such as Jean Watson, Patricia Benner, and Anne Boykin and Savina Schoenhofer, nursing’s essence is that of caring (Zaccagnini & White, 2011). The interpersonal focus of nursing within a caring and nurturing framework is the building block of all nursing theories (Brunton & Beaman, 2000; Chinn & Kramer, 1999; Green, 2004; Nicoteri & Andrews, 2003; Visintainer, 1986). If one accepts this as a core element of being a nurse, it would be difficult to imagine one losing this essence when acquiring advanced education that contains skills and competencies associated with the practice of medicine. In fact, NPs should familiarize themselves with nursing

theory in order to use it to guide their practice. By doing so, NPs can practice beyond the medical model, offering a unique approach to the relationship, assessment, and treatment plan.

In an effort to expand on the concept of nurse practitionering, Stewart (2008) conducted a descriptive study of 90 NPs in Connecticut who responded to an online survey about “nurse practitionering” and what they believed it encompassed. Fifty-nine respondents (65.6%) stated that nurse practitionering is a unique term that describes what they do, which is different from practicing solely nursing or medicine. Since many activities of practice overlap and are subjective, participants were not given definitions of nursing activities or medical activities. Regarding how much time they perceived they spent in solely nursing activities, 36.7% of participants believed it was low, between 0% and 25%. In contrast, 34.4% of NP participants stated that the amount of time they spent performing medical activities was between 36% and 50%. These results are included in **Table 2-1**.

The respondents entered key terms and phrases that described providing care to patients as a nurse practitioner. Participants were not given terms or phrases from which to choose; rather, this portion of the survey was open-ended. The researcher grouped similar terms when deemed appropriate. The most frequently used key phrases in order of the

TABLE 2-1 Percentage of Clinical Practice Time Spent in Nursing and Medical Activities (*N* = 90)

Time	Nursing Activities	Medical Activities
0–25%	36.7% (<i>n</i> = 33)*	13.3% (<i>n</i> = 12)
26–50%	30.0% (<i>n</i> = 27)	34.4% (<i>n</i> = 31)*
51–75%	25.6% (<i>n</i> = 23)	32.2% (<i>n</i> = 29)
75–100%	7.8% (<i>n</i> = 7)	20.0% (<i>n</i> = 18)

*Bold type denotes highest value.

number of times mentioned were *nurture/care/empathy* ($f = 31$), *educate* ($f = 30$), *assess/diagnose/treat/prescribe* ($f = 30$), *holistic* ($f = 22$), *listener* ($f = 17$), *collaborate* ($f = 13$), *advocate* ($f = 11$), and *coach* ($f = 5$). The frequency of the key phrases and terms used in this pilot study confirms that the core of nurse practitionering is based on the nursing model. Key phrases and terms relating to medical practice included *diagnose/treat/prescribe*, which were used as frequently as the nursing category, except in the area of nurture, care, and empathy which was slightly higher.

In an effort to expand on the key phrases from the previous study, Stewart (2009) invited 150 NPs in Connecticut to participate in interviews to share their perceptions of nurse practitionering. A total of 14 individual interviews was conducted with a convenience sample of experienced NPs. The 14 participants were all females between the ages of 31 and 70 years who were currently practicing as nurse practitioners. The following four themes were identified after analyzing the interviews; authentic listening, empathy, negotiating, and going above and beyond.

Authentic Listening

The NPs in this study were exemplars of authentic listeners. According to Bryant (2009), listening well involves being present, being interested, spending time, and showing respect. One NP explained:

I think the biggest reason why people like to come here is they say, "You listen. The docs don't listen to me." It is probably what I do the most and, one of the nurses got very frustrated with me and said, "You nurse practitioners, when a patient comes in to see the doctor and their finger is the problem, the doctor just looks at the finger and the patient is out. You go and you guys talk about everything. You have to talk about everything!"

Another NP described the time she spends teaching patients:

I prescribed the medications, I go out, I get the inhaler, you know, the sample inhaler and the sample spacer, and I go right back in and I tell the patient, "This is what I am ordering, and this is how you use it," versus the pediatrician or the pulmonologist who says, "Here are your medications. I'll have the nurse come in to teach you how to use it."

Empathy

Empathy is the ability to relate to the patient's thoughts and feelings and develop an understanding of what the patient is experiencing (Baillie, 1996). The NPs in this study were genuinely concerned about the patient's psychosocial well-being, family matters, and future goals and aspirations:

This woman this morning has lots of what I perceive as small complaints. She's a relatively healthy 28-year-old woman, and I asked her, "Tiffany, are you working?"

She said, "No."

I said, "When was the last time you worked?"

She said, "Oh, 9 years ago, before my daughter was born." Then she said, "It's really hard to get a job."

I asked, "Do you have your high school diploma?"

She said, "No."

So I recommended to her a local learning center program. I encouraged her, and that's where I think the nurse practitioner is different. It was me listening first, caring about what she was telling me, and then offering her something and trying to be an advocate for her.

Empathy enabled another NP to gain a deep understanding of what motivated the patient:

She has a disabled child at home that needs total care. That's something that I know about her and her situation. That's an example of, I guess, of advocating and coordinating and knowing that a lot of people don't have transportation. Like if I want to send them to radiology, I'll ask them, "What time of the day is

good for you?” because a lot of these people are grandmothers raising grandkids, and they need to arrange their life. Some of them are pretty capable of making appointments for themselves, but others are not. They are scared to or they don’t think that they’re going to do it right. Maybe we are enabling them by doing it for them, but we will take the extra time and, you know, ask “What’s the best day for you to go for that ultrasound? Morning or afternoon?”

Negotiating

Authentic listening and empathy enabled the NPs in this study to communicate more effectively and negotiate with patients when formulating treatment plans. An integrated literature review on communication styles of NPs and the impact on patients found that NPs who are trained to use a patient-centered communication style are most likely to have patients with better understanding of their health and treatment options and who are more likely to follow the treatment plan, thereby having better health outcomes (Charlton, Dearing, Berry, & Johnson, 2008). This same result was found in this study in NPs who involved patients in the decision-making process and actively negotiated with patients:

One of the things here that we do well, I think, is negotiate with the patients. Part of when I see people I’m not going to be paternalistic and tell them you have to do this, this, and that. I have a woman I saw this morning; she came in for follow-up of her labs. She has hypertension, and the first time she had a hemoglobin A1C of 6, and she has a family history of diabetes, so we talked. She’s not a dummy; she is a registered nurse. She just became a registered nurse, just got out of school, and I said “Let’s talk about this new thing that’s coming up. Do you have diabetes? Or are you prediabetic? Let’s discuss it.” So we negotiated what she was going to do next. I didn’t want to say to her, “You have to start on more meds today.” Her fasting sugars have been normal, the A1C was 6, and she is a woman that takes care of herself, pretty much.

Now she may go on metformin in 3 months, but I know she doesn’t like to take pills. She cares about a healthy lifestyle, so we negotiated: try lifestyle changes for 3 months and check the A1C in 3 months; if it goes up, then we’ll talk about starting medication.

Going Above and Beyond

NPs describe going beyond what is expected or required of the role of primary care provider. The NPs in the study were motivated to do more for their patients and ensure that patients were satisfied with their care.

My patient that came in this morning was status posthospitalization. When she was in the hospital, they did a big cardiac and neuro workup. I had sent her out by ambulance the week before, and they kept her for 4 days because they did a really good workup on her, but they didn’t do a stress test, so she needed to have that done. And so, I coordinated today for her to have a stress test, and I picked a Spanish-speaking cardiologist for her because I thought she would be more comfortable with that. And then they also recommended that she see a therapist because she’s on an antidepressant, so we talked about that today, and I coordinated that for her.

Another NP described her ability to take on a difficult patient and gain his trust, thereby improving his adherence to the treatment plan and reducing costs of overuse of the emergency room.

Treating marginalized patients with multiple comorbidities is challenging. This challenge is amplified by mental illness and substance abuse, combined with mistrust of the health-care system. An example of this begins with the discharge of a difficult patient from a clinic for threatening front desk staff and a few nurses. He was belligerent, and when he felt he was not being respected, he threatened staff members, including his physician. He had been followed in the medical resident clinic for his chronic medical illnesses but was not addressing his anger management, cocaine abuse, obsessive compulsive disorder, and depression, and ultimately he was not

adherent to medications or medical appointments either. The patient had been fired by multiple agencies in the town he lives in for the same behaviors, and at this point was about to be fired from the only medical provider left within walking distance. He does not own a car and could not afford to travel by bus. Final discharge from the clinic and care would render this man with no primary care locally, except the emergency room.

A final attempt was made to have the patient receive his care with a nurse practitioner, as she could at least provide continuity, if he showed up for the appointment, and she was not afraid. But really, the NP provided more than the same face in the clinic each visit. The NP provided this man with a milieu of empathy and teamwork between patient and care provider. Her approach to practice sparked a level of trust of the practitioner. The patient recognized the NP's genuine interest in providing him individualized care and respect. She built upon this practitioner-patient relationship. The NP helped the patient realize his control of his healthcare commitment and his role in his health outcome. This empowerment and trust lead to successful engagement in following through for his routinely scheduled medical visits as well as medication adherence. When the patient was ready to address his mental health and addiction, he asked the NP to be his advocate.

The NP's commitment to holistic patient-centered care led to reinstatement of his mental health services. And today, this patient is significantly healthier, drug free, treating his medical and mental illness, and is one less person sitting in the emergency room.

Another NP described the impact one can have when going the extra step for a patient:

While at a precollege arts experience, a teen came to the clinic to ask for help with a sore throat. While assessing her I began discussing her comfort with being away from home for the first time. She mentioned that she was really surprised that having three meals a day made her feel so comfortable. (Students eat in the college cafeteria during the program). Further questioning revealed that she rarely

ate except at school as she qualified for free lunch because "There is an empty refrigerator in my house." When asked if her school had a breakfast program, she said that they did but her mom "was too busy to apply—says it is too complicated." Her strep culture was positive, so I prescribed antibiotics and had the resident assistant pick them up from the pharmacy. Meanwhile, I asked the young lady if she would like to speak to the nurse practitioner at her school to contact social services for assistance with not only the breakfast program but also what else the assessment would allow. At that point I learned that her mom was in rehab and unable to be reached—that this student had been assigned a foster care person—who I contacted regarding care and treatment for the strep throat and confirmed the rest of the story. Activation of social services through contact with the NP at the school-based health center started the process in motion. Additional contact with her throughout the 5 weeks proved to positively impact this child's life.

The NPs in this study expressed how much they loved being nurse practitioners. They believed in the added value and unique contributions of the NP to health care and got a lot of gratification from putting in extra time and effort. This finding is supported by a similar study that showed NPs believe that their lives are enhanced and cite experiencing internal rewards and gratification from their interactions with patients:

I think the most gratifying thing is when I sit down with them and explain their disease and really spend the time with them that they need. I feel like they really understand the necessity for the treatment plan that I recommend, and I really feel like if I spend the time with them that they are so grateful because they feel like you've really invested in them. . . . I think that most nurse practitioners will probably say something to this effect, but when they sit down with their patients, they try to treat them like they would want one of their family members treated. And so when people really see that you're really doing that for them, and distinguish it from the way that they feel like

they've been treated by other providers in the past or when they really recognize the amount of energy and the amount of giving—when they really see that—there's nothing more gratifying than that. (Kleinman, 2004)

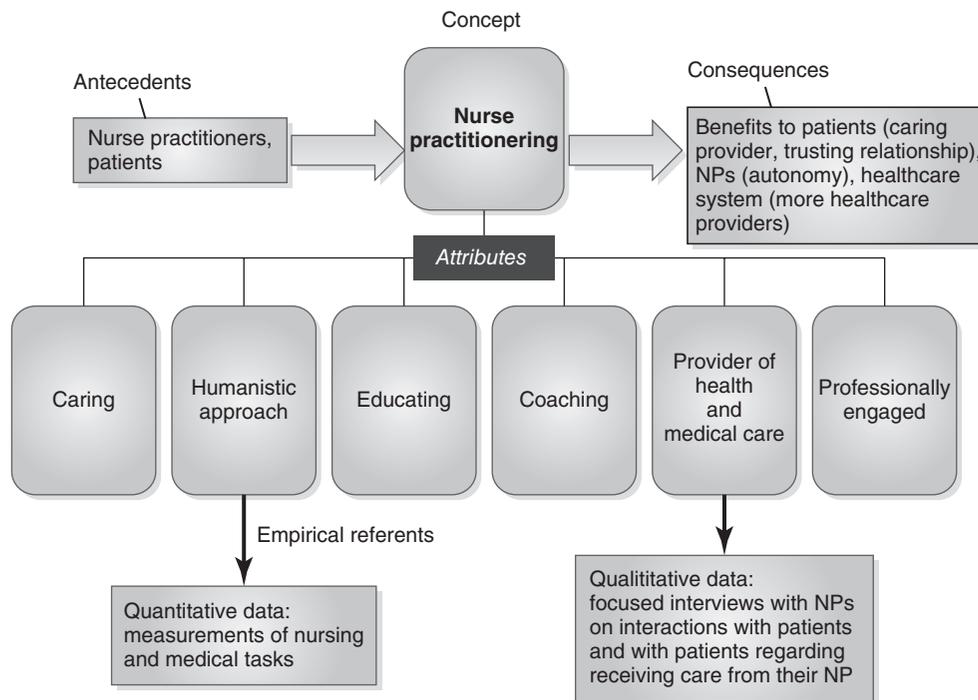
The above quantitative and qualitative pilot studies validate similar components uncovered by Kleinman (2004) regarding nurse practitioners and their relationships with patients. Essential meanings in her phenomenological study included “openness, connection, concern, respect, reciprocity, competence, time, and professional identity” (p. 264).

Based on research, review of the literature and both formal and informal interviews, a

concept map depicting nurse practitionering was developed (Figure 2-1). From that, the Stewart Model of Nurse Practitionering was developed to depict this model of nurse practitioner practice (Figure 2-2). This model has as its core the nursing model—the foundation of NP practice. As the NP student evolves through the educational program, scientific knowledge and attributes of the medical model are incorporated in order to provide accurate assessment, medical diagnoses, and appropriate evidence-based treatment modalities to patients who need health care. The circles within the larger circle represent unity and wholeness.

FIGURE 2-1

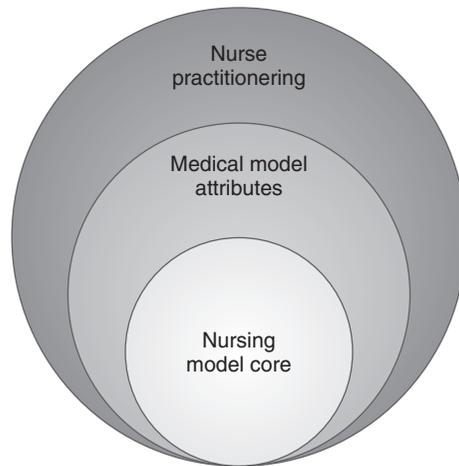
Model of nurse practitioner practice.



Stewart, J., & DeNisco, S. (2015). *Role development for the nurse practitioner*. Burlington, MA: Jones & Bartlett Learning.

FIGURE 2-2

The Stewart Model of Nurse Practitioning.



Stewart, J., & DeNisco, S. (2015). *Role development for the nurse practitioner*. Burlington, MA: Jones & Bartlett Learning.

It is evident that to function successfully within this model, the NP must retain the crucial interpersonal skills required to provide education surrounding health promotion and disease management. Brykczynski (2012), in an article discussing qualitative research that looked at how NP faculty keep the nurse in the NP student, suggested that holistically focused healthcare providers consider thinking of “patient diagnoses” instead of either medical or nursing diagnoses (p. 558). Nurse practitioner students and novice NPs need to beware of minimizing the importance of nursing as the core foundation from which excellence in practice develops. Rather, all NPs should emphasize the art and science of nursing and nursing philosophies and theories as the building blocks of providing health care to patients. It is these very qualities that make NPs unique—what engenders trust and confidence, as well as positive patient-NP

relationships, which is the circle labeled in Figure 2-2 as “nurse practitionering.”

An opinion article in the *New York Times* clearly noted that nurse practitioners approach patient care differently from how physicians do, and that research has proven that the NP approach is as effective and “might be particularly useful for treating chronic disease, where so much depends on the patients’ behavioral choices” (Rosenberg, 2012, para. 5). Sullivan-Marx and colleagues (2010) posited that the NP encompasses both the holistic nursing caring model and the physician’s curing model—that NPs have a paradigm flexible enough to be able to move between the two. Who better than NPs/DNPs to tackle the inequities in health that have been tied to variations in socioeconomic status, racial and ethnic discrimination and stressors, and policies relating to social and economic justice?

DISCUSSION QUESTIONS

1. What was the purpose for the initial role of the nurse practitioner? Did that role differ from the role of the nurse practitioner in today's healthcare system?
2. Who are advanced practice registered nurses (APRNs)?
3. What are the master's and DNP essentials, and what are they used for?
4. Describe the NP core competencies as identified by NONPF, and discuss how students can attain basic mastery of those competencies.
5. What are elements of role transition from RN to APN, and what are you currently experiencing in this process?
6. The concept of "nurse practitionering" has been introduced in this chapter. Comment on your responses to this idea.

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