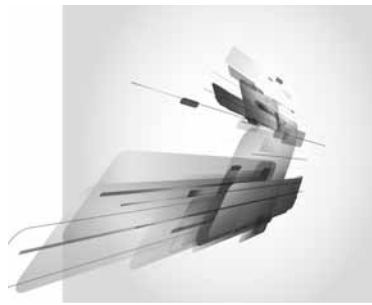


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PART I

Scientific Underpinning of the Nurse Practitioner Role



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CHAPTER 1

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

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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.

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University of Virginia School of Nursing, 2012*

Nurse practitioners (NPs) have reached a tipping point as a profession (Buerhaus, 2010). Malcolm Gladwell states that the “tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire” (Gladwell, 2000, 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 America 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 (DHHS, 2011; Van Leuven, 2012). In addition, the Patient Protection and Affordable Care Act signed in 2010 instituted comprehensive health insurance reform and expanded healthcare insurance coverage to 32 million Americans (DHHS, 2011). Researchers have validated the cost, quality, and competence of NPs' role in providing primary care with outcomes that are similar to 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 in an article to illustrate how NPs functioning independently can meet the cost-effective needs of healthcare reform while providing high-quality care for patients in multiple settings.

There have been many specific and important research articles published over a span of 4 decades that speak to the excellent quality of care provided by nurse practitioners (American Association of Nurse Practitioners [AANP], 2010a). At least 89% of NPs are educated to provide primary care (AANP, n.d.); however, in some states, many NPs are not working in primary care possibly because of the state's restrictions on requiring collaborators and written agreements with physicians. Many states have recognized this barrier and have removed those requirements, and many insurance companies are including 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. Seminar discussions regarding pertinent issues must be part of the education of student NPs and included in discussion among those 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 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). This nurse practitioner program was developed not only to advance the nursing profession; it was also developed in response 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 (Weiland, 2008; Bruner, 2005). The first program was a pediatric NP program based on the nursing model, yet the program advanced the clinical practice of these students by teaching them how to provide primary care and how to make medical diagnoses.

These early NP pioneers were focused on having a positive effect on advancing the profession, to "make a difference," and to gain autonomy (Weiland, 2008, p. 346). However, due to the socioeconomic and political climate of the times, the NP was viewed to be a cost-effective way to provide healthcare providers for 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. Idaho was the first state to endorse nurse practitioners' scope of practice to include diagnosis and treatment in 1971. NP programs doubled between 1992 and 1997. By the year 2000, there were 321 institutions that offered either a master's level or a postmaster's-level NP program (Health Resources and Services Administration [HRSA], 2004). By 2002, over 30% of NPs were working with

vulnerable populations including the homeless, indigent, chronically ill, and the elderly (Jenning, 2002). Today there are between 150,000 and 180,000 nurse practitioners in the United States, with approximately 158,000 of these professionals in clinical practice as an NP in primary care, acute care, and rural health care (AANP, 2010b; 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, many schools are accepting more applicants for the NP track than before. In 2011 there were over 11,000 graduates of the approximately 360 NP programs in the United States (AANP, n.d.; 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 educational programs to train nurses in the NP role were more often 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 there were efforts to interchange the clinical nurse specialist (CNS) and NP roles. Today there are well over 330 graduate-level NP programs, and many have gone to offering only a clinical doctorate—the Doctor of Nursing Practice (DNP)—for NP education in response to the American Association of Colleges of Nursing's (AACN's) recommendation that advanced practice nurses be educated at that level by 2015.

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

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 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 nonpharmacologic 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, NPs are one of the four roles that fall under the umbrella definition for APRN; however, using the title APRN does not clearly define which role and educational background the professional has. Each APRN role differs from the others, and state regulatory agencies vary in requirements for licensing in each state, and in many cases, for each APRN role.

THE MASTER'S ESSENTIALS

The American Association of Colleges of Nursing (AACN) prepared the *Essentials for Master's Education in Nursing* (AACN, 2011). There are nine essentials that focus on outcomes and are for all master's-level programs. In addition, direct patient care provider (APRN) education must offer three separate courses on the “3 Ps,” which are advanced pharmacology, advanced pathophysiology, and advanced physical assessment. The nine essentials are (AACN, 2011):

- 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 healthcare 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 COMPETENCIES¹

In addition to the AACN, which strives to advance the education of nurses in general, the National Organization for Nurse Practitioner Faculties (NONPF) sets the standards for nurse practitioner programs. NONPF has stated there are core competencies for nurse practitioners in all tracks and specialties. These are listed here so the NP student can review and understand 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.

¹ National Organization of Nurse Practitioner Faculties (NONPF). (2012). *Domains and core competencies of nurse practitioner practice*. Washington, DC: Author. Reprinted with permission by the National Organization of Nurse Practitioner Faculties.

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.
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 components of the competencies that must be met for role development are necessary and useful for developing curricula, and for evaluating the NP student during the educational training period, as well as containing standards to which the practicing NP can be held accountable.

DOCTOR OF NURSING PRACTICE (DNP)

In response to the confusion arising from the variety of doctoral degrees that nurses seeking to advance their education were obtaining, the AACN developed a task force to address the issue in 1999 (Zaccagnini & White, 2011). Until this point, nurses had obtained doctorates in education (EdD), PhDs in nursing or other disciplines, doctorates in nursing science (DNS/DNSc), and doctorates in nursing (ND). In 2004, the AACN formally approved the doctor of nursing practice (DNP) degree, which is focused on clinical practice in contrast to the research-focused doctoral degree obtained with a PhD. This degree is not only for NPs, but offers a clinical doctorate for all nurses who seek to improve healthcare delivery

systems and patient outcomes. Although an original goal was to have the DNP as entry level for the NP by 2015, the complexities associated with the endeavor, particularly at the state licensure level, makes this unlikely to enforce in such a short time. However, AACN endorses the DNP as a goal for all APRNs (AACN, 2013). The DNP is recognized as the terminal practice degree (AACN, 2006).

Why the need for a DNP 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 that typically are 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 offers the NP student additional education and preparation to meet the needs of the complex healthcare system of the near future. In addition, NPs work collaboratively with numerous other doctorally prepared clinicians whose doctorate is clinically focused, including pharmacists (PharmD), physical therapists (DPT), physicians (MD), doctors of osteopathy (DO), naturopaths (ND), and others. To achieve educational parity, the clinical doctorate (DNP) is recommended for nurse practitioners.

There are currently 184 DNP programs enrolling students in the United States, and there are at least another 101 DNP programs being developed (AACN, 2013). Over 8,900 nurses were enrolled in a DNP program in 2012 (AACN, 2013). At this time, 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 our 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 our PhD colleagues to focus on theory development and the NP/DNP 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 for the DNP to meet quality indicator criteria. These essentials were developed to build upon the baccalaureate and master's

essentials and are aligned with recommendations from the Institute of Medicine's (IOM) multiple reports emphasizing quality in education, evidence-based practice, and nurses practicing to the full extent of their scope of practice (Zaccagnini & White, 2011). The DNP essentials are listed below.

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)

In addition, the DNP essentials also contain language that reflects the need for the *3 Ps* and the expertise required for APNs, which is detailed below 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, Spross, & Hanson, 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 does not confer a change in scope of practice. What it does afford is the opportunity to improve health outcomes for patients and populations by being given the tools to do so. Opportunities abound for the DNP/NP: the ability to clinically practice anywhere; 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 it unique?

NURSE PRACTITIONERS' APPROACH TO PATIENT CARE

Sometimes I am asked why I did not become a doctor instead of an NP. My response is that becoming a nurse practitioner gave me the best of both worlds, nursing and medicine. I support my answer stating that nursing continues to be one of the top trusted professions in the United States (Gallop, 2012). I also point out that NPs have extremely high patient satisfaction scores. 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 reported that they felt that the physician “always” listened carefully, compared to more than 80% of NP patients (Creech, Filter, & Bowman, 2011). In a study of over 1.5 million veterans, satisfaction levels were highest in primary care clinics when the healthcare provider was an NP (Budzi, Lurie, Singh, & Hooker, 2010). The authors state that the interpersonal skills of NPs in patient teaching, counseling, and patient-centered care contribute to positive health outcomes and patient satisfaction. Encouragement to hire more NPs to increase access to cost-effective quality care for the largest healthcare system in the United States was a conclusion reached by these researchers.

Of course, it is important to review and analyze quantitative research regarding the cost-effectiveness and improved health outcomes when NPs are providing 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.

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 II. 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. 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 thought this was not only 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 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 to Dr. Z, which by this point had been going on for over 6 months, and she replied, "I think I know what you have."

Dr. Z. suspected that I had acquired eczema from being over-medicated. 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 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. Having 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 2 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

In an effort to articulate what a nurse practitioner actually does, it is easy to discuss the tasks involved with the daily work of the NP. These tasks involve reviewing laboratory tests, performing physical examinations, charting, writing prescriptions, and ordering radiological procedures, yet this approach describes the profession or duties of the NP, and not the actual art of nurse practitioner. Dr. Loretta Ford described *holistically oriented goals for self-care* as what sets NPs apart from physicians in primary care (Weiland, 2008).

Nurse practitioner (as a unique verb) incorporates the vital elements of nursing and philosophical theories, communication skills, diagnostic skills, coaching and educating, and most importantly, developing reciprocal relationships with patients. It is the foundation of nursing that forms the basis for taking a holistic approach to the interview, assessment, diagnosis, and mutually agreed upon goals for patient care, which help NPs to engage patients as full partners in aspects of their health care.

Florence Nightingale recognized the main difference between nursing and medicine by writing that while medicine focuses on disease, nursing focuses on illness and suffering with the goal(s) being to ease suffering and promote disease prevention (Nightingale, 2009). Physicians are trained in a different framework than NPs. In an interesting article, "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 practitioner in that intersection.

The role of the nurse practitioner has the foundation of nursing 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 team, as well as among some NP students, as to what NP practice truly means.

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 developed by the American Nurses Association, Royal College of Nursing, and the International Council of Nurses; however, it seems that Florence Nightingale wrote the first definition of a holistic approach to patient-centered care:

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, 2009)

Nursing Theories for Nurse Practitioners

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

BOX 1-1 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 1-2**) 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. Watson's Theory of Human Caring meets the criteria for Carper's four fundamental ways of knowing, and Watson defines the metaparadigm of person, environment, nursing, and health in her theoretical base.

Hildegard Peplau (1952) focused as well on the relationship between patient and nurse during which the nurse takes on the role of counselor, resource, teacher, technical expert, surrogate, and leader, as needed. Whether one is practicing professionally in the United States or elsewhere in our 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 framework (1981) uses personal, interpersonal, and social interacting systems to form a theory for nursing. Interestingly, when one reviews the Calgary Cambridge guide to the medical interview for physicians in training (Kurtz, Silverman, & Draper, 1998), many of the concepts are the same. The focus is

BOX 1-2 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.
8. Create a healing environment for the physical and spiritual self that respects human dignity.
9. Assist with basic physical, emotional, and spiritual human needs.
10. Open to mystery, and allow miracles to enter.

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, CO: University Press of Colorado. Reprinted by permission of Jean Watson.

on the concerns of the patient for both of these methods for interacting with patients. 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 frequently eliciting the patient's input, it is easier to develop mutual understanding and develop interventions and goals 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. Preventative Services Task Force recommendation, "Evaluating Primary Care Behavioral Counseling Interventions: An Evidence-based Approach." Developing mutually respectful relationships with patients is more likely to prevent patients' resistance to advice on healthy living and behavior change suggestions by healthcare providers. 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, Orleans, Pender, & Allan, 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 they really have to say, to understand what they really believe is wrong or right, and to let them work with you to develop goals. The ability to be culturally sensitive, and to be flexible and willing to collaborate and compromise when needed and appropriate

will help to form the framework for a successful patient–NP relationship, and most importantly, assist 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; however, the student NP should start practicing these skills starting as soon as the educational program begins.

NURSE PRACTITIONERS' UNIQUE ROLE

In a survey seeking to identify barriers for nurse practitioners to use standardized nursing language (SNL) for documenting nursing practice, the researchers found that NP survey participants identified that their role was a blending of the nursing and medical models, and most were not aware of what SNL consisted of (Conrad, Hanson, Hasenau, & Stocker-Schneider, 2012). Jacqueline Fawcett (in Cody, 2013) exhorts us to sever our “romance” with medical science and nonnursing professions, and in particular, with NPs being compared to 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.

A qualitative study by Carrier, Gardner, Dunn, and Gardner (2006) was undertaken in Australia and New Zealand where NPs were interviewed to illustrate the core role of NPs. Three components were described: dynamic practice, professional efficacy, and clinical leadership. Dynamic practice described the clinical skills and expertise the NP uses in direct patient care, including physical assessment and treatment. Professional efficacy was what the researchers titled the aspects of NP practice that are highly autonomous and accountable. This level of practice does not exclude the need for collaboration; however, the NP acts as an integral member of the multidisciplinary team. The participants also described the overlap in role boundaries that occurs with NPs and physicians. Another aspect of professional efficacy was described as being an illustration of the NP–patient relationship. Being able to integrate the complex components of psychosocial aspects in addition to the concrete physical aspects means taking the time needed in a patient visit to do so, and to develop the therapeutic link for a significant relationship. Finally, the researchers described the advanced education and clinical experience that the NP brings to the advanced professional role. NPs understand 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 access to quality care. Therefore, NP leadership occurs in both the direct practice environment as well as within 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 NPs and associated attributes. 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. The authors 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, nor within the nursing community; thus, there may be confusion with the term. The goal for this endeavor is not to elevate or denigrate one profession or another, but to better understand the components of nurse practitionering.

Hagedorn (2004) posits 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 Boykin and 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 be familiarizing themselves with nursing theories in order to use nursing theory to guide their practice. By doing so, one is practicing beyond the medical model, offering a unique approach to the relationship, assessment, and treatment plan.

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

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

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

*Bold denotes highest value.

The respondents were requested to enter key terms and phrases that described what is encompassed when 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. Similar terms were grouped together where deemed appropriate. The most frequent key phrases in order of the 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 majority of the key phrases and terms in this pilot study confirm that the core of nurse practitionering is based on the nursing model. Key phrases and terms relating to medical practice included diagnosing and treating/prescribing, which were as frequent as the caring (nursing) category, but the nursing elements were mentioned most often.

In an effort to expand upon the key phrases, invitations to participate in interviews to share their perceptions of “nurse practitionering” were sent to 150 NPs in Connecticut. A total of 14 individual interviews were held with a convenience sample of experienced NPs willing to participate and share their perceptions. The 14 participants of the interviews were all female, between the ages of 31 and 70 years, and currently practicing as nurse practitioners.

Authentic Listening

The NPs in this study were exemplars for authentic listening. According to Bryant (2009), listening well involves being present, 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 are 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 (Charlton, Dearing, Berry, & Johnson, 2008) 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. This was found in NPs in this study 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 our 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 describes her ability to take on a difficult patient and help to gain his trust, thereby improving his adherence to the treatment plan, and reducing costs for overusing 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 describes 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 love being nurse practitioners. They believe in the added value and unique contributions of the NP to health care and get a lot of gratification from putting in extra time and effort. This is supported

by a similar study that showed NPs feel that their lives are enhanced and cite 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 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 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 and formal and informal interviews, a concept map depicting nurse practitioner practice was developed (**Figure 1-1**). From that the Stewart

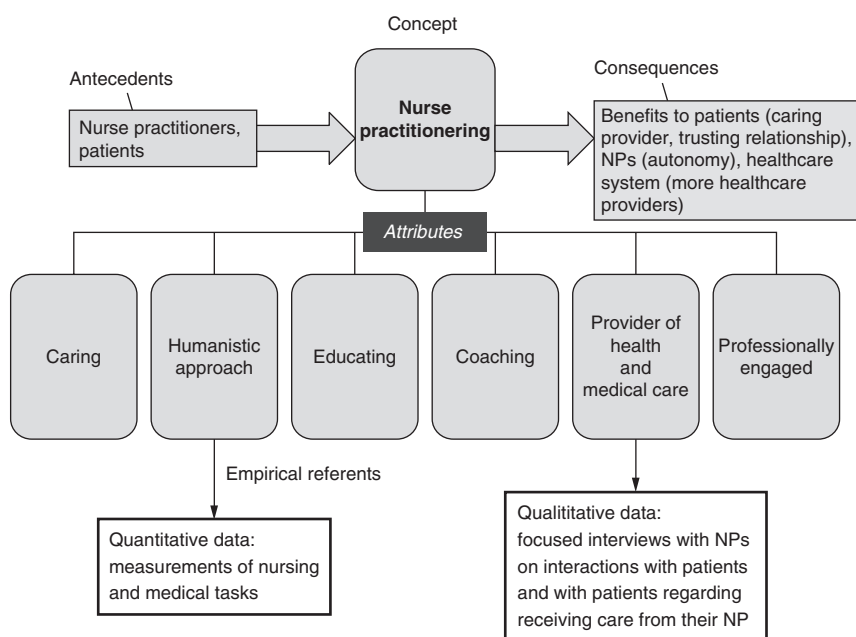


FIGURE 1-1 Model of nurse practitioner practice.

Model of Nurse Practitioner practice was developed to depict this model of nurse practitioner practice (**Figure 1-2**). 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 needing health care. The circles within the larger circle represent unity and wholeness.

It is evident that in order 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, suggests that holistically focused healthcare providers consider thinking of “patient diagnoses” instead of either medical versus 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 philosophies and theories as the building blocks for providing health care to patients. It is these very qualities that make NPs unique—what it is that instills trust and confidence, as well as positive patient–NP relationships—which is the circle labeled in Figure 1-2 as “nurse practitioner.” In an opinion article in the *New York Times* (Rosenberg, Oct. 24, 2012), it is clearly noted that nurse practitioners approach patient care differently than physicians do, and

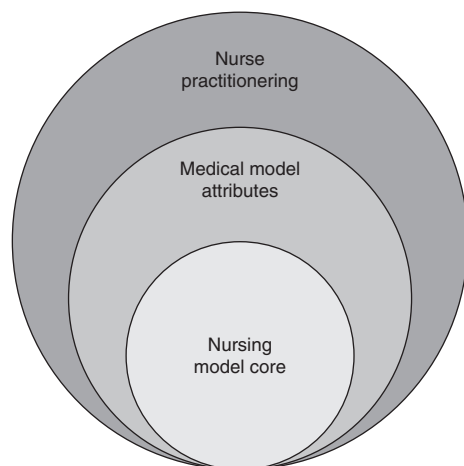


FIGURE 1-2 The Stewart Model of Nurse Practitioner.

that research has proven that it is as effective, and “might be particularly useful for treating chronic disease, where so much depends on the patients’ behavioral choices” (para. 5). Sullivan-Marx et al. (2010) posit that the NP encompasses both the holistic nursing caring model and more than the physician’s curing model—that NPs have a paradigm flexible enough to be able to move between the two. Who better than NP/DNPs to tackle the inequities in health that have been tied to variations in socioeconomic status, racial and ethnic discrimination and stressors, as well as policies relating to social and economical justice?

Seminar Discussion Questions

1. What was the purpose for the initial role of the nurse practitioner, and does it 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 practitioner” has been introduced in this chapter. Comment on your responses to this idea.

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