HEALTH AS EXPANDING CONSCIOUSNESS GUIDING INTEGRATIVE
PRIMARY CARE PRACTICE FOR FAMILY NURSE PRACTITIONERS

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STATEMENT BY THE AUTHOR

This master’s report has been submitted in partial fulfillment of requirements for an advanced degree at the University of Arizona.

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ABSTRACT

Consumers are driving innovation and creatively applying new technologies in ways that defy how traditional healthcare is being conducted. Consumers want to be known and to be heard, and especially when addressing chronic health conditions, they want more options other than medication or surgery. Nursing is in the position to assist consumers with this trend. The project addresses this consumer demand for complementary and alternative primary care practice. Newman’s theory Health as Expanding Consciousness guides the integration of nursing with complementary and alternative (CAT) primary care.

Nursing theory guides nurse practitioners practice. Within the context of Health as Expanding Consciousness, the theory was selected to guide FNPs in the integration of CAT and primary care for clients, families, and communities. In considering the theory, questions arise. Can HEC guide care when standard primary care visits are fifteen minutes or less? Is it possible for FNPs to use HEC to guide primary care based on the overall pattern and uniqueness of the client? If symptoms are a representation of the pattern of the whole, doesn’t changing the symptoms of a client mean changing the overall pattern? Does symptom treatment suppress and emerging pattern? Is a change in the pattern reflective of an expansion of consciousness? The opportunity to facilitate client awareness beyond the presenting health condition may be possible.
CHAPTER ONE

Introduction

Andrew Weil, MD (medical doctor) views integrative health as vital to decreasing the gap “between what the consumer wants and what physicians are trained to do” (Program for Integrative Medicine, n.d.). This gap also involves nurse practitioners (NPs), who practice primary care. Consumers want options other than drugs and surgery to treat medical problems, notably chronic health conditions such as anxiety, arthritis, headaches, muscle strains, and sprains (Astin, 1998; Mezey, McGivern, & Sullivan-Marks, 2003). Consequently, consumers are seeking non-traditional providers and resources outside primary care to assist them (American Holistic Nursing Association, n.d.; American Anti-Aging Medical Association, n.d.; Astin, 1998; Birchtree Center, n.d.; Bruguera, Barrera, Ampurdanes, Forns, & Tapias, 2004; Feldman, Duffy, De Civita, Malleson, Philibert, & Gibbon, et al, 2004; Siegel, Brown-Bradley, & Lekas, 2004; van Haselen, Reiber, Nickel, Jakob, Fisher, 2004). Reasons consumers give for their dissatisfaction with traditional treatment include ineffectiveness, too many side effects, too costly, lack of personalized care, desire to feel empowered about healthcare choices, and congruence with spiritual beliefs or worldview (Astin, 1998; Eisenberg, et al., 1998). Consumers are both aware of and want advice on nutritional supplements and the effects of nutrition on health (Bjerklie, 2003; Cowley, Underwood & Braiker, 2002; Kalb, Springen, & Underwood, 2002; Langone, 1996; Park, 2002; Toufexis & Cole, 1995; Wallis & Horowitz, 1991). Consumers are demanding the category of treatments termed complementary and alternative therapies (CAT). Consumers are also requesting
practitioners to be sensitive to the mind-body connection, and to be willing to see clients as more than their diseases (Roberts & Roberts, 2003; Wardell, 2004). Consumers are demanding practitioners who will not laugh at, dismiss (Wardell, 2004), or react adversely to complementary and alternative therapies.

NPs have a compelling and unique opportunity to be forerunners in meeting a consumer demand for CAT modalities that have been scientifically established (Astin, 1998; Eisenberg, Davis, Ettner, Appel, Wilke, Van Rompay, et al., 1998; Kessler, Davis, & Foster, 2001). There is also strong evidence in the literature that consumers are satisfied with NPs (Edwards, Oppewal, & Logan, 2003; Ganapathy & Zwemer, 2003). As nurses, NPs have integrated a holistic view of health and evidence-based biomedical knowledge into the practice of primary care (U.S. Department of Health and Human Services, 2002). The competencies for NPs, regardless of age groups served, include assessing and diagnosing health status, protecting health, preventing disease, providing treatment, acting as a teacher-coach, maintaining a sustaining partnership with clients and families, managing and negotiating the healthcare delivery system, ensuring quality and providing culturally sensitive care (U.S. Department of Health and Human Services, 2002). NPs have the competencies needed to facilitate client’s choices and are trusted by consumers. To meet the opportunity, specific practice guidelines for NP primary care practitioners (PCP) wanting to incorporate CAT into primary care would be helpful (Burman, 2003; Gordon, 2004; Patterson, Kaczorowski, Arthur, Smith, & Mills, 2003).

However, there are challenges in being able to provide integrative practice. Nursing has a holistic framework, but building the scientific body of knowledge for CAT
modalities is challenging, given the conflicting paradigms related to holism and traditional scientific methods. In addition, many NPs lack the understanding and training in specific CAT practices, and knowledge of and how to integrate them into practice (Burman, 2003; King, Pettigrew, & Reed, 2000). NPs need a nursing theory to guide their practice of integrating evidence-based biomedical knowledge and CAT for the health and well-being of their clients (American Association of Colleges of Nursing [AACN], 1996), as well as having the awareness and education in the appropriate uses, benefits, and limitations of CAT.

Conflicting worldviews exist when combining the biomedical and nursing models (Dunphy & Winland-Brown, 2001). Nursing is concerned with how the client and family respond to both treatment and illness, foresees client distress, and attempts to understand what the “illness experience” (p. 87) means to the client and family. When nurses become NPs, nursing remains central to practice. According to Dunphy and Winland-Brown, NPs “gain skill in the medical domain of practice, ...learn...diagnostic reasoning possibilities, and new treatment options for specific medical problems” (p 87). Caring for the client still pertains. The APN strives to individualize treatment and care. The goal of primary care, while not explicitly stated, is to intervene in disease process by either preventing or managing health conditions. Also implicit in intervention is action.

A deterrent to using Margaret Newman’s Health as Expanding Consciousness (HEC) (1999), is that the theory directly conflicts with the intent of primary care. For Newman, health is central to the theory, “and is seen as a process of developing awareness of self and the environment” (McEwen & Wills, 2002, p. 189). With
increasing awareness, clients come up with varied and different responses to life. Consciousness expands. Other concepts are central to the theory and will be discussed later (McEwen & Wills, 2002). HEC guides NPs to assist clients to understand their overall individual pattern, rather than focusing on a dichotomy between health and illness. If a pathological physiological process is identified, the process is recognized as a part of the overall pattern within the pattern of health (Newman, 1999). One of the primary assumptions of HEC is that recognizing that the overall pattern of health potentially facilitates the expansion of consciousness. HEC is a “way of being with the client – a way of offering the client an opportunity to know, be known, and to find their way” (Newman, 2005, p. xiv). Practice guided by HEC echoes consumers’ desires for healthcare other than medication and surgery. Practice guided by HEC does not determine what to do with the client, but how to be with the client.

This scholarly project has two purposes. The first purpose is to describe CAT and how CAT can be used in primary care practice (Astin, 1998; Eisenberg, 1998). The second purpose is to explore the use of Newman’s nursing theory Health as Expanding Consciousness (HEC) (Newman, 1999; Picard & Jones, 2005) in FNP primary care integrated practice.

**Background and Significance**

*Blending of the Biomedical Model and CAT*

In essence, the blending of the biomedical model (allopathy) and CAT emphasizes a therapeutic relationship, and makes use of all appropriate therapies, both conventional and alternative. The principles of integrative medicine include the
development of a healing partnership and the use of both conventional Western and CAT therapies to help the body heal itself. In addition, practitioners themselves adopt health and healing practices. This project uses the term integrative practice to include nurse practitioners.

**Complementary and Alternative Therapies**

A landmark study by Eisenberg, et al., (1998) estimated that in 1990, about 34% of Americans utilized at least one “alternative therapy” (p. 1574). In 1997, the percentage had increased to 42%. Astin (1998) also validated this finding, as well as concluding that the use of CAT was more in keeping with client values. These studies indicate a need for competent practitioners who can help clients understand their healthcare options regarding complex health issues, and make decisions to use Western medical practice with CAT.

The overarching theme for using all forms of CAT is the desire to balance mind, body, and spirit (Lorenzi & Robinson, 2001). The term complementary and alternative therapies (CAT) is an all-inclusive term that includes those therapies and treatments not considered part of the biomedical or conventional medical orientation, or allopathy, which is the practice of Western medicine (Dossey, 1997). Eisenberg, et al. (1998) defined complementary and alternative therapies as those that are used in combination with Western medicine (Eisenberg, et al., 1998). CAT included, but is not limited to: prayer; acupuncture and traditional Chinese medicine; acupressure; ayurveda (traditional East Indian method of healing); homeopathy; osteopathy; energy healing such as Reiki or Therapeutic or Healing Touch, Qigong (Chinese energy exercises); craniosacral
manipulation; reflexology; mind-body therapies such as guided imagery; biofeedback, yoga, meditation, hypnosis, Tai chi chuan, and music therapy; chiropractic care; natural products such as aromatherapy, herbs, botanicals, and enzymes; deep breathing exercises, massage, myofascial release techniques, structural re-patterning techniques such as Alexander, Feldenkrais, Trager, or Rolfing; and nutriceuticals (nutritional supplements) (Dossey, 1997; Eisenberg, et al. 1997; Life Extension Foundation, 2004; NCCAM, 2004; Robinson & Kish, 2001). Considerable research is being conducted on many therapies. A search conducted on the “Web of Science” on October 22, 2004, found the frequency of citings for the following general categories: prayer, 2002; herbal remedies, 606; massage, 236; chiropractic, 198; and homeopathy, 78.

Economics of CAT

Eisenberg, et al. (1998) estimated that anywhere from $21.2 to $32 billion dollars were spent for CAT. Consumers spent $12 billion in out-of-pocket payments to CAT practitioners, $3.3 billion for high-dose vitamins and $5.1 billion for herbal remedies (p. 1573). In 1994, the Robert Wood Johnson Foundation conducted a study and determined that at least 25 million people saw a CAT practitioner (Paramore, 1997). More recent economic research from the United States has not been published. However, more research is being done on integrative health and CAT. The National Institutes of Health National Center for Complementary and Alternative Medicine (NCCAM) increased an initial budget of $2 million to $212 million for 2005 (NCCAM, n.d.). This indicates a growing interest in this orientation and the government’s commitment to support it. Numerous economic studies have been conducted in Europe and Australia. In Australia,
for instance, a study published in 2004 found that 1.9 million visits were made to CAT practitioners with an impact of at least AUD$85 million in 2003 (Bensoussan, Myers, Wu, & O’Connor, 2004).

CAT Utilization

In a study conducted by the NCCAM in cooperation with the Centers for Disease Control and Prevention (CDC) in 2002 as part of the National Health Interview Survey, over 31,000 American adults indicated that more than one-third had utilized CAT during the past year. When prayer is included as CAT, the percentage increased to 62% (NCCAM, 2004, ¶ 1). The director of the National Center for Health Care Statistics, Edward J Sondik, Ph. D., stated, “What we are seeing is that a sizeable percentage of the public puts their personal health into their own hands” (NCCAM, 2004. ¶ 6). The development of the NCCAM resulted from insistent consumer pressure. Practitioners, knowledgeable about CAT as well as biomedical knowledge are needed to create healing partnerships with consumers.

Allopathy—The Biomedical Model

Clients are asking for something different from allopathic medicine, which is a biomedical orientation that focuses on the body or mind. Allopathy is defined as “a method of treating disease with remedies that produce effects different from those caused by the disease itself.” (American Heritage Dictionary, 2000). The Department of Labor describes MDs as allopathic doctors. MDs primarily diagnose and treat disease and injury, and may counsel patients on lifestyle changes as part of their treatment (United States Department of Health and Human Services [USDHHS], 2004). Allopathy focuses
on the treatment of signs and symptoms of illness or infirmity, but does not necessarily
determine and concentrate on the underlying pattern (USDHHS, 2004). The focus is on
the physical and mental aspects of disease and acute care treatment. The physicians’
intervention is designed to eliminate, alter, or change signs or symptoms experienced in
the body or the mind, and there may be a specialist for treating each organ system. As
part of the larger healthcare system, primary care demands a problem-oriented approach.
The biomedical system drives any care given, how it is paid for, and how the care is
delivered. Intervention is key to how care is currently provided.

*Primary Care Nurse Practitioner*

NPs in today’s cost conscious, consumer-driven healthcare environment
increasingly provide primary care. Primary care is defined as “continuing,
comprehensive, and personal health care” (UCSF, n. d., ¶1). Medicare defines primary
care as a basic level of care that MDs, doctors of osteopathy (DO), and NP’s provide
(Medicare, ¶ 1). The Institute of Medicine (IOM) Committee on the Future of Primary
Care (1996) defines primary care in the following way:

*Primary care is the provision of integrated, accessible health care services by
clinicians who are accountable for addressing a large majority of personal health
care needs, developing a sustained partnership with patients, and practicing in
the context of family and community.* (pp. 1).

Primary care is an excellent opportunity for NPs to provide theory-based,
integrative health care. Consumers are combining both allopathic and CAT to treat
chronic conditions, and conditions that do not respond well to only allopathic treatment
Some consumers prefer CAT as offering more control over decisions, and as being more congruent with their values and beliefs related to health and wellness (Astin, 1998; Mayaan, 2004; Tullar, personal communication, August, 2003). The homeless, underinsured or uninsured may use complementary and alternative therapies when access to the allopathic medical community is not available (Tullar, personal communication, 2002).

Health as Expanding Consciousness

The Essentials of Master’s Education for Advanced Practice Nursing (American Association of Colleges of Nursing (AACN, 1996) mandates that APNs (advanced practice nurse), including NPs, utilize theories from nursing and other professions in clinical practice, and that care focus on the “whole of a person’s health and illness experiences” (AACN, 1996, p. 10). By allowing “the nursing clinician to develop a comprehensive and holistic approach to healthcare” (AACN, 1996, p. 10), APNs are directed to apply nursing theories in healthcare environments.

Margaret Newman’s nursing theory, Health as Expanding Consciousness (HEC) is proposed to guide primary care practice in this project. For readers unfamiliar with Newman’s theory, HEC requires a broader, more encompassing perspective and less fragmentary worldview to frame care. Contrary to the orientation of the biomedical model, Newman’s theory is not oriented toward intervention. Newman sees her theory as an extension of Martha Roger’s Science of Unitary Beings, which regards the “patterning
of persons in interaction with the environment [as] basic to the view that consciousness is a manifestation of an evolving pattern of person-environment interaction” (Newman, n.d. p. 2, ¶2).

Fawcett (2001), LoBiondo-Wood & Haber (2002), McEwen & Wills (2002), and Robinson & Kish (2002) classify Newman’s theory as a grand theory. Grand theories are broad in scope and comprehensive in order to encompass “all the views that interest nurses–humans, environment, and health” (LoBiondo-Wood & Haber, 2002, p. 114). Newman classified her theory as a unitary-transformative grand theory, and will be discussed in detail later. The theory assumes that human beings are: 1) Unitary beings that cannot be known by the sum of their parts; 2) Self-regulating and self-evolving; 3) Imbedded in and interacting with the larger energy system known as the universe; 4) Known for their ways of being, patterns of energy, and distinctness from others (Newman, 1992).

Newman cites Bentov (1978) as defining consciousness “as the informational capacity of the system”, and stated, “this system has the capacity to interact with the environment” (Newman, n.d., p. 2, ¶ 2). The system does not include just thought and emotional awareness, but encompasses all the relational dimensions that exist between a human being, including the full range of biochemical functions, and the “larger, expanding pattern of the universe” (Newman, n.d, p.2, ¶2). Newman echoes Rogers’ view that health and illness are contained within what is termed a unitary process, meaning simply that human beings are related to the larger universe (Newman, 1999). Health and illness are no longer seen as part of a continuum and no longer separate
entities from human consciousness. The idea that health is a higher state of consciousness and illness is a lower state of illness is not valid. Unlike CAT, which views health as a continuum of balance and harmony, HEC views health as a way of being in the world.

Newman’s theory reflects a paradigm shift. Central is the idea that illness is not a separate function, but is a part of an evolving pattern of patient-environment interaction. (Newman, n.d., p. 2, ¶1). Within HEC, the nurse-client relationship is not fragmented or hierarchical; it is a partnership that encourages exploring the patterns that exist for the person experiences, among them are the state of health and expanding consciousness.

Newman was influenced by Teilhard de Chardin’s (1965) “belief that a person’s consciousness continues to develop beyond the physical life and becomes a part of the universal consciousness” (Newman, 1999, p. xxv). Hence, illness does not diminish a person. If consciousness continues after death, it seems that consciousness does not cease to expand with illness. Because the NP is a nurse, the NPs role includes assisting the client to understand the overall evolving patterns. Symptoms are part of the overall pattern, and HEC is not based on the needs or intervention, either. In other words, the NP facilitates the client to see him or herself as more than just his or her state of health. The pattern of health is part of a larger picture of life and consciousness.

One unique aspect of the theory is that NPs and clients experience being changed or transformed by this process. The nurse or nurse-researcher engages the participant (patient) in a dialogue about events most important to them, and the nurse creates an opportunity for “reflection, awareness, and potential insight” (Picard & Jones, 2005, p.
6). Identifying patterns in life, patterns that can affect health, can lead to an expansion of consciousness (Newman, 1999).

Both the NP and the client are affected by patterns. A healing unit rather than a traditional expert-patient relationship is created. The healing unit creates an equal partnership where both parties are needed to develop insight, and move toward recognizing the patterns relevant to a person’s life. Because the NP experiences an equal and profound affect on his or her life and insight, the NP experiences an expansion in consciousness as well as the client.

Summary

Eisenberg, et al. (1998) pointed out to the healthcare community in the last century many consumers are independently seeking out CAT for healthcare. The results of this study were cited 1379 times according to the Web of Science search engine. The healthcare community has been attentive to the findings of this study. Research is being conducted to evaluate the efficacy, safety, applicability of the therapies consumers are choosing. NCCCAM is funding some of this research. There is a gap in what consumers want and what the current biomedical system supports. There is a need for healthcare professionals to provide competency in educating and advising clients in CAT.

Nurse practitioners are in a position to fill the gap between what the consumer wants and what healthcare practitioners provide both in the form CAT and providing more personalized care as acknowledged in the Eisenberg, et al. (1997) and Astin (1998) studies. But with the demands of what consumers want, there are barriers in the current healthcare system. It is difficult to introduce new ideas that change the dynamics of care.
As clients are asking for a broader point of reference from their clinicians, primary care providers need to consider and be educated about other treatment and care options, especially when clients experience chronic health conditions. NPs interested in HEC have both the challenge and opportunity to innovate and provide the caring, creative presence that Newman (1999; 2005) espouses, and consumers are demanding. Blending integrative practice with the unitary-transformative nursing theory is fraught with challenges. These will be discussed in Chapter Three.
CHAPTER TWO

Literature Review

The volume of literature related to the FNP primary care not related to disease process or management is scant. Therefore, education related articles and text are used as resources. Chapter Two will review the literature on three relevant topics relevant to FNPs using HEC to integrate the biomedical model and CAT: 1) primary care, including the components of primary care 2) the role of FNPs in primary care, 3) the development of HEC as a unitary-transformative (UT) theory.

Primary Care

The literature review focuses on primary care associated with FNPs, but excludes a focus on any particular disease process. Results revealed a gap in the literature related to primary care practice associated with FNPs. However, three major sources of information were identified, one focused on the future of primary care developed in the IOM report; a second, the competencies developed by the USDHHS (United States Department of Health and Human Services); and third, the integration of nursing and primary care as outlined in a major textbook by Hamric, et al. for primary care. A physician-based website developed by primary care policy fellows provides a supporting description of primary care.

The Institute Of Medicine Report on the Future of Primary Care

The Institute of Medicine (IOM, 1996) published the results of a two-year study on the state and future of primary care. The response to the growing dependence on care provided by medical specialists and the related growth of hospital-based care prompted
the IOM to conduct the study. Past efforts to encourage primary care included training primary care clinicians, financial support for primary care services for disadvantaged populations, and developing health maintenance organizations (HMOs) and other organizations that promote primary care. However, improvement in the utilization of primary care was ineffective. According to the report, a growing body of evidence suggested the increased use of specialization and hospital-based services led to spiraling costs, access problems to basic care for some populations, and it failed to effectively address health problems that create disability or death.

According to the IOM report (1996), healthcare cost reduction was a driving force in the marketplace. However, the report states that any changes made in the healthcare system solely based on cost were likely unsupportable by the American public. The IOM report stated that primary care was the foundation of the healthcare system. The IOM report also stated that the committee’s focus was on “ensuring that primary care is shaped by concern for “meeting people’s needs for healthcare” (p. 14).

Part of the work of the IOM committee was to develop a clear definition of primary care to guide healthcare policy for both public and private sectors. The report describes “primary” as first contact, or entry into the healthcare system. Primary care is central and fundamental to health care. This latter idea of primary care supports the multidimensional view of primary care envisioned by the IOM committee. The IOM Committee (1996) defined primary care as follows:

*Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority*
of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (p. 1)

The IOM definition emphasized the patient [client]-clinician relationship, and other relationships in the healthcare delivery system. Primary care included integrated services that are comprehensive, coordinated, and continuous. Accessibility meant the ease with which clients could initiate interaction with clinicians, and efforts to eliminate any barriers that prevent this occurring. Health care services referred to the range of services that provide for health promotion and disease prevention and management.

The IOM committee worked with five assumptions: 1) Primary care can address a large number of problems in the population and is the logical foundation for the healthcare system. 2) Primary care is essential to quality healthcare and includes desired health outcomes, patient satisfaction, and efficient use of resources. 3) Vital to primary care is trust and partnership between clinicians and clients. 4) Primary care is an important mechanism for achieving a stronger emphasis on health promotion, care of the chronically ill, especially among the elderly with numerous problems. 5) The trend toward integrated health care systems in a managed care environment will continue and will provide both opportunities and challenges for primary care.

The committee provided several recommendations to promote and develop primary care. The Committee recommended that primary care and health care coverage be available to all Americans. The report also called for a widely available system that paid for primary care, and that payment reflected the monetary value of the services provided. Primary care needed to include a team approach, as well as provide care for the
underserved and those with special needs. There should be collaboration between primary care, public health, mental health, and long-term care. Primary care is “information intensive” (p. 3), and is based both in the biomedical and social sciences. Physical and mental health should not be considered separately. Tools for monitoring primary care needs to be developed, and outcomes made widely available. The report found that one challenge was identifying the core competencies to reflect the committee’s vision of primary care and primary care teams. To facilitate the last recommendation, academic health centers were charged with developing “primary care [as] a core element of their mission, and to provide leadership in education, research, and service delivery related to primary care” (IOM, 1996, p. 188).

Reported IOM Core Competencies in Primary Care for Nursing

The IOM report identified fifteen core competencies for the common educational curricula of family medicine, pediatric, or internal medicine residencies, and elaborated at length. While the report identified core competencies required for nursing, the report was not as extensively described or detailed as the physicians’ curricula. Six core competencies were identified based on the work of the National Organization of Nurse Practitioner Faculty (NONPF). The competencies were organized into six domains: (1) managing client health or illness status; (2) maintaining the nurse-client relationship; (3) carrying out the teaching-coaching function; (4) developing the professional role; (5) managing and negotiating health care delivery systems; and (6) monitoring and ensuring the quality of health care practice. When NONPF met to create discuss the competencies,
a seventh competency was added—cultural competence (For the competencies of NPs in general, see Appendix A).

_Nurse Practitioner Primary Care Competencies in Specialty Areas: Family_

USDHHS published a report on the NP core competencies for specialty areas in primary care. The National Organization of Nurse Practitioner Faculty (NONPF) in association with the American Association of Colleges of Nursing (2002) evaluated and wrote the core competencies. The AACN outlined the initial graduate curriculum in 1996. The main objective of the panel was that of developing a national consensus for the entry-level core and specialty competencies for NPs. The intent was to set the standard for guiding graduate level nursing education for NPs in five primary care areas, and defining the purposes and goals of the professional role of nurse practitioner in a primary care setting.

The competencies provide a clear set of expectations to employers, the public, and students regarding the nurse practitioner role and specialty areas. The specialty areas are adult, family, gerontologic, pediatrics, and women’s health. The panel developed a set of foundational core competencies for all NPs, and each specialty has core competencies associated with it. This scholarly project will briefly describe the domains for the FNP as described above from the Hamric, et al. (2000) text, and the associated core competencies. (For a listing of the specific competencies for FNPs, see Appendix B).

_FNP Core Competencies_

According to the USDHHS publication (2002), FNP primary care practice encompasses newborns, infants, children, adolescents, pregnant and post-partum women,
and older adults within the context of the family unit. The FNP is an expert in family nursing. The competencies are elaborated below:

*Health Promotion, Health Protection, Disease Prevention, and Treatment.* Within this role, the FNP integrates scientific, theoretical, and contemporary clinical knowledge to assess and manage both health and illness states. The domain includes the competencies of assessing health status, diagnosing health status, planning care and implementing treatment.

*Assessment of health status.* Describes the assessment of all aspects of health status for the purposes of health promotion, health protection, and disease prevention. The FNP uses evidence-based clinical practice guidelines to guide screening activities, identify health promotion needs, and provide anticipatory guidance.

*Diagnosis of health status.* Describes the diagnosis of health status. The diagnostic process includes critical thinking, differential diagnosis, and integration of various data.

*Plan of care and implementation of treatment.* Describes the goal of planning and implementing interventions to restore the client to a stable state and improve the client’s health. The FNP’s role is to stabilize the patient, minimize complications, and improve health potential.

*Nurse Practitioner-Patient Relationship.* Competencies in this area of patient care are that FNPs demonstrate effective personal, collegial, and collaborative approaches. The competencies refer to the emphasis on interpersonal relationships associated with client outcomes.
Teaching-Coaching Function. These competencies first describe the FNP’s capacity to communicate knowledge and psychomotor skills. The coaching function engages the ability to interpret and create individualized plans through advocacy, modeling, and tutoring.

Professional Role. These competencies relate to the FNP improving direct care and management, and improving the profession overall. The FNP is committed to “the implementation, preservation, and evolution of the FNP role” (p. 23). The FNP builds collaborative, interdisciplinary relationships to provide the best possible client care.

Managing and Ensuring the Quality of Health Care Practice. These competencies ensure quality care through consultation, collaboration, certification, continuing, education, and evaluation. The monitoring function implies that the FNP will monitor their own practice and engage in interdisciplinary peer and systems reviews.

Cultural Competence. These competencies are associated with the FNP providing care congruent with the client’s cultural and spiritual beliefs, and making health care resources available to patients from diverse cultures.

Role of FNPs in Primary Care

In the previous section, the components of primary care were presented. Further clarification about the role of the FNP in primary care is examined in this section. A literature for recent research on FNP primary care practice yielded articles on disease process and management. No articles were found on FNPs conducting primary care practice (1999-2004) in the CINAHL database. Numerous articles written by family physicians on current practice were cited in MEDLINE and CINAHL database searches;
these articles were excluded as this scholarly project focused solely on NPs. For this reason, clarity about primary care is referenced from an APN text and website focused on primary care.

The text *Advanced Nursing Practice: An Integrative Approach* (2nd Ed.) (Hamric, et al, 2000) provides an overview of primary care and NP primary care. The text aligns with the components of primary care as defined in the IOM definition. The components noted below are: integrated, accessibility, clinician, accountable, majority of personal healthcare needs, sustained partnerships, and cultural competency.

*Components of Primary Care for FNsPs*

The practice should provide integrated care, which refers to “the provision of comprehensive, coordinated, and continuous services” that addresses any health problem from birth to death (Hamric, et al., 2000, p. 410). Both services and appropriate information need to be provided to clients by an individual practitioner or an interdisciplinary team (clinician continuity) and there should be effective communication of the client’s health record (record continuity). A practice’s accessibility “describes the ease with which care is obtained” (p. 410.) This term emphasizes the removal of barriers to access care such as administrative barriers, location, culture, and language. The practice must provide a clinician (p. 410), “an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health care services to clients” (p. 410). Primary care needs to be accountable (Hamric, 2000) to both clinicians and systems in which the clinicians work. Clinicians are accountable for the care they provide, are responsible for patient satisfaction, use of resources, and
observe ethical behavior. A practice must provide for the majority of personal health care needs, which means the practitioner needs to be competent to manage the majority of clients’ health care issues. Referral is made when further evaluation or management is needed. Primary care must allow a sustained partnership based on a relationship of trust, respect, and responsibility developed by the clinician, the client, and client’s family over time. Primary care practice must occur within the context of family and community, which refers to understanding the broader living conditions that exist with the client, and includes family make-up, which may or may not include blood relations, housing, environmental conditions, work, and cultural group. Community may not just include members of the health plan, community, or the clinic in which the client is served. NPs recognize the importance of preventive health and public health trends within a community and the inferred health promotion and disease prevention strategies.

Nursing models of care emphasize “considering the human response to illness” (Hamric, et al., 2000, p. 411). The NP uses the holistic approach for assessment and treatment, and integrates elements from both nursing and medical models. NP practice utilizes many skills and competencies in the primary care setting; expert reasoning and various healthcare strategies assist the NP in cost-effective care delivery.

To add to Hamric, et al.’s perspective, a physician oriented and developed website sponsored by the Primary Care Society, describes the components of primary care in terms of the Ideal Vision of Primary Care. Schlaff, Director of the Futures Project and MPH Programs at Tufts University School of Medicine, states that there is no “perfect model for primary care” (n. d., ¶ 1). Schlaff wrote that primary care providers and
provider systems need to adapt to the needs and values of the community served. All primary care practices should share the features noted below: accessibility, accountability, sustained partnership, and context of family and community.

Schlaff (n.d.) considered that care does need not to be performed solely by one practitioner or at one site when addressing integrated services. Schlaff suggested that for each client there is a provider that can access and understand the full range of issues clients face in the healthcare system. The clinician should have full knowledge of services available within the client’s healthcare system, and should work in partnership with the client to access services, including specialty care. The clinician both advocates for client within the system and educates the client about the system.

Accessibility (Schlaff, n.d.) entails financial, perceptual, and objective dimensions. This component translated into clients receiving the care needed that is reasonably affordable and convenient. Barriers to care must be continually assessed and removed by the primary care system or practice. Preventive services that affect population health should be accessible to clients with care structure based on “sound clinical and public health science” (n. d., ¶ 2).

Accountability (Schlaff, n.d.) intended that clinicians must do their best to provide timely information and care to clients to assist them in sharing in the decisions of healthcare, provide comprehensive education about their conditions, and be responsive to their clients’ issues and concerns. Clinicians need to remove barriers to access such as administrative barriers, location, culture, and language. Clinicians and systems have a duty to make systems and services as “understandable and comfortable as possible”
(n. d., ¶ 4). Clients need to have confidence that clinicians only provide necessary care. Clinicians must be protected from over-treatment and be willing to advocate for necessary care.

Sustained partnerships (Schlaff, n.d.) described clients willing to participate in “the integration of care” (n. d., ¶ 5) even when other providers provide a bulk of the services. The clinician ensured that the client’s values and preferences are considered in planning treatment. Duplication of services is avoided. For healthy clients, primary care clinicians seek to provide on-going, comprehensive preventive care for those willing to accept these services. Provision of services to sustain a partnership at any stage of life or disease process is maintained.

A primary care practice must exist within the context of family and community. Schlaff (n.d.) stated that clinicians “need to understand as much they can about the social, psychological, and cultural background and needs of their clients, and attend to these as well biologically mediated illness” (n. d., ¶ 6). Clinicians must offer the best biomedical knowledge has to offer, while accepting clients’ values and beliefs in decision-making. Clients must be educated in a language they understand. Clients and families must understand the full range of services available to them; clinicians work with clients to use these services in the best possible way to manage their healthcare.

**CAT Education of FNPs**

Just as there was limited literature related to primary care and FNPs, there was also limited literature on educating NPs about the CAT. The literature reviewed included 1) a 2002 report entitled the White House Commission on Complementary and
Alternative Medicine Policy, and 2) three studies related to including CAT in the nursing and FNP curricula.

As already presented, the amount of information mandated as necessary for a comprehensive APN and NP education is daunting. Even though consumers on their own initiative are seeking remedies other than medication and surgery to manage health promotion and illness treatment, there are few educational opportunities for NPs to learn about integrative health, or even holistic nursing. Limited studies have been conducted on how NPs become knowledgeable about CAT.

*The White House Commission on Complementary and Alternative Medicine Policy*

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) found that since the public uses both conventional healthcare and CAT, training in CAT is essential for all the health professions. At the same time however, the report acknowledges some of the challenges in implementing this finding. Among these challenges are: professions, organizations, and institutions have difficulty changing, lack of incentive to adopt curricula, lack of consensus on curricula, lack of funding, ability to adequately train faculty, and limited ability to include more in an already full curricula. These challenges are valid for advanced nursing education (Burman, 2003).

The commissioners of the WHCCAMP, in a concluding statement, noted that even though 72% of the medical schools surveyed provide for some form of CAT education. The only mention it made about nursing education was that nurses should be educated as well.
Once again, there was very limited information about the extent of education, knowledge, and application of CAT to FNP primary care in the literature. Three studies were found, and it is clear that much more could be done to inform clinicians about integrative practice.

In the first study, Sohn & Loveland Cook (2002) surveyed 151 NPs in Oregon and Missouri to investigate the current level and source of NP knowledge about CAT. A secondary goal was to determine the extent of NP referrals involving CAT. A cross-sectional descriptive study research design was utilized. Sohn and Loveland Cook (2002) identified that only 24% of the sample reported NP program curriculum education as a source of knowledge about CAT more than 60% reported personal experience, 64.4% identified lay journals, 61.1% relied on professional journals. 54.8% attended workshops and seminars, and 54.1% attended continuing education courses. Sohn & Loveland Cook found that 83% of the NPs surveyed recommended CAT to their clients. The most frequently cited CATs in the study were massage (50.3%), chiropractic care (46.9%), and acupuncture or acupressure (39.9%).

The authors suggested that the findings revealed that NPs responded positively to society’s demand for CAT. Fifty-four percent reported supporting the use of CAT in healthcare. One participant in the study wrote, “a nurse is a healer, teacher, counselor, guide”. Sohn & Loveland wrote, “In that role [the NP] must know of and offer to the [client] any remedy that may improve the quality of life with the least harm” (p.15). The findings indicated that NPs are recommending or referring CAT without a strong
foundation of scientific knowledge and with a lack of formal training. This may put both clients and clinicians at risk if a client suffers an injury or adverse reaction while utilizing the recommended CAT. That NPs responded to the public demand without a solid educational base makes it imperative that the NP curriculum be expanded.

Sohn and Loveland Cook concluded that NPs embraced the holistic principle and guided client care by incorporating CAT in practice. The authors demonstrated the need for more NP program curriculum education in CAT, especially information grounded in scientific studies. “A closer partnership between nursing education and the practice community can help guarantee that a formal NP curriculum adequately prepares NPs to meet the changing healthcare demands of this country” (p. 16).

In the second study, King, Pettigrew, & Reed (2000) conducted a study using a convenience sample of 2,740 registered nurses (RN) on the use of CAT to treat themselves, on their clients, and referral of clients to CAT. Four hundred fifty responded to the questionnaire. In using CAT on themselves, the most frequently used CAT was prayer (81%), diet (74%), and herbal products (41%). The most frequently used CAT with the clients was diet (38%), prayer (30%), and visualization/guided imagery (28%). Most frequent referrals were dietary advice (43%), prayer through a clergy person (30%), and visualization/guided imagery (21%).

The study also asked nurses to state what therapies the RNs used most for chronic pain control, symptom management, and well-being. For pain control, RNs used guided imagery both for themselves and clients. For symptom management, RNs used diet, prayer, and guided imagery the most. For client symptom management, RNs reported
either use or referral of diet, guided imagery, and prayer. For wellbeing, RNs reported using diet, herbal products, and prayer most commonly. For client wellbeing, diet, prayer, and guided imagery were either used or referrals were made.

In the study, a Lickert scale of 1 to 5 was used to assess the knowledge of 20 CAT, and the perceived efficacy of these CAT; “1” was no knowledge and “5” was formal training for each of the therapies. When the authors questioned RNs about their knowledge, the RN’s mean level of knowledge was lower than the belief in the effectiveness of the therapies. Reed, et al. concluded that the evidence demonstrated that RNs used and referred clients to CAT, yet had little formal education about CAT. The authors stated “as professionals, nurses are obligated to be knowledgeable about this trend, whether one agrees or disagrees about the particulars of [CAT], in order to provide holistic and competent care for the consumer” (p. 47). The study confirmed that a broader educational foundation in CAT was needed for nursing as a whole.

Finally, Burman (2003) conducted a study to evaluate the status of CAT education in FNP programs. The term “CAM” was used, a commonly accepted term for complementary and alternative medicine; however, to maintain project integrity, the term “CAT” will be substituted. 249 questionnaires were sent to FNP directors in the United States; 54% or 135 were useable questionnaires. FNP programs from public (67.4%) and private (32.6%) institutions participated. 98.5% of respondents reported CAT content in the curriculum. Some respondents commented that CAT was “minimally integrated” as there was faculty resistance to its addition to the curriculum and the curriculum was full already. 80% of the programs integrated CAT into course that existed, and 18% of the NP
programs integrated CAT into existing courses as well as utilizing stand-alone courses for education. Two programs had stand-alone courses only. When CAT was integrated into existing programs, the most commonly cited courses were pharmacology, disease management, and health promotion. In addition, 69.8% of respondents reported their faculty used self-study to learn about CAT, 30.2% employed faculty who practiced in the area of CAT, and 18.3% employed faculty with CAT and/or holistic nursing certification. Almost 16% reported faculty had no CAT education. Burman also evaluated faculty’s view of CAT competencies. Respondents considered many competencies to be important or very important.

Education needs to focus on ways to inform faculty and students about CAT competencies. Burman developed a list of core competencies adapted from the USDHHS publication to FNP primary care practice oriented towards CAT, and requested that faculty rate the importance of a list of 23 competencies. Among the competencies were eliciting information on, and educating clients on CAT; using evidence-based approach to CAT, and “uses nursing theory to delineate [a] nursing approach to client care” (p. 32) were listed as very important. (For Burman’s Integration of CAT and FNP Competencies, see Appendix C). Participants in the study did not report the demonstration of the knowledge of CAT or the competence to conduct specific CAT as important. Burman acknowledged that the current definition of CAT is “medically focused and does not incorporate nursing’s holistic philosophy” (p. 32). Burman reported that many educators wanted a definition of CAT that was more relevant and useful to APNs.
The focus of CAT on “other” creates barriers to incorporating information into advanced practice curricula. Burman indicated that creative ways to incorporate CAT content is needed, and developing new courses with new content is not possible. Burman feels that integration and reinforcement is possible. Integration of CAT into FNP curricula can be facilitated by various learning strategies. Burman stated that many educators have little background in CAT. Burman considered distance learning might be a way to educate faculty. Burman concluded that the study findings helpful for FNP faculty planning to incorporate CAT into current curricula to prepare NPs for safe practice. “These results are relevant in regions of the world were biomedicine and alternative traditions coexist” (p. 34).

These three studies demonstrate that while nurses and FNPs know and accept that clients use CAT, will recommend and refer CAT to clients, and will use it for themselves, there is a lack of foundational education about the different kinds of treatment available, and the effectiveness of CAT. Innovative ways need to be developed to create more educational opportunities for competency in CAT knowledge and practice.

**Health as Expanding Consciousness**

HEC, a theory developed by Margaret Newman, has been used to guide nursing care. The review of the literature will focus on one seminal article by Newman (1995) originally published in 1987 which described the process of using nursing diagnosis to identify client patterns. What is important about the article is not the article’s influence on nursing diagnosis, but her description of pattern identification and the process of expanding consciousness and its effect on both clients and nurses. When this article was
written, Newman had not yet identified the nursing theory HEC, and clearly, the article demonstrates the roots firmly in place for theory development.

Pattern recognition is a core concept to HEC. Newman (1995) wrote that pattern recognition was crucial to “nursing’s emerging pattern” (p. 79). Newman understood that nursing was undergoing a revolution similar to that caused by Copernicus, who discovered that the sun did not revolve around the earth, which was a radical idea 500 years ago. We now all know that the earth revolves around the sun. Similarly, Newman wrote that nursing identified disease as the center of the world of nursing. Newman described a long history of aligning nursing with medicine in “prevention, treatment, and rehabilitation of persons, families, and communities in relation to disease” (p. 79). Some people began to see that disease was not the center of things, but rather an aspect of how a person “manifests” (p. 79) him or herself. Newman reminded the reader of Nightengale’s practice of minimizing disease and emphasizing health. Nightengale pointed out that the nature of disease is disruptive, and that “understanding health comes from observation and experience” (p. 80). Newman focused on these two words in the article.

Newman wrote about the people who influenced her thinking about health and disease. Newman pointed to Marilyn Ferguson as outlining a paradigm shift from a disease-centered focus to a person-centered focus. Newman wrote:

…we no longer view disease as totally negative or as an entity unto itself, but rather as information about the whole, as a manifestation of pattern. We seek then not to simply eliminate the symptoms of disease but to identify and understand the
pattern of which the symptoms are a part. In the old paradigm based on etiology
and treatment of disease, the professional is the authority and as such prescribes
what the client should do. In the new paradigm based on pattern recognition, the
professional is a therapeutic partner and joins the client in the search for pattern,
with its concomitant understanding and impetus for growth (p. 81).

Newman acknowledged Martha Rogers’ contribution to her understanding.
Rogers (1971) wrote that pattern is the “identifying characteristic of a person’s wholeness
and that the need in nursing practice is to identify sequential patterns of man’s evolving
pattern with the environment” (p. 81).

Newman emphasized that in sequential pattern recognition, the “pattern evolves
over time” (p. 81). The pattern of relationships from childhood is different from that of
present time, and still retains some essential characteristic from one time to the next.
Newman pointed out that it is possible to discern the pattern without referring to the past,
and “therefore, and probably in a crisis, that is probably where one starts” (p. 81).

In the article, Newman described a case study of a young mother, alone in a new
city with her children, providing day care to other children. One of the babies in her care
experienced Sudden Infant Death Syndrome (SIDS). After this infant’s death, the client
was disorganized, disinterested in her own children, and experienced fatigue, insomnia,
and tearfulness. A nurse spoke with the client, offered suggestions about how to care for
her children during this time, and gave the client information about a support group. After
some time, the client attended support groups and utilized resources in the community.
When the client was asked about the nurse’s contribution to the situation, the client felt
the nurse was “an organizing force through which the client was able to move” (p. 83). From this case study, Newman identified three predominant patterns of interaction. The first was a relatively closed pattern of interaction. The next was disorganization and disruption. The third pattern was one of reaching out to give and receive help. After the crisis, the client experienced a higher energy exchange between herself and the environment, and better relationships. Newman saw this as “simply a reflection of what is” (p. 83). It required no interference or interpretation. Pattern identification does not “imply causality” (p. 83). From Newman’s point of view, the sequence revealed a pattern of expanding consciousness, i.e., a pattern of increased quality and diversity of interaction with the environment. The nurse acted as a source of power, as a pure reference beam which helped the client focus and move beyond herself to relate to others in more caring, meaningful ways (p. 83).

Newman saw the role of the nurse, within this paradigm, “to help clients recognize their own patterns” (p. 83). Newman wrote that nurses often ask her what is done with the pattern once it is identified. Newman did not see pattern identification as a guide to specific action.

_A burst of insight occurs when, suddenly, everything fits together; everything makes sense. And when that happens, the pathway of action opens up. It is like throwing light on a situation. Then one can see clearly and take action. It is different in every situation and therefore cannot be prescribed in advance. It is facilitated by another person’s involvement in the interactive process, and that’s where nursing comes in_ (p. 85).
Newman wrote “as nurse practitioners [adopt this approach] of pattern recognition “the skill of sensing into the whole becomes integral to practice. Sensing into the whole is the action component crucial to a paradigm of pattern, and this activity is more one of sensing into oneself than of observing another” (p. 86).

A “phenomenon of interference” (p. 86) is described as a rock being thrown into a lake, and circular waves spread out from the point of entry. Another rock is thrown in the lake with its own pattern of expanding waves. Within seconds, the waves reach each other and create a new pattern. Newman termed this an “interference pattern” (p. 86). Eventually, the two patterns become “one pattern containing information about the whole of both” (p. 86). Newman encouraged nurses to imagine waves from one person interacting with waves of the other person, “forming an interference pattern that contains information from each pattern and eventually becomes the whole. The way to get in touch with the pattern of the other person is to sense into one’s own pattern” (p. 88).

Newman acknowledged that this approach was not objective. Some nurses may consider the lack of objectivity as invalidating the approach. Newman, however, had different perspective. Subjective and objective were no longer separated in the paradigm of pattern recognition. The pattern recognition eliminates dichotomies. Nurses “have access to the total information of our world through ourselves” (p. 89). Newman wrote that nurses can offer the insight of “knowing thoroughly”.

Newman concludes with the following statement:

*I am convinced that we in nursing want more for ourselves and for the patients we serve. We want the authenticity and meaning and satisfaction that comes when*
our relationships with patients have made a difference. Each of us has experienced the coherence of such moments from time to time and we want to be able to explicate that knowledge of the whole to others. As we are able to do this, we can have confidence that our practice derives from a nursing paradigm (p. 89).

Selected recurring themes in HEC are reviewed below.

**Therapeutic Relationship**

Newman (1999) emphasizes that the old pattern of nurse-client relationship was based on the idea that humans are made up of separate parts of the biomedical system. Mind, body, and spirit are closely aligned and should not be considered separately from each other. (Hamric, Spross, & Hanson, 2000). Holism recognizes that the human being “is more than the sum of its parts” (Smuts, 1926, p. 113), functions as a whole within the larger universe and cannot be separated into finite units (Hamric, et al., 2000; Smuts, 1926). Each person is a unique, complex system within the larger systems of family, community, and universe. In the biomedical system, the clinician’s responsibility is to find out what is wrong and to fix the problem. When HEC guides practice, the goal is to understand what pattern exists, and relate to the pattern as both clinician and client gain awareness. The point of view recognizes patient expertise and the meaning of the illness or health experience (Hamric, et al. 2000, Newman, 1999). Movement, knowing, and pattern recognition are central to gaining awareness.
Movement

Movement occurs when the NP and client intersect. Because the client is in chaos, more reflective ways are needed to respond to situations (Picard & Jones, 2005). At this point, clients can no longer return to life as they have known it. At times, how to proceed may not become immediately known. The FNP and client persevere until a new pattern emerges. This is a radically different way to practice as it does not impose or facilitate an action or evidence-based biomedical or CAT treatment option. It allows the process itself to reveal the course of action. Practice, in this case, means assisting clients to understand the meaning of their health experience, understand the pattern, and allow for the opportunity for action (Picard & Jones, 2005).

Knowing

One of the unique aspects of Newman’s theory is the expanded dimension of the ways that nurses, and in the case of this paper FNPs, can become aware of what it is that they really know, and how it is that they know. Newman (1995) wrote that beyond the knowing the client’s overall pattern is the process of “sensing into one’s own field” (p. 193). The FNP is required to be aware of the internal experience and trust that the information being received in the moment is valid. When the clinician does this, what develops is an increased capacity to be part of the healing energy that is created within the intentional relationship. It is necessary to reflect on the meaning and choice within the particular relationship with openness and curiosity.
Pattern Recognition

An essential component to the relational process of HEC is pattern recognition (Newman, 1989, 1999; Picard & Jones, 2005). Health patterning unique to each individual, family, and community unfolds in its unique way through a series of visits (Newman, 1999). There is a caring attentiveness in the relationship between NP and client to develop whatever needs to transpire from the partnership. In the process known as praxis, identifying patterns occurs in stages, rather than all at once (Newman, 2005). The current pattern of a person’s life contains information about the past and possibilities of how things may unfold in the future. Often when a client comes before the NP, it is at a time when things are no longer working the way they used to, and a different choice needs to be made. Newman, within this framework, sees that the goal is to help the client see the patterns that exist now, understand what new rules will emerge, and to move to another way of being, of understanding. Understanding a person’s pattern occurs in the process of the clinician and client relating (Newman, 2005).

The relationship ends when the identification of action is made clear. However, in the context of family practice, ongoing partnerships are the norm. Newman (1999) wrote that there is a need “for an understanding of the whole” (p. 97). The ability to understand different phases of the client’s and clinician’s lives and overall pattern is essential. It involves the sustained unfoldment of ongoing pattern recognition when one situation is complete and action taken; then the cycle of another level of pattern recognition begins again. There is always something else to uncover, discover, and integrate, regardless of age, sex, or culture. The FNP and client do not eliminate previously valuable information,
but view it from yet another perspective. From the patterns recognized earlier, from a sustained relationship, new understanding may be gained. In this context, consciousness is expanded.

Praxis

Praxis is research as practice (Newman, 2005). The basic process entails the clinician engaging the client in a dialogue as data gathering about meaningful events in the client’s life. The clinician then creates “the opportunity for reflection, awareness, and potential insight” (Picard & Jones, 2005, p. 13). A schematic diagram allows the client to see themes the clinician heard during the dialogue (Litchfield, 2005). Through the process of praxis, both the clinician and client are able to understand the overall pattern. In essence, praxis is scholarly practice.

Unitary Transformative Nursing Theory

In the book *A Developing Discipline: Selected Works of Margaret Newman* (1995) from 1991, Newman, Sime, and Corcoran-Perry described a “focus for the discipline of nursing and to discuss the differing paradigmatic perspectives for the nature of nursing knowledge” (p. 36). Newman, et al. submitted that nursing is the study of “caring in the human health experience” (p. 36). The authors found considerable evidence to support caring, health, and health experience as central concepts to nursing. Newman stated that this focus dictated that nursing’s purview include caring and the human health experience. Without these two aspects, knowledge could not be considered nursing knowledge. Theories reflect different perspectives or worldviews, or perhaps, different paradigms. This project will focus on “paradigmatic perspective” (1995, p. 37) as
described by Newman, Sime, & Corcoran (1995) with comments by Lee (2005). These perspectives reflected a shifting focus from “physical to social to human science”. These paradigms are termed particulate-deterministic, interactive-integrative, and unitary-transformative.

In the particulate-deterministic paradigm, what is observable is seen as real, demonstrable, having concrete evidence that is accepted when scientifically verified and measured. Newman, et al. see change as a result of previously determined conditions. This perspective is closely aligned with reductionism and rationalism. Examples of this are measuring physical parameters such as chemistry blood levels, or how the surrounding environment affects the body. This paradigm provides a framework for critical care research (Newman, Sime, & Corcoran, 1995).

The interactive-integrative paradigm is an “extension of the particulate-deterministic paradigm” (Newman, 1995, p. 38). Observable facts are seen as having many, interconnected elements in relation to a “specific context” (p. 38). Change is the result of many previously determined conditions, though subjective information can be used to comprehend observable facts. Newman, et al. see this as a move towards holism; though, with the goal of “knowing the patient through the sum of its parts” (Lee, 2005, p. 189). Importance is placed obtaining information in many ways. Knowledge can be deduced not only by observation, but also from reports, history, family, and other information. Lee cites an example of this as being “the interplay of body-mind-environment factors in health” (Lee, 2005, p. 190). An example of this would be how nurses care for clients by responding to both the verbal and non-verbal clues.
The UT relationship, according to Newman, et al., represented a paradigm shift. Newman described UT in the following way:

…phenomena [being viewed] as a unitary, self-organizing field imbedded in a larger self–organizing field. There is interpenetration of fields within fields and diversity with a unified field. Change is unidirectional and unpredictable as systems move through stages of organization and disorganization to more complex organization. Knowledge is personal, involves pattern recognition, and is a function of both the viewer and the phenomenon viewed. The subject matter includes thoughts, feelings, choices, and purpose (Manen, 1990). Inner reality depicts the reality of the whole. From this perspective, caring in the human health experience would be studied as a unitary-transformative process of mutuality and creative unfolding (p. 38).

Newman (1992) admitted that the paradigms described by Newman, Sime, & Corcoran-Perry (1991) did not fit into categories already developed in nursing science. Newman described in each paradigm—particulate-deterministic, interactive-integrative, and UT—“the first of the paired words describes the view of the entity being studied and the second describes the notion of how change occurs” (p. 44). Newman wrote that the biophysical sciences are single-paradigm sciences with a broad consensus. Biopsychosocial sciences involve competing paradigms and allow both objective and subjective data. Human science expands the view of humans as a unitary phenomenon. Newman also states, “identifying the paradigms is easy. The hard part is acknowledging
the pervasive nature of paradigms” (p. 50). Newman wrote that the UT paradigm is a shift from the “scientific medical model to a model based on holism (Johnson, 1990)” (p. 52).

Newman, et al. described the UT paradigm as significant. Information is “seen as a unitary self-organizing field imbedded with a larger, self-organizing field” (1991, pg. 38). “A process of mutuality and unfolding” (Newman, 1995, p. 46) is the basis of inquiry by both the viewer and the subject when exploring pattern recognition. In other words, both the nurse practitioner and the client engage in the experience and are able to see the pattern. The paradigm disallows predictability and control as part of the nursing process. Pattern is seen as part of a person’s wholeness. What occurs happens in the moment, is a reflection of both person and environment. In this shared process, the nurse practitioner engages in the moment and the NP’s deliberate presence with the client helps reveal the truth and “foster personal choice” (Lee, 2005, p. 190). In this paradigm, both the NP and the client could experience change.
CHAPTER THREE

Practice Application of HEC

Practice Exemplar

An example of an application of HEC modified to fit a primary care clinic setting with care provided by an FNP student recently occurred. J.M., an 18-year-old Yaqui Indian female came to the primary care clinic for a two-day migraine, accompanied by nausea, vomiting, photophobia, phonophobia, increased somnolence with pain, though was experiencing less pain and no vomiting at the time of the visit. The extent of the migraines resulted in withdrawal from most activities of daily living, especially over the past six months, though the migraines started suddenly about eighteen months earlier. The FNP student, quickly assessed vital signs and the state of the client, and quickly decided to focus on relationship, as the client was not in acute physical distress. Within the framework of HEC, an interjection adapted to setting and person was created to open conversation—“Tell me about your life that is important to you right now”. This led to an exploration of what the young woman termed a “lack of life”. The client was unable to attend school due to the pervasive nature of the migraines and associated symptoms. When she did not have a migraine, she was tired and had trouble concentrating. She was unable to sustain an ongoing relationship with her mother outside of her mother taking her to doctors, and frequently would experience attacks if she entered the living room. Her friendships were failing, and she was unable to have a boyfriend, because she was “always sick”. She experienced significant emotional distress, and wanted more to life than being in pain. She was teary during the visit at times. The medication she was taking
no longer was working, and she was feeling very discouraged about life. The client expressed gratitude to have someone to be so interested in her experience. Her mother was present and crying, and providing supporting information. The mother was very worried about her daughter, especially since the migraines had become worse in the last month. The mother also expressed both relief and frustration in regards to the number of scans and x-rays that the client had been given and “everything has come up negative.”

The FNP student gave an oral description of the pattern observed overall in the course of the conversation and asked for clarification on some points. Both the daughter and mother agreed that the overall pattern of their relationship centered on the daughter’s needing care during the past 18 months due to pain and disability.

At this point in the conversation, the daughter was wondering if there were other treatments available to relieve the pain, and “help me get on with my life. While the client did ask for symptom relief, the second part of the comment offered an opportunity to move to another point, to learn something new, and to possibly expand consciousness. The chaos of the situation was a point where nothing was working, and the client and mother both were aware of this realization. Both were ready to see other options, affording an opportunity to look at the pattern. The FNP student at this point offered and gave pain and nausea medication for immediate symptom relief, and an abortive and anti-nausea medication for home use, which had not been previously offered. Within the context of CAT treatment and integrative practice, the FNP student offered a protocol combining bioidentical hormone replacement therapy with nutritional supplements as an alternative to medication treatment, and explained the rationale for this choice. In
addition, a discussion of different modalities of alternative treatment available at the alternative medicine clinic, and education on triggers, medication, and topical modalities to treat pain was offered. Both the client and the mother were surprised at the extent of information available to treat migraines. They left feeling hopeful and willing to try different things. Both of them thought that Internet searches and reading about migraine management were something that they could do together. There was a sense of relief expressed that they “could be mother and daughter again”. At this, the natural end to the visit occurred.

Reflections on Practice

The above exemplar describes a young woman struggling with the challenges of physical and emotional distress related to migraine. Presenting at the time when she was in chaos, it was here that the client and the FNP student intersected, as Newman (1999, 2005) described. In this instance, the intersecting occurred in the context of a primary care setting during a triage visit, within the biomedical model; something was wrong, and the FNP student should do something to fix the problem.

Newman’s theory is not concerned with ‘fixing the problem’. It is a way to be with clients, and to allow the client and FNP student, in this case, to understand the overall pattern. Theoretically, J. M.’s symptoms were part of the overall pattern of her life. The challenge is that HEC is not based on needs or intervention. The goal was to help J. M. come to understand her symptoms. Both the client and her mother entered into a brief relationship with the FNP during her time at the clinic. The goal is to present to opportunity to expand consciousness.
As I was the FNP student engaged with J. M. as she came into the clinic with her mother, the opportunity was presented to create another type of situation for J. M. As she and her mother dialogued with me, it was clear that HEC could guide my actions, as J. M. was in the ‘movement’ phase of HEC. Life as she had known it no longer worked. As this was the first and perhaps the only visit with the client, persevering until a pattern emerged or unfolded was not possible. The process was not sustained to allow enough time to let a course of action reveal itself. There was, however, a brief opportunity for the client to begin to understand her pattern.

While exploring HEC to guide my interactions with J. M., I was aware of my internal experiences and took cues from “sensing into [my own] field” (Newman, 1995, p. 193). This meant that I had to trust the information that was being perceived, and be confident in the knowledge that I was standing in my truth. The intent was to be as resent as possible to create “an authentic relationship” in the moment (Newman, 1999, p. 97). There was openness and curiosity among the client, her mother, and I in exploring the health experience J. M. was reporting. In primary care, there would be the opportunity to develop an ongoing relationship, and continue to develop insight into her overall pattern. It is likely that she would develop some further insight, and take action based on this insight to help her live life. The opportunity would exist for J.M and her family to experience expanded consciousness.

*Shifting Paradigms*

For the first part of the visit, I was able to hold true to HEC, and allow the experience and the relationship to unfold. And yet, the moment came when J.M
wondered out loud if there were anything I could do to “help [her] get on with [her] life”? It was as if that question was an unconscious cue to take action, and actually make something happen. Two paradigms came up against each other. It is not possible to encourage something to unfold and to take action or intervene stop the unfolding at the same time.

Using the HEC to guide practice momentarily, I was able to be more expansive, and to see other possibilities, as in the UT paradigm. Then, with the request to ‘help’ a shift occurred, and the interactive-integrative paradigm was more apparent. The need to be exacting, precise, define measurable parameters (particulate-deterministic paradigm) was not necessary, and it was very helpful to the situation to be able to see the fuller range of experience, rather than “J. M. had a headache”. I was aware of the many connections and interrelationships that may have influenced J.M.’s health experience. She was sleeping poorly, had nausea, eating poorly, was experiencing migraine pain, her home, school, and social life severely disrupted. My assessment used the biomedical model or biopsychosocial model, including the physical, emotional, and mental dimensions of J. M. There was a mandate, as it were, to intervene in J.M.’s health experience request and in the nature of primary care. I acted on the mandate and the obligation to apply the core competencies (DHHS, 2002) of managing client health or illness status and respect the nurse-client relationship. I informed both J. M. and her mother of all the treatment options open to her, including understanding about possible migraine triggers (American Council for Headache Education [ACHE], 2004); this required the teaching-coaching competency. My priority was to learn about her
experience to understand how to best care for her encompassed the professional role competency. Discussing options, such as her preferences and cultural biases, a plan was developed with her input that was agreeable to her and her mother. Through both the connection of relationship and the intervention, both the mother and J. M. left the clinic feeling more hopeful.

When recommending that J. M. consider visiting the alternative medicine clinic for treatments with massage, chiropractic adjustments, or acupuncture, or trying the multimodal treatment with bioidentical hormones and nutritional supplements, an integrative practice approach was taken. Integrative practice and CAT are based on an intervention approach to healthcare. Instead of prescribing a medication, a treatment or remedy is recommended. These approaches will possibly change symptoms, but how will these interventions change J. M.’s overall pattern? Extinguishing the symptoms may alter the emergent pattern if symptoms are a manifestation of the pattern. If nursing is interested in symptom management, what implications does this have for the discipline to use HEC?

*Symptoms*

Using the biomedical model in conjunction with nursing practice, ostensibly, the FNP gathers information about “symptoms”, and then creates the appropriate therapeutic intervention. When writing about symptoms, it is possible to narrowly focus on J. M’s physical condition, which was migraine headache. Of course, the dimensions of migraine headache usually interfere with every aspect of the client’s life to some degree. The question begs attention: If symptoms are a representation of the pattern of the whole,
doesn’t it mean by changing the symptoms of a client the overall pattern is changed? Is a change in the pattern reflective of an expansion of consciousness?

Reflective Evaluation

The situation with J. M. was not unusual in the primary care setting. Normally, two to five clients a week would be evaluated and treated for migraine in the clinic in which I interned. What was different about my interactions with J. M. is that the intent was to be guided by HEC in practice. There are challenges with using HEC in the primary care setting. It is important to acknowledge them.

First, as previously mentioned, I experienced a shift from one paradigm to another. This is not inconsistent with the practice experience of Lee (2005). Lee wrote that in care delivery, many times the particulate-deterministic paradigm was very apparent especially in the intensive care unit setting. However, in terms of HEC, Lee wrote that the quality of relationship between the nurse and client made it “possible to connect in a transforming way” (p. 188). HEC offers the client the opportunity to be “known as the focus of inquiry” (p. 193). There is the chance to know the client, to understand their circumstances, and to know their story. HEC affects the dynamics of care delivery. HEC focuses on the clinician’s ability to be open, caring, and receiving. The goal is to trust the process. The clinician can move easily from relational to analytical modes, and intuition is valued as a way of knowing as well. It may be possible to aide clients to expand consciousness and be known, even if it is not within the UT paradigm; though, this would be ideal.
Newman (1999) wrote about the need to seek “new patterns and arenas of practice” (p. 134). Newman wrote that the healthcare system is moving away from the concept of health being the absence of disease, to a system that “recognize[d] a dynamic, evolving pattern of the whole” (p. 134). My experience does not bear this out in the primary care settings in which I have been educated. Evidence-based medicine and practice is very much a topic of conversation. There is a driving need to be definitive in naming symptoms and listing signs of diagnosis and treatment in documentation in order to receive reimbursement. And even if this is done with great skill and accuracy, the correct coding is required or reimbursement will not occur. The current healthcare system does not pay for clinicians to have mutually beneficial relationships with clients, even if consciousness expands.

For many years I have studied the literature on CAT. I have a natural affinity for what I understood was a ‘holistic orientation’. It was a surprise to find that while there are certain benefits to the use of CAT in primary care practice, it is not very different in intent than the biomedical model. What I realized was that CAT is an interventionist orientation. For example, benefits of CAT include being able to advise clients in safe and efficacious use of supplements and best practices when clients complain of discomfort or pain. In researching CAT, RCT (randomized control trial) is often the gold standard, when testing herbs or acupuncture points. This finding is supported in Chapter One. In some ways, I have come to understand that I just have a ‘bigger tool box’ and more choices to assist clients when intervention is indicated or requested. Thus, CAT reflects the interactive-integrative paradigm. This paradigm acknowledges the interrelationships
that exist, but falls short of the expansive UT worldview of HEC, which is not centered on action. The CAT orientation is still about ways of doing rather than ways of being.

Can HEC guide care when standard primary care visits are fifteen minutes or less? Well, not in the truest sense of HEC. Time is an essential factor in the efficacy of nursing care (Newman, 1999). When nurses (NPs) are “freed from bureaucratic constraints” (p. 56) both clinician and client can coordinate relationship and interaction for growth and change depending on what the client needs. Though, as previously stated, HEC is not “needs-based”. And central to HEC is allowing the process to unfold in its own time and way. It is important, though, not to ‘throw the baby out with the bath water’.

With a lack of idyllic resolve, HEC can guide some aspects of primary care, whether or not it is an integrative health practice incorporating CAT and biomedical knowledge. Allowing the pattern time to unfold, both the clinician and client gain the awareness that the pattern will be known. Even if the relationship unfolds more slowly in short encounters than with the extended visits of HEC researchers, the pattern will still make itself known. The question that comes to mind and one that bears investigation is this: Is it possible for FNPs to use HEC to guide primary care based on the overall pattern and uniqueness of the client? Yes, when the knowledge of the overall pattern and uniqueness of the client is used to guide care. So, if we partially employ HEC, what aspects of practice can it guide? The opportunity to create the client’s awareness beyond the presented health condition is one possibility. HEC can guide practice to enter into the relationship with the client, collect data, and to choose an intervention that matches the
overall pattern of the client’s experience. The integrated primary care intervention is accomplished with the understanding that intervention is not part of the HEC framework.
APPENDIX A

DOMAINS AND CORE COMPETENCIES OF
NURSE PRACTITIONER PRACTICE

(USDHHS, 2002)
DOMAINS AND CORE COMPETENCIES OF NURSE PRACTITIONER PRACTICE

Introduction

The core competencies of nurse practitioner practice are essential behaviors of all nurse practitioners that should be demonstrated upon graduation regardless of the specialty focus of the program. The domains and competencies of nurse practitioner practice constitute a conceptual framework for nurse practitioner practice and the foundation for specialty competencies.

In 1990, the National Organization of Nurse Practitioner Faculties (NONPF) released the first set of domains and competencies. NONPF subsequently updated and revised them in 1995 and 2000. The core competencies presented here additionally include revisions and recommendations made by the National and Validation Panels, as well as selected competencies found in Curriculum Guidelines & Regulatory Criteria for Family Nurse Practitioners Seeking Prescriptive Authority to Manage Pharmacotherapeutics in Primary Care, Summary Report 1998, published by the US Department of Health & Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. The NONPF Board of Directors approved this version of the core competencies.

Domains and Core Competencies

All nurse practitioners should be able to demonstrate these core competencies at graduation. Each set of specialty competencies builds upon this set of core competencies. Throughout the competencies, patient is defined as the individual, family, group, and/or community.
DOMAIN 1. Management of Patient Health/Illness Status

Competencies

The nurse practitioner demonstrates competence in the domain of management of patient health/illness status when she or he performs the following behaviors in the following areas.

A. Health Promotion/Health Protection and Disease Prevention.

1. Differentiates between normal, variations of normal and abnormal findings.

2. Provides health promotion and disease prevention services to patients who are healthy or have acute and chronic conditions, based on age, developmental stage, family history, and ethnicity.

3. Provides anticipatory guidance and counseling to promote health, reduce risk factors, and prevent disease and disability, based on age, developmental stage, family history, and ethnicity.

4. Develops or uses a follow-up system within the practice to ensure that patients receive appropriate services.

5. Recognizes environmental health problems affecting patients and provides health protection interventions that promote healthy environments for individuals, families, and communities.

B. Management of Patient Illness.

1. Analyzes and interprets history, including presenting symptoms, physical findings, and diagnostic information to develop appropriate differential diagnoses.
2. Diagnoses and manages acute and chronic conditions while attending to the patient’s response to the illness experience.

3. Prioritizes health problems and intervenes appropriately including initiation of effective emergency care.

4. Employs appropriate diagnostic and therapeutic interventions and regimens with attention to safety, cost, invasiveness, simplicity, acceptability, adherence, and efficacy.

5. Formulates an action plan based on scientific rationale, evidence-based standards of care, and practice guidelines.

6. Provides guidance and counseling regarding management of the health/illness condition.

7. Initiates appropriate and timely consultation and/or referral when the problem exceeds the nurse practitioner’s scope of practice and/or expertise.

8. Assesses and intervenes to assist the patient in complex, urgent, or emergency situations.

   a. Assesses rapidly the patient’s unstable and complex health care problems through synthesis and prioritization of historical and immediately derived data.

   b. Diagnoses unstable and complex health care problems utilizing collaboration and consultation with the multidisciplinary health care team as indicated by setting, specialty, and individual knowledge and experience, such as patient and family risk for violence, abuse, and addictive behaviors.
c. Plans and implements diagnostic strategies and therapeutic interventions to help patients with unstable and complex health care problems regain stability and restore health in collaboration with the patient and multidisciplinary health care team.

d. Rapidly and continuously evaluates the patient’s changing condition and response to therapeutic interventions, and modifies the plan of care for optimal patient outcomes.

*Appropriate to Both Subdomains*

1. Demonstrates critical thinking and diagnostic reasoning skills in clinical decision-making.

2. Obtains a comprehensive and problem-focused health history from the patient.

3. Performs a comprehensive and problem-focused physical examination.

4. Analyzes the data collected to determine health status.

5. Formulates a problem list.

6. Assesses, diagnoses, monitors, coordinates, and manages the health/illness status of patients over time and supports the patient through the dying process.

7. Demonstrates knowledge of the pathophysiology of acute and chronic diseases or conditions commonly seen in practice.

8. Communicates the patient’s health status using appropriate terminology, format, and technology.


10. Uses community/public health assessment information in evaluating patient needs, initiating referrals, coordinating care, and program planning.
11. Applies theories to guide practice.

12. Applies/conducts research studies pertinent to area of practice.

13. Prescribes medications based on efficacy, safety, and cost as legally authorized and counsels concerning drug regimens, drug side effects, and interactions with food supplements and other drugs.


15. Selects/prescribes correct dosages, routes, and frequencies of medications based on relevant individual patient characteristics, e.g., illness, age, culture, gender, and illness.

16. Detects and minimizes adverse drug reactions with knowledge of pharmacokinetics and dynamics with special attention to vulnerable populations such as infants, children, pregnant and lactating women, and older adults.

17. Evaluates and counsels the patient on the use of complementary/alternative therapies for safety and potential interactions.

18. Integrates appropriate non-pharmacologic treatment modalities into a plan of management.

19. Orders, may perform, and interprets common screening and diagnostic tests.

20. Evaluates results of interventions using accepted outcome criteria, revises the plan accordingly, and consults/refers when needed.

21. Collaborates with other health professionals and agencies as appropriate.
22. Schedules follow-up visits to appropriately monitor patients and evaluate health/illness care.

*DOMAIN 2. The Nurse Practitioner-Patient Relationship*

*Competencies*

The nurse practitioner demonstrates competence in the domain of the nurse practitioner-patient relationship when s/he:

1. Creates a climate of mutual trust and establishes partnerships with patients.
2. Validates and verifies findings with patients.
3. Creates a relationship with patients that acknowledges their strengths and assists patients in addressing their needs.
4. Communicates a sense of “being present” with the patient and provides comfort and emotional support.
5. Evaluates the impact of life transitions on the health/illness status of patients and the impact of health and illness on patients (individuals, families, and communities).
6. Applies principles of self-efficacy/empowerment in promoting behavior change.
7. Preserves the patient’s control over decision making, assesses the patient’s commitment to the jointly determined, mutually acceptable plan of care, and fosters patient’s personal responsibility for health.
8. Maintains confidentiality while communicating data, plans, and results in a manner that preserves the dignity and privacy of the patient and provides a legal record of care.
9. Monitors and reflects on own emotional response to interaction with patients and uses this knowledge to further therapeutic interaction.
10. Considers the patient’s needs when termination of the nurse practitioner-patient relationship is necessary and provides for a safe transition to another care provider.

11. Evaluates patient’s and/or caregiver’s support systems.

12. Assists the patient and/or caregiver to access the resources necessary for care.

**DOMAIN 3. The Teaching-Coaching Function**

*Competencies*

The nurse practitioner demonstrates competence in the domain of the teaching-coaching function when s/he:

**Timing**

1. Assesses the patient’s on-going and changing needs for teaching based on a) needs for anticipatory guidance associated with growth and developmental stage, b) care management that requires specific information or skills, and c) patient’s understanding of his/her health condition.

2. Assesses patient’s motivation for learning and maintenance of health related activities using principles of change and stages of behavior change.

3. Creates an environment in which effective learning can take place.

**Eliciting**

1. Elicits information about the patient’s interpretation of health conditions as a part of the routine health assessment.

2. Elicits information about the patient’s perceived barriers and supports to learning when preparing for patient’s education.
3. Elicits from the patient the characteristics of his/her learning style from which to plan and implement the teaching.

4. Elicits information about cultural influences that may affect the patient’s learning experience.

**Assisting**

1. Incorporates psychosocial principles into teaching that reflect a sensitivity to the effort and emotions associated with learning about how to care for one’s health conditions.

2. Assists patients in learning specific information or skills by designing a learning plan that is comprised of sequential, cumulative steps and that acknowledges relapse and the need for practice, reinforcement, support, and reteaching when necessary.

3. Assists patients to use community resources when needed.

4. Educates patients about self-management of acute/chronic illness with sensitivity to the patient’s learning ability and cultural/ethnic background.

**Providing**

1. Communicates health advice, instruction and counseling appropriately using evidence-based rationale.

**Negotiating**

1. Negotiates a mutually acceptable plan of care based on continual assessment of the patient’s readiness and motivation, resetting of goals, and optimal outcomes.
2. Monitors the patient’s behaviors and specific outcomes as a useful guide to evaluating the effectiveness and need to change or maintain teaching strategies, such as weight-loss, smoking cessation, and alcohol consumption.

*Coaching*

1. Coaches the patient throughout the teaching processes by reminding, supporting, encouraging, and the use of empathy.

**DOMAIN 4. Professional Role**

*Competencies*

The nurse practitioner demonstrates competence in the domain of professional role when she or he:

**Develops and Implements Role**

1. Uses scientific theories and research to implement the nurse practitioner role.
2. Functions in a variety of role dimensions: health care provider, coordinator, consultant, educator, coach, advocate, administrator, researcher, and leader.
3. Interprets and markets the nurse practitioner role to the public, legislators, policy-makers, and other health care professions.
4. Advocates for the role of the advanced practice nurse in the health care system.

*Directs Care*

1. Prioritizes, coordinates, and meets multiple needs and requests of culturally diverse patients.
2. Uses sound judgment in assessing conflicting priorities and needs.
3. Builds and maintains a therapeutic team to provide optimum therapy.

4. Obtains specialist and referral care for patients while remaining the primary care provider.

5. Advocates for the patient to ensure health needs are met.

6. Consults with other health care providers and private/public agencies.

7. Incorporates current technology appropriately in care delivery.

8. Uses information systems to support decision-making and to improve care.

**Provides Leadership**

1. Recognizes the importance of participating in professional organizations.

2. Evaluates implications of contemporary health policy on health care providers and consumers.

3. Participates in legislative and policy-making activities that influence advanced nursing practice and the health of communities.

4. Advocates for access to quality, cost-effective health care.

5. Evaluates the relationship between community/public health issues and social problems (poverty, literacy, violence, etc.) as they impact the health care of patients.

**DOMAIN 5. Managing and Negotiating Health Care Delivery Systems**

**Competencies**

The nurse practitioner demonstrates competence in the domain of managing and negotiating health care delivery systems when she or he:
Managing

1. Demonstrates knowledge about the role of the nurse practitioner in case management.
2. Provides care for individuals, families, and communities within integrated health care services.
3. Considers access, cost, efficacy, and quality when making care decisions
4. Maintains current knowledge of the organization and financing of the health care system as it affects delivery of care.
5. Participates in organizational decision-making, interprets variations in outcomes, and uses data from information systems to improve practice.
6. Manages organizational functions and resources within the scope of responsibilities as defined in a position description.
7. Uses business and management strategies for the provision of quality care and efficient use of resources.
8. Demonstrates knowledge of business principles that affect long-term financial viability of a practice, the efficient use of resources, and quality of care.
9. Demonstrates knowledge of relevant legal regulations for nurse practitioner practice including reimbursement of services.

Negotiating

1. Collaboratively assesses, plans, implements, and evaluates primary care with other health care professionals using approaches that recognize each one’s expertise to meet the comprehensive needs of patients.
2. Participates as a key member of an interdisciplinary team through the development of collaborative and innovative practices.

3. Participates in the planning, development, and implementation of public and community health programs.

4. Participates in legislative and policy-making activities that influence health services/practice.

5. Advocates for policies that reduce environmental health risks.

6. Advocates for policies that are culturally sensitive.

7. Advocates for increasing access to health care for all.

**DOMAIN 6. Monitoring and Ensuring the Quality of Health Care Practice**

*Competencies*

The nurse practitioner demonstrates competence in the domain of monitoring and ensuring quality health care practice when she or he:

*Ensuring Quality*

1. Interprets own professional strengths, role, and scope of ability to peers, patients, and colleagues.

2. Incorporates professional/legal standards into practice

3. Acts ethically to meet the needs of patients.

4. Assumes accountability for practice and strives to attain the highest standards of practice.

5. Engages in self-evaluation concerning practice and uses evaluative information, including peer review, to improve care and practice.
6. Collaborates and/or consults with members of the health care team about variations in health outcomes.

7. Uses an evidence-based approach to patient management that critically evaluates and applies research findings pertinent to patient care management and outcomes.

8. Evaluates the patient’s response to the health care provided and the effectiveness of the care.

9. Uses the outcomes of care to revise care delivery strategies and improve the quality of care.

10. Accepts personal responsibility for professional development and the maintenance of professional competence and credentials.

11. Considers ethical implications of scientific advances and practices accordingly.

**Monitoring Quality**

1. Monitors quality of own practice and participates in continuous quality improvement based on professional practice standards and relevant statutes and regulation.

2. Evaluates patient follow-up and outcomes including consultation and referral.

3. Monitors research in order to improve quality care.

**DOMAIN 7. Cultural Competence**

**Competencies**

The nurse practitioner demonstrates cultural competence when she or he:

1. Shows respect for the inherent dignity of every human being, whatever their age, gender, religion, socioeconomic class, sexual orientation, and ethnicity.
2. Accepts the rights of individuals to choose their care provider, participate in care, and refuse care.

3. Acknowledges personal biases and prevents these from interfering with the delivery of quality care to persons of differing beliefs and lifestyles.

4. Recognizes cultural issues and interacts with patients from other cultures in culturally sensitive ways.

5. Incorporates cultural preferences, health beliefs and behaviors, and traditional practices into the management plan.

6. Develops patient-appropriate educational materials that address the language and cultural beliefs of the patient.

7. Accesses culturally appropriate resources to deliver care to patients from other cultures.

8. Assists patients to access quality care within a dominant culture.

9. Develops and applies a process for assessing differing beliefs and preferences and takes this diversity into account when planning and delivering care.

**Spiritual Competencies**

1. Respects the inherent worth and dignity of each person and the right to express spiritual beliefs as part of his/her humanity.

2. Assists patients and families to meet their spiritual needs in the context of health and illness experiences, including referral for pastoral services.

3. Assesses the influence of patient’s spirituality on his/her health care behaviors and practices.

4. Incorporates patient’s spiritual beliefs in the plan of care appropriately.
5. Provides appropriate information and opportunity for patients and families to discuss their wishes for end of life decision-making and care.

6. Respects wishes of patients and families regarding expression of spiritual beliefs.

Specific competencies reflect the role of the nurse practitioner in relation to genetics screening, counseling, prevention, and treatment of genetic disease. We wish to highlight this role in light of the recent scientific advancements and the role of nurse practitioners in incorporating this new knowledge to benefit patients. The National Coalition for Health Professional Education in Genetics (NCHPEG) has developed core competencies in genetics essential for all health care professionals. Please refer to the NCHPEG Web site for further information and the competencies:

http://www.nchpeg.org. NONPF reviewed these competencies in fall 2000.
APPENDIX B

FAMILY NURSE PRACTITIONER COMPETENCIES

(USDHHS, 2002)
FAMILY NURSE PRACTITIONER COMPETENCIES

These are entry-level competencies for the family nurse practitioner that supplement the core competencies for all nurse practitioners. The population in primary care family practice includes newborns, infants, children, adolescents, adults, pregnant and postpartum women, and older adults. The focus of care is the family unit, as well as the individuals belonging to the family however the family chooses to define itself. The family nurse practitioner is a specialist in family nursing, in the context of community, with broad knowledge and experience with people of all ages. Family nurse practitioners demonstrate a commitment to family-centered care. Family nurse practitioners practice primarily in ambulatory care settings. Upon graduation or entry into practice, the family nurse practitioner should demonstrate competence in the categories described below:

*Health Promotion, Health Protection, Disease Prevention, and Treatment*

The family nurse practitioner is a provider of direct health care services. Within this role, the family nurse practitioner synthesizes theoretical, scientific, and contemporary clinical knowledge for the assessment and management of both health and illness states. These competencies incorporate the health promotion, health protection, disease prevention, and treatment focus of family nurse practitioner practice.

A. Assessment of Health Status

These competencies describe the role of the family nurse practitioner in assessing all aspects of the patient's health status, including for purposes of health promotion, health protection, and disease prevention. The family nurse practitioner employs evidence-based clinical practice guidelines to guide screening activities, identifies
health promotion needs, and provides anticipatory guidance and counseling addressing environmental, lifestyle, and developmental issues.

1. Obtains and accurately documents a relevant health history for patients of all ages and in all phases of the individual and family life cycle.

2. Assesses (a) the influence of the family or psychosocial factors on patient illness, (b) conditions related to developmental delays and learning disabilities in all ages, (c) women's and men's reproductive health, including, but not limited to, sexual health, pregnancy, and postpartum care, and (d) problems of substance abuse and violence.

3. Performs and accurately documents appropriate comprehensive or symptom-focused physical examinations on patients of all ages (including developmental and behavioral screening and physical system evaluations).

4. Performs screening evaluations for mental status and mental health.

5. Identifies health and psychosocial risk factors of patients of all ages and families in all stages of the family life cycle.

6. Demonstrates proficiency in family assessment.

7. Demonstrates proficiency in functional assessment of family members (e.g., elderly, disabled).

8. Assesses specific family health needs within the context of community assessment.

9. Identifies and plans interventions to promote health with families at risk.

10. Assesses the impact of an acute and/or chronic illness or common injuries on the family as a whole.
11. Distinguishes between normal and abnormal change with aging.

B. Diagnosis of Health Status

The family nurse practitioner is engaged in the diagnosis of health status. This diagnostic process includes critical thinking, differential diagnosis, and the integration and interpretation of various forms of data. These competencies describe this role of the family nurse practitioner.

1. Identifies signs and symptoms of acute physical and mental illnesses across the life span.
2. Identifies signs and symptoms of chronic physical and mental illness across the life span.
3. Orders, performs, and interprets age-, gender-, and condition-specific diagnostic tests and screening procedures.
4. Analyzes and synthesizes collected data for patients of all ages.
5. Formulates comprehensive differential diagnoses, considering epidemiology, environmental and community characteristics, and life stage development, including the presentation seen with increasing age, family, and behavioral risk factors.

C. Plan of Care and Implementation of Treatment

The objectives of planning and implementing therapeutic interventions are to return the patient to a stable state and to optimize the patient's health. These
competencies describe the family nurse practitioner's role in stabilizing the patient, minimizing physical and psychological complications, and maximizing the patient's health potential.

1. Provides health protection, health promotion, and disease prevention interventions/treatment strategies to improve or maintain optimum health for all family members.

2. Treats common acute and chronic physical and mental illnesses and common injuries in people of all ages to minimize the development of complications, and promote function and quality of living.

3. Prescribes medications with knowledge of altered pharmacodynamics and pharmacokinetics with special populations such as infants and children, pregnant and lactating women, and older adults.

4. Adapts care to meet the complex needs of older adults arising from age changes and multiple system disease.

5. Identifies acute exacerbations of chronic illness and intervenes appropriately.

6. Evaluates the effectiveness of the plan of care for the family, as well as the individual, and implements changes.

7. Evaluates patient's and/or other caregiver's support systems and resources and collaborates with and supports the patient and caregivers.

8. Assists families and individuals in the development of coping systems and lifestyle adaptations.
9. Makes appropriate referrals to other health care professionals and community resources for individuals and families.

10. Provides care related to women's reproductive health, including sexual health, prenatal, and postpartum care.


12. Performs primary care procedures, including, but not limited to, suturing, minor lesion removal, splinting, microscopy, and pap tests.

13. Recognizes the impact of individual and family life transitions, such as parenthood and retirement, on the health of family members.

13. Uses knowledge of family theories and development to individualize care provided to individuals and families.

14. Facilitates transitions between health care settings to provide continuity of care for individuals and family members.

15. Intervenes with multigenerational families who have members with differing health concerns.

16. Assists patient and family members to cope with end of life issues.

17. Applies research that is family-centered and contributes to positive change in the health of and health care delivery to families.
II. NURSE PRACTITIONER-PATIENT RELATIONSHIP

Competencies in this area demonstrate the personal, collegial, and collaborative approach, which enhances the family nurse practitioner's effectiveness of patient care. The competencies speak to the critical importance of interpersonal transactions as they relate to therapeutic patient outcomes.

1. Maintains a sustaining partnership with individuals and families.

2. Assists individuals and families with ethical issues in balancing differing needs, age-related transitions, illness, or health among family members.

3. Facilitates family decision-making about health.

III. TEACHING-COACHING FUNCTION

These competencies describe the family nurse practitioner's ability to impart knowledge and associated psychomotor skills to patients. The coaching function involves the skills of interpreting and individualizing therapies through the activities of advocacy, modeling, and tutoring.

1. Demonstrates knowledge and skill in addressing sensitive topics with family members such as sexuality, finances, mental health, terminal illness, and substance abuse.

2. Elicits information about the family's and patient's goals, perceptions, and resources when considering health care choices.

3. Assesses educational needs and teaches individuals and families accordingly.
4. Provides anticipatory guidance, teaching, counseling, and education for self-care for the identified patient and family.

**IV. PROFESSIONAL ROLE**

These competencies describe the varied role of the family nurse practitioner, specifically related to advancing the profession and enhancing direct care and management. The family nurse practitioner demonstrates a commitment to the implementation, preservation, and evolution of the family nurse practitioner role. As well, the family nurse practitioner implements critical thinking and builds collaborative, interdisciplinary relationships to provide optimal care to the patient.

1. Demonstrates in practice a commitment to care of the whole family.

2. Recognizes the importance of participating in community and professional organizations that influence the health of families and supports the role of the family nurse practitioner.

3. Interprets the family nurse practitioner role in primary and specialty health care to other health care providers and the public.

4. Serves as a resource in the design and development of family community-based health services.
V. MANAGING AND NEGOTIATING HEALTH CARE DELIVERY SYSTEMS

These competencies describe the family nurse practitioner's role in handling situations successfully to achieve improved health outcomes for patient, communities, and systems through overseeing and directing the delivery of clinical services within an integrated system of health care.

Maintains current knowledge regarding state and federal regulations and programs for family health care.

MONITORING AND ENSURING THE QUALITY OF HEALTH CARE PRACTICE

These competencies describe the family nurse practitioner's role in ensuring quality of care through consultation, collaboration, continuing education, certification, and evaluation. The monitoring function of the role is also addressed relative to monitoring one's own practice as well as engaging in interdisciplinary peer and systems review.

*Covered in the core competencies.* (See Appendix A).

VI. CULTURAL COMPETENCE

These competencies describe the family nurse practitioner's role in providing culturally competent care, delivering patient care with respect to cultural and spiritual beliefs, and making health care resources available to patients from diverse cultures.

*Covered in the core competencies.* (See Appendix A).
APPENDIX C

COMPLEMENTARY AND ALTERNATIVE MEDICINE

COMPETENCIES FOR FNPS

(BURMAN, 2003)
COMPLEMENTARY AND ALTERNATIVE MEDICINE

COMPETENCIES FOR FNPs (Final Version)

(Author’s note: Burman uses the abbreviation CAM, rather than CAT.)

Domain 1: Management of Client Health/Illness Status

1. Elicits information about CAM use and preferences from clients in nonjudgmental way.

2. Negotiates a mutually acceptable care plan based on clients' preferences in relation to conventional and CAM therapies.

3. Demonstrates knowledge of the following commonly used CAM therapies, including basic theory/principles of the therapy, clinical indications, possible adverse effects and interactions with conventional treatment, and indications for collaboration/referral:

   a. Mind-body medicine (e.g., yoga; Tai chi; meditation; imagery; hypnosis; biofeedback; support groups; soul retrieval; music, art, or dance therapy; journaling; spiritual healers).

   b. Alternative medical systems (e.g., acupuncture and oriental medicine, Native American medicine, Ayurvedic medicine, homeopathy, naturopathy).

   c. Biologically based therapies (e.g., phytotherapy or herbalism; special diet therapies; orthomolecular medicine; pharmacological, biological, and Instrumental interventions).
d. Manipulative and body-based systems (e.g., chiropractic therapy; massage and body work, that is osteopathic manipulative therapy [OMT], cranial-sacral OMT, reflexology, Pilates method, polarity, acupressure, rolling; hydrotherapy; colonics).

e. Energy therapies (e.g., therapeutic touch, healing touch, Reiki).

4. Evaluates clients’ responses to health care, including conventional and CAM therapies.

5. Collaborates with CAM practitioners.

6. Arranges for appropriate follow up for clients using CAM therapies.

7. Accurately documents plans-of-care, including recommendations about CAM.

8. Performs specific CAM therapies, including:
   a. Herbal medicine for common illnesses.
   b. Nutritional medicine (e.g., vitamin and mineral supplements).
   c. Health promotion.
   d. Mind-body medicine (e.g., imagery, meditation, biofeedback).
   e. Manipulation (e.g., acupressure for common pain symptoms).
   f. Homeopathy for common Illnesses.
   g. Energy therapies (e.g., healing touch, therapeutic touch).

Domain 2: The Nurse-Client Relationship

1. Respects client’s use of CAM.

Domain 3: The Teaching-Coaching Function

Domain 4: Professional Role

1. Uses nursing theory to clearly delineate nursing approach to client care, including the role of CAM in advanced nursing interventions.
2. Uses sound judgment when assessing conflicting priorities and needs related to conventional and CAM therapies.

Domain 5: Managing and Negotiating Health Care Delivery Systems

1. Demonstrates knowledge of relevant laws and regulations governing CAM, including practice acts; training, licensure, and credentialing of CAM providers; the Dietary Supplement Health and Education Act; and malpractice issues related to collaboration with CAM providers.
2. Demonstrates knowledge of reimbursement of CAM providers.

Domain 6: Monitoring and Ensuring the Quality of Health Care Practice

2. Evaluates CAM therapies regarding efficacy, safety, interactions, indications, and contraindications by critically evaluating and using research findings on CAM use and outcomes.

Domain 7: Cultural Competence

1. Respects possible effectiveness of CAM therapies and acknowledges inadequacies of conventional medicine.
2. Acknowledges and respects their own and clients' cultural and spiritual beliefs about health and healing.
3. Understands how cultural and spiritual beliefs affect health behavior, including use of both conventional and CAM therapies.

4. Understands patterns of CAM use regionally and nationally, including reasons why clients are likely to seek CAM.

*Note. These competencies are based on the most recent NCCAM classification system (2002).*

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REFERENCES


