Advanced Practice Nursing and Conceptual Models of Nursing

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This column focuses on advanced practice nursing. A definition and central competency of advanced practice are given and four roles assumed by advanced practice nurses are identified. Questions related primarily to the advanced practice role of nurse practitioner are raised. Two nurse scholars who teach and practice discuss their experiences as advanced practice nurses, with an emphasis on the importance of using a conceptual model of nursing as a guide for their practice.

As we all know, the profession of nursing currently allows entry into practice via multiple routes, including hospital-based diploma programs, associate degree programs, baccalaureate degree programs, and Doctor of Nursing (N.D.) programs. The goal of all of those programs is to educate so-called generalist nurses, who are prepared to work in most, if not all, healthcare settings. Other programs, most now at the master’s degree level, prepare specialist nurses who work in particular healthcare settings and/or with particular populations. Many of the master’s degree programs prepare nurses for what has come to be called advanced practice nursing. The purpose of this dialogue is to explore the meaning of advanced practice nursing and the contributions made by advanced practice nurses to nursing science. Two of my faculty colleagues from the University of Massachusetts Boston, Diana M. L. Newman and Margaret McAllister, agreed to engage in a discussion of their experiences as advanced practice nurses. Both Dr. Newman and Dr. McAllister have been nurse educators for many years. Both also have continued direct nursing practice throughout their nursing careers.

Many Questions About Advanced Nursing Practice

The idea for our discussion arose when I began to ponder the fate of nursing conceptual models and theories as the nurse practitioner movement spread throughout the United States and concomitant anecdotal reports of the elimination of master’s degree nursing program courses about nursing knowledge began to surface. At about the same time, I became aware of the use of the term, advanced practice nursing, in objectives for master’s degree nursing program curricula. What, I wondered, was the link between nurse practitioner education and education for advanced practice nursing?

Hanson and Hamric (2003) provided an answer to my question. They defined advanced practice nursing as “the application of an expanded range of practical, theoretical, and research-based therapeutics to phenomena experienced by patients within a specialized clinical area of the larger discipline of nursing” (p. 205). They identified four distinct advanced practice role specialties: nurse midwife, nurse anesthetist, clinical nurse specialist, and nurse practitioner. The core competency of each specialty role, according to Hanson and Hamric, is “direct clinical practice” (p. 205). According to Hanson and Hamric, then, a nurse practitioner is an advanced practice nurse.

My next question was, what activities are performed by advanced practice nurses that make their practice advanced nursing? Hanson and Hamric (2003) provided a potential answer. In tracing the evolution of advanced practice nursing,

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they noted that activities now frequently associated with advanced practice nursing are those “not valued by physicians” (p. 204). Sandelowski’s (1999) comments indicate that the answer to that question should be a resounding “No!” She pointed out that the demand for nurse practitioners, whom she characterized as physician extenders, has historically “derived not from a demand for expanded nursing services but rather from a need to offset physician shortages and to render health care more inexpensively” (p. 60). It is not surprising, then, that Brown and Draye (2003) described the nurse practitioner advanced practice role as a “unique blending of nursing and medicine” (p. 393). One could easily argue, I think, that the nurse midwife and the nurse anesthetist advanced practice roles, if not the clinical nurse specialist role, also are blends of nursing and medicine. Clearly, as can be inferred from Sandelowski’s (1999) claims, when advance practice nursing roles focus on the activities of medical practice, the interests of physicians, organized medicine, hospitals, and other healthcare institutions are served, rather than the interests of nursing or the interests of the public.

This brief examination of advanced practice nursing raised several more questions:

- What does it mean to blend nursing and medicine?
- Would the opposition encountered by early nurse practitioners from “physicians, other nurses, insurance carriers, and pharmacists” (Brown & Draye, 2003, p. 394) have occurred if advanced practice nursing was really nursing instead of a blend of nursing and medicine?
- Why do we call nursing practice that incorporates activities traditionally associated with medicine advanced practice nursing?
- What are the implications of stipulating that the core competency of advanced practice nursing is “direct clinical practice” (Hanson & Hamric, 2003, p. 205), when clinical denotes hospital or clinic-based care of sick individuals (Parse, 2002)?
- What is the source of theoretical knowledge mentioned in Hanson and Hamric’s (2003) definition of advanced practice nursing?

I invite readers to submit their responses to each of these questions to me, for inclusion in future columns. As I eagerly await those responses, the remainder of this column focuses on my question about the source of theoretical knowledge for advanced practice nursing. That question returned me to where I had started my pondering, that is, wondering about the fate of nursing conceptual models and theories in the contemporary climate of advanced practice nursing. Dr. Newman’s and Dr. McAllister’s contributions to this dialogue are especially informative.

JF: Diana, how does a conceptual model of nursing guide advanced practice nursing? More specifically, what is the special contribution of conceptual models of nursing to advanced practice nursing?

DMLN: I think it is important to point out that conceptual models of nursing are inclusive rather than exclusive. That means that conceptual models of nursing foster a focus on the whole person. Thus, a conceptual model of nursing guides advanced practice nursing by helping the nurse to focus on the whole person. For example, an advanced practice nurse (APN) might begin to focus on respiratory problems experienced by a patient with the medical diagnosis of chronic obstructive pulmonary disease, but use of a conceptual model of nursing would encourage the APN to focus on the whole patient and his/her family in a systematic manner.

In addition, conceptual models of nursing typically include consideration of the patient’s perception of the situation. In contrast, a medical perspective usually does not account for the patient’s perception or other person and family variables but rather draws attention primarily to the medical diagnosis. The holistic nature of conceptual models of nursing is helpful not only in direct nursing practice, but also the documentation of that practice. Documentation systems are devoid of holistic aspects if they focus primarily on the medical diagnosis, with only some incidental anecdotal information about the psychological, developmental, sociocultural, or spiritual aspects of the patient.

Use of a conceptual model of nursing facilitates autonomous nursing practice, which is one aspect of professionalism; knowledge and service are other aspects. Due to the broad scope of a conceptual model of nursing, its use also encourages use of diverse ways of knowing, including empirics, ethics, aesthetics, personal knowing, and sociopolitical knowing (Carper, 1978; White, 1995).

JF: Your last point is particularly intriguing. Carper’s (1978) and White’s (1995) work on diverse ways of knowing highlights the manner in which non-empirical ways of knowing also can inform advanced practice nursing. If APNs could explicitly link the ways of knowing with the concepts of each conceptual model of nursing, they certainly would make a major contribution to the discipline.

DMLN: I agree. Furthermore, the focus on diverse ways of knowing lends considerable support to the knowledge component of professionalism, and addresses the research
skills and expert coaching and guidance competencies of advanced practice nursing (Hanson & Hamric, 2003).

Professionalism also encompasses the clinical and professional leadership competency of APNs (Hanson & Hamric, 2003). I submit that the advanced practice nursing leadership competency demands the highest level of professionalism, which can be attained by expert use of a nursing conceptual model. Indeed, by using a conceptual model of nursing, each APN serves as an exemplar of professional nursing for all healthcare professionals, students, and the larger society.

JF: I agree! Diana, would you tell our readers what experiences you have had in the use of conceptual models of nursing in your own practice?

DMLN: During 40 years of nursing practice, I have had a variety of experiences in nursing education, practice, and research. Those experiences include undergraduate and graduate curriculum development, adult and pediatric oncology nursing practice, mental health and psychiatric nursing practice, maternal child health nursing practice, medical-geriatric psychiatric nursing practice, and home health nursing practice. Conceptual models of nursing have made the strongest contribution to nursing education throughout my nursing career. I have observed that although the transition from the medical model curriculum to an integrated, conceptual model-based curriculum may be confusing at times, the end result is a holistic curriculum that links nursing concepts in a concrete way that satisfies nurse educators, fulfills course and terminal objectives, and helps students to learn an effective knowledge base that will have a lifelong impact on their nursing practice. Moreover, I have noticed that many of my colleagues who use a conceptual model of nursing to guide nursing curriculum development are loathe to return to a medically-focused curriculum because it is limiting in scope and does not convey the nursing perspective that is essential for successful practice.

Conceptual models of nursing help to focus my practice in all situations. Frequently, the direct practice site is very busy and the nurse has to deal with many variables at once in a stressful environment. Using a conceptual model of nursing helps me to focus on best nursing practices, which may not be otherwise explicit in a busy nursing practice situation. For example, the spiritual variable may not be a routine part of the plan of care, but a conceptual model of nursing that guide my practice to include spirituality as understood by the patient will remind me to include assessment of the person’s perception of spirituality. In addition, sometimes the focus may be on one area of patient health, such as dementia. But the Neuman systems model (Neuman & Fawcett, 2002), which I use frequently, directs me to account for physiologic, psychological, developmental, sociocultural, and spiritual aspects of the patient, which may advance patient health in ways equal to or better than a sole focus on dementia.

Clearly, practice guided by the concepts of a conceptual model of nursing is more appropriate for advanced practice nursing than a disease treatment model. Conceptual models of nursing enhance nursing practice at all levels. They are the very foundation of education for and practice of advanced nursing.

JF: Diana, Thank you very much for your insights. Margaret, would you please share your thoughts about advanced practice nursing with our readers?

MMcA: I would like to take this opportunity point out that the Shuler nurse practitioner practice model is one conceptual model of nursing that informs advanced practice nursing, particularly the nurse practitioner (NP) role specialty (Shuler & Davis, 1993a, 1993b). According to this model, the gestalt that develops over time to guide the NP’s practice is the expert ability to see the patient as whole and to appreciate that the patient represents a complex constellation of physical, psychological, spiritual, social, psychological, environmental, and economic life factors. These factors interact and contribute to the person’s unique wholeness and influence the person’s ability to participate in health promotion, health maintenance, and disease modifying actions. The Shuler model helps NPs to see beyond the immediate objective and subjective findings. Awareness of the person’s life factors guides the NP to formulation of a holistic plan of care. NPs intervene, based on their perception of the person’s unique wholeness, and provide throughputs that assist the person to maintain or regain health by means of comprehensive health maintenance, disease prevention, or health restoration.

In summary, the Shuler model is one example of a conceptual model of nursing that provides a gestalt that guides the NP’s assessment of the person’s needs, which inform the processes of care. The model is, then, an example of the rich theoretical foundation for the practice of NPs, or what can be called nurse practitionering.

JF: Thank you, Margaret, for telling us about the Shuler model. Would you please tell us more about how NP practice is structured?

MMcA: I believe that knowing merges with caring and allows the NP to formulate a plan of care that responds to the universal self care deficits of people identified through a subjective and objective process of assessment. I am convinced that the caring role of the NP is truly that of nursing rather than medicine. Many have argued that caring is the foundational framework for nursing (for example, Newman, Sime, & Corcoran Perry, 1991), and Bryczynski (1989) identified caring as the basis for the NP’s clinical judgment.

I believe that NP role development happens during NP educational programs through the use of a cognitive mapping process that encompasses the functional domains of the NP role as described by Bryczynski (1989) and the domains and competencies identified by Benner (1984) adapted to focus on management of patient health and ill-
ness. Those domains and competencies are one example of the evolution of the complexity of the NP role.

We understand from Rogers (1992) that we are constantly changing, always evolving toward more complex patterns. The complexity of nursing in the NP role is an example of what Rogers might describe as increasing complexity and complimentarity as nursing responds to meet the needs of society. I submit that the role of the NP has become more complex over time not out of a need or desire to perform tasks that physicians no longer want to perform, but rather in response to societal needs. Let us recall that the NP role as developed by Ford and Silver (Silver, Ford, & Day, 1968) at the University of Colorado grew out of the need to respond to the shortage of healthcare providers in the area of maternal child health. Nursing, as an element of society, responded to meet the needs of children. Nurses were identified as having the unique skills and abilities that were appropriate initially for well child care and later adapted to illness care that do not require the knowledge and education required for the practice of medicine.

We now understand that the patient teaching we provide today will contribute to the complexity of human beings and help to mold their future patterns of health. Patient reception to our teaching is based on identified needs for knowing and a desire to change patterns that may have been inadequate or may represent lack of knowledge for sufficient coping and adaptation. Failure to have knowledge or failure to understand the significance of health-related knowledge is only one factor that influences the degree of variance in patient care. Forces that promote change and promote health include the extent to which the NP is willing to invest in exploring resources that may assist human beings to redirect their energy toward health promoting behavior change. Here, learning theories inform us, as do developmental theories, community theories, family systems theories, and theories of diffusion of innovations.

JF: How can NPs contribute to advanced practice nursing?

MMcA: I believe that the major theoretical foundation for advanced practice nursing will be found in the development of our intellectual capabilities. Intellectual dialogues will help all APNs to learn from a process of self-reflection. The goal of self-reflection and intellectual dialogues is coming to know what theories inform our practice and in what constellation of circumstances and patient needs we respond to facilitate goal attainment, adaptation, and self-care agency needs.

I also believe that much of what we now do in advanced practice nursing is on an unconscious or intuitive level of awareness. Contemporary NP educational programs often lack opportunities to learn the ideas of nurse theorists or provide the exposure that stimulates dialogue about nursing and the questions you raised earlier in this column. We are consumed with teaching medicine, rather than the theory-guided processes that will achieve the outcomes that research addressing NP practice has documented (Mundinger & Kane, 2000). Nurse educators can all too easily lose sight of how NPs can benefit from intellectual exploration of the application of theory to practice. Our challenge is to provoke the application of theory to NP practice and to study the practice processes that bring about desired patient outcomes. As we advance in education and learn from the knowledge embedded in practice, we evolve toward a higher level of complexity as a profession and an independent discipline.

In closing, I hope that this dialogue will stimulate additional discussions about various nursing theoretical models and concepts that enlighten and inform NP practice in the acute, long term care, and primary care settings.

JF: That is my hope as well. Again, readers are invited to submit their ideas about advanced practice nursing to me for inclusion in future columns.

References


