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An Exploratory Study of Nurse Practitioners as Holistic Care Providers

Abstract

The rapid changes in the health care industry have created a significant increase in the number of nurse practitioners (NPs) as primary care providers. The significant increase in the need for NPs has challenged the providers of advanced nursing programs to meet educational needs and to keep abreast with the number of changes in the scope of practice. As a result, the role of nurse practitioners continues to develop in areas which will affect the care provided to patients and the application of a holistic philosophy of care by the nurse. Understanding the lived experiences of NPs facing this role transition can provide data for nurses, patients, and educational programs. The purpose of this qualitative phenomenological study was to explore the experiences of practicing nurse practitioners in the primary care provider role and their ability to apply holistic practices. The methodology used was semi-structured interviews. After the data was collected, coded, and analyzed three findings emerged. The first finding indicated nurse practitioners' value and strive to provide holistic health care yet do not provide spiritual care. The second finding indicated the participants saw the current health care system as broken. Specific examples were conflicts related to working in a medical model of care, limited time and high productivity expectations, and the need of additional evidence-based research supportive of holistic health care. The final outcome presented the impact upon NPs of professional burnout and unexpected patient expectations. It should be noted at the conclusion of every interview the participants expressed feelings of hope and a bright future for their profession as it evolves and grows.

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An Exploratory Study of Nurse Practitioners as Holistic Care Providers

By

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of the requirements for the degree
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Supervised by

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Ralph C. Wilson, Jr. School of Education

St. John Fisher College

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Dedication

First and foremost, I dedicate this work to my five wonderful children. They tolerated my absence and supported me during this journey. In addition, I want to thank my extended family for always being there when needed and stepping in to help my children as I focused on continuing my education.

I want to extend a special thank you to Dr. VanDerLinden for providing guidance, clarity, and encouragement. I would not have been able to complete this task without the direction and inspiration provided by both Dr. VanDerLinden and Dr. Quigley. Dr. VanDerLinden and Dr. Quigley are extremely valuable assets to the DEXL program.

Biographical Sketch

Cindy E. Stevens is currently a faculty member in the Division of Nursing at Keuka College in Keuka Park, NY. Ms. Stevens attended Keuka College from 1974-1978 and graduated with a Bachelor of Science degree in Nursing 1978. Subsequently, Ms. Stevens practiced the nursing profession in multiple rural and urban settings. Her nursing practice included acute and subacute care in addition to serving in the United States Air Force Nurse Corps.

Ms. Stevens returned to further her education and completed a Master of Science degree in Health Care Administration from King's College at Wilkes Barre, PA in 1998. In addition to her license as a registered nurse, she received a license as a Nursing Home Administrator in 1999 after completing all requirements and courses at Marywood University, PA. From 2002-2004 Ms. Stevens attended Drexel University, Philadelphia PA and completed a Master of Science in Nursing. After multiple years of clinical practice Ms. Stevens' focus is teaching nursing at the associate, bachelor, and master's curriculum levels.

Next, Ms. Stevens pursued her doctoral studies in the Ed.D. Program in Executive Leadership at St. John Fisher College starting in 2017. Under the direction of Dr. Kim VanDerLinden and Dr. Loretta Quigley she was able to tackle research related to the application of holistic health care by nurse practitioners and completed her degree in 2019.

Abstract

The rapid changes in the health care industry have created a significant increase in the number of nurse practitioners (NPs) as primary care providers. The significant increase in the need for NPs has challenged the providers of advanced nursing programs to meet educational needs and to keep abreast with the number of changes in the scope of practice. As a result, the role of nurse practitioners continues to develop in areas which will affect the care provided to patients and the application of a holistic philosophy of care by the nurse. Understanding the lived experiences of NPs facing this role transition can provide data for nurses, patients, and educational programs. The purpose of this qualitative phenomenological study was to explore the experiences of practicing nurse practitioners in the primary care provider role and their ability to apply holistic practices. The methodology used was semi-structured interviews. After the data was collected, coded, and analyzed three findings emerged.

The first finding indicated nurse practitioners' value and strive to provide holistic health care yet do not provide spiritual care. The second finding indicated the participants saw the current health care system as broken. Specific examples were conflicts related to working in a medical model of care, limited time and high productivity expectations, and the need of additional evidence-based research supportive of holistic health care. The final outcome presented the impact upon NPs of professional burnout and unexpected patient expectations. It should be noted at the conclusion of every interview the

participants expressed feelings of hope and a bright future for their profession as it evolves and grows.

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Chapter 1: Introduction

Consumers of health care in the United States experience poor health outcomes compared to similar worldwide wealthy nations. The US ranks last on mortality, infant mortality, and second to last on healthy life expectancy (Davis, Stremikis, Schoen, & Squires, 2014) Even when health care providers deliver excellent medical care, the conditions their patients return to after leaving the health care setting may prevent the achievement of their interventions (Hacke & Gaskins, 2019)

The Organization for Economic Cooperation and Development (OECD) (2019) international membership includes 35 countries inclusive of the United States and was established 60 years ago to assess and create policies with goals to improve lives. Research data collected by OECD determined the United States spends double the amount of money on medical care as other countries, yet it performed worse on health outcomes (Papanicolas, Woskie, & Jha, 2018). Even though the US surpassed other countries in health care spending, it ranks close to the lowest for health outcomes related to life expectancy. Examination has showed that medical care correlated only to 10-15% of avoidable mortality, demonstrating that social factors can generate unfortunate health consequences (McGinnis, Russo, & Knickman, 2002).

According to the Centers for Medicaid and Medicare Services (CMS) (2018) health care spending in the US increased 3.9% in 2017 equating to \$3.5 trillion dollars or \$10,739 per person. Health spending accounted for 17.9% of the US gross domestic product which is far beyond what other countries spent. Despite the amount of money

allocated for health care the US was ranked 11th in overall health care indicators (Davis, et al., 2014). Multiple studies have been conducted in response to the poorly rated outcomes.

The U.S. government attempted to address quality, cost, and the growing needs of an aging population via legislative and public health policy changes. One major policy change was the Deficit Reduction Act of 2005 which targeted hospitals who participated in the Inpatient Prospective Payment System (IPPS) and required facilities to collect and submit Hospital Consumer Assessment of Health care Providers and Systems Survey, (HCAHPS) data in order to receive their full IPPS payment (Centers for Medicaid and Medicare Services, 2017).

The patient survey results created adjustments which identified patient approval with medical care as a vital but rather debatable health care quality metric. Recently, the Medicare Provider Payment Modernization Act of 2014 adjusted the rate formula for reimbursement by supporting a model with ties to health care quality measures and patient satisfaction (Centers for Medicaid and Medicare Services, 2017). Research indicated patient satisfaction is a separate and equally important component of quality of care but does not reliably correlate with measures of quality and safety of patient care. In addition, inconsistent trends associated with patient satisfaction were noted across multiple studies (Tevis, Schmocker, & Kennedy, 2014).

Survey instruments with suitable psychometric properties were implemented by health care institutions yet the literature assessing the relationship between healthy outcomes and patients' perceptions of care have conflicting conclusions. Non-patient participation has affected results and created concern with the HCAHPS surveys validity,

indicating more research is needed to more accurately measure patient satisfaction (Tyser, Abtahi, McFadden, & Presson, 2016). In response to the government's desire to gather patient satisfaction data the Press Ganey Company developed a survey tool which is currently distributed by more than 33,000 health care institutions (Press Ganey Associates, 2019). In an effort to contain health care costs legislation has been implemented which directly impacts reimbursement based on patient outcomes. Data being collected includes a connection between nursing care, patient outcomes, and reimbursement. In the fall of 2018, Press Ganey entered into a collaboration with Jean Watson of Watson Caring Science Institute opening a door to future nursing data related to patient outcomes (Press Ganey Associates, 2019). Watson, a prominent nurse theorist, strongly supports the implementation of holistic health care (Watson, 1985).

The Robert Wood Johnson Institute (RWJI) and the Institute of Medicine (IOM) of the United States released a report entitled *The Future of Nursing* (2011) . This report requested the U.S. nursing profession help fill a projected void of primary care providers by expanding the role and number of nurse practitioners (NPs) in the United States. An increase of NPs was projected to fill the shortage of primary care providers as predicted by the Association of American Medical Colleges (AAMC). The 2018 AAMC report, *The Complexities of Physician Supply and Demand*, shows a projected shortage of between 42,600 and 121,300 physicians by the end of the next decade. The shortage of care providers is related to a growing population. The anticipated population growth includes an increase in the number of older Americans with a 12% growth in the general population, a 55% growth in residents aged 65, and a 73% increase in the number of

people over age 75 (AAMC, 2018). This is further complicated by the fact that one third of the current practicing physicians will be over age 65 in the next decade.

To meet the projected shortage the nursing profession responded by increasing the number of educational programs and graduate NPs. In January 2019 the American Association of Nurse Practitioners (AANP) survey results stated the number of nurse practitioners had grown in the United States from 120,000 in 2007 to 270,000 in 2019. Over a third of the NPs have been in practice for 5 years or less (American Association of Nurse Practitioners, 2019). The expanded educational level and the corresponding evolution of the nursing scope of practice has changed the role of nurses in the health care industry. As more nurses transition into the role of an advanced practice nurse they are faced with challenges associated with expanded responsibilities and their ability to deliver holistic care. The practitioners are supported by research that indicates there are positive consequences for patients receiving holistic care as well as improvements in the overall treatment course (Jasemi, Valizadeh, Zamanzadeh, & Keogh, 2017).

Foundations of Holistic Care in Nursing

Florence Nightingale is considered the founder of the nursing profession and as such, Nightingale directed nurses to practice health care through a holistic lens. The discipline of nursing was established on the bedrock of holistic care which is anticipated to continue in all types of nursing practice. The philosophy of holistic care views human beings as complex creatures whose health and wellness are multifaceted. As such, an individual's overall health is based on a balance of the complexity of the entire being and, at the center, remains the patient. Holistic care addresses the physical, mental, spiritual, and environmental needs of a patient to promote health (Carson, 1989; Dossey, 2010;

Nightingale, 1860). As a continuum of Nightingale's holistic philosophy, the World Health Organization (WHO) in 1948 defined health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," (World Health Organization [WHO], 1948, p. 10).

Nightingale's all-inclusive holistic standards of nursing care, as championed by the WHO, have continued to evolve into the framework of holistic health care taught in current nursing education. Registered nurses' educational backgrounds range from an associate degree to a doctoral degree. Nursing care is practiced in multiple settings with various levels of patient interaction. However, regardless of the educational level, nurses are taught to value a holistic perception of humans which includes the mind, body, and spirit (Watson, 1985).

Governing professional organizations. The framework of holistic health care is also the bedrock of all nursing governing professional organizations (Dossey, 2010; Watson, 1985). The American Association of Colleges of Nursing (American Association of Colleges of Nursing [AACN], 2008) in addition to the International Council of Nurses (International Council of Nurses [ICN], 2012), the American Nurses' Association (American Nurses' Association [ANA], 2015) Scope and Standards of Nursing Practice, Nurses Social Policy Statement, and the Code of Ethics, and the ANA Code of Ethics for Nurses with Interpretative Statements (2015) all consider the goal of holistic nursing is to heal the whole person by focusing on the interconnectedness of the mind, body, and spirit creating an optimal level of wellness (AACN, 2008; McGuiness, 1989). Indeed, these holistic entities have become core values which can be considered ethical mandates of professional nursing standards (ANA, 2015).

Additionally, NPs are guided by the National Organization of Nurse Practitioner Faculties (NONPF) whose terminal competencies include cultural/spiritual care (2002). However, the application of cultural/spiritual care competency is not measured or tracked. Rather, current quality care measures focus on physiological clinical competency with general questions related to overall treatment by a health care provider (US Department of Health and Human Services, 2017).

Health care industry. The U.S. health care industry has undergone many changes over the previous decade including the way services are delivered. According to Shanafelt, Dyrbye, and West (2017) there are several new concerns which affect the provision of health care. Current health care providers face an industry delivery system expectation related to a tighter reimbursement, multiple financial pressures, greater expectations regarding productivity, increased workload, a fast-expanding medical knowledge base requirement, clerical duties, an increased amount of inspection determined through quality indicators, and cost containment.

The health care industry changes explored in the current study are efficiency, limitations, and conceivable consequences as they relate to the practice of NPs. Today's health care environment has evolved into a service attentive to efficiency driven by the rising costs of health care. Changes in service delivery with a productivity focus present possible limitations in the application of holistic care. The average amount of time for a routine physician driven primary care visit is 17 minutes (Konrad et al., 2010). The allotted time scheduled for a health care visit has the potential to limit an NP's ability to address all elements of holistic care.

Provision of health care. During a visit to a health care provider the traditional medical model of disease-diagnosis-treatment-cure-discharge provides a framework for making clinical decisions using scientific-based research to guide medical interventions (Blasdell, Klunick, & Purseglove, 2002). Nurse practitioners see an average of 80 patients per week (for 15-20 minutes) in a primary care clinic with productivity expectations comparable to physicians (Xue & Tuttle, 2017). Nursing is founded in holistic care and most physicians limit their professional practice by incorporating a medical model of health care which focuses on the diagnosis and treatment of disease (Klebanoff & Hess, 2013). With the current dynamics of health care, holistic care is overlooked as physicians attempt to diagnose and release patients as quickly as possible.

Problem Statement

The increasing provision of primary health care by NPs internalizing a holistic care philosophy in an evolving health care industry has yet to be fully explored. As the role of the advanced practice nurse develops there is a potential for philosophical struggles related to efficiency and care limitations. Philosophically, the NP is faced with the application of a holistic nursing foundation while providing care founded in an industry governed by efficiency and grounded in a medical model of care.

Theoretical Rationale

The theoretical framework for this study is the human caring theory identified by Jean Watson (1985), nurse theorist. Watson supports a holistic view of patients and her research has identified three major elements which distinguish nursing practice from traditional Western medical practice: (a) the establishment of a transpersonal caring relationship by the clinical practice nurse to establish a reciprocal trust between the nurse

and patient; (b) the occurrence of a caring moment or time when the nurse applies holistic care as a person-to-person interaction creating a space for healing; and (c) following practice guidelines which provide a process to put heart centered caring into action supporting the nursing profession's foundation in holistic health care (Watson, 1985; 2012). The caring process provides tools for the nurse to holistically help a person respond to the effects of a disease and to achieve or maintain health at an optimum level of wellness or die a peaceful death (Watson, 1985).

In essence, Watson's theory of caring asserts the human caring experience is central to a positive patient experience (Watson, 2012). Additional research found application of a holistic caring theory enhances both nurse and patient fulfillment as nurses reported increased professional fulfillment and patients reported an environment that aided their healing (Brewer & Watson, 2015). The Watson theory of caring directly supports the common thread throughout professional nursing to provide care to a patient's mind, body, spirit and environment as outlined by Florence Nightingale in 1890.

Statement of Purpose

The purpose of this study is to explore the lived experiences of nurse practitioners who are fulfilling the role of primary care providers in rural Upstate New York. As the role of the nurse practitioner continues to evolve, understanding the potential impact and the intrinsic value of holistic practices, if any, are paramount towards creating a NP's professional identity. The research sought an improved understanding of the evolution of the NPs' daily practice as it relates to their role and ability in this cost-conscious health care environment to provide holistic care.

Research Questions

This study addressed the following research questions from the perspective of a nurse practitioner:

1. How does the nurse practitioner apply a holistic philosophy in his/her practice?
2. How has the nurse practitioner role changed with regards to holistic care?

Potential Significance of the Study

There are three identified areas which support the significance of this study. First, the study was backed by the National Organization of Nurse Practitioner Faculties (NONPF) established-professional nurse practitioner expectations through individual leadership practice and terminal competencies (NONPF, 2014). Second, previous work by Gould, Johnstone, and Wasylki (2007) revealed NPs are concerned about future preservation of their holistic philosophy due to new role expectations. Lastly, research will potentially provide further information to the body of knowledge of this phenomenon for reflection as the nurse practitioner profession continues to develop and expand its role. Although no governing body currently measures or tracks the application of holistic care, anecdotal experiential qualitative research may identify additional rationale to solidify holistic practice ideals in the clinical setting. The study has the potential to benefit society and the recipients of health care.

Also, application of holistic care supports the ideology of social justice by addressing elements beyond the immediate pathophysiological needs of patients. Second, the information will benefit practicing NPs by improving their knowledge regarding how the role has evolved for others in their profession. Third, the findings will be available to

schools of nursing to provide feedback as to the effectiveness of the internalization of holistic care. The fourth and final potential benefit is to society and the recipients of health care. A holistic approach to health care has demonstrated improved patient outcomes, satisfaction, and overall patient centered care.

Definition of Terms

Holistic Health Care- a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the patient, his or her response to illness, and the effect of the illness on the ability to meet self-care needs (Dossey, Keegan, & Guzzetta, 2005) (Appendix A).

Holistic Nursing - nursing practice that has healing the whole person as its goal. A holistic nurse is licensed nurse who takes a “mind-body-spirit-environment” approach to the practice of nursing. Holistic nursing is based on a philosophy of living and being that is grounded in caring, relationship, and interconnectedness. A holistic nurse recognizes and integrates the principles and modalities of holistic healing into daily life and clinical practice. Holistic nursing encourages nurses to integrate self-care, self-responsibility, spirituality, and reflection in their lives (Klebanoff & Hess, 2013).

Nurse Practitioner (NP) - a registered nurse (RN) who has completed advanced nursing education who performs physical exams and diagnoses and treats illnesses and other health problems that fall within the specialty area of practice in which the NP is certified (New York State Office of the Professions, 2016).

Primary Care - 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 (U.S. National Library of Medicine, 2018).

Primary Care Provider (PCP) - a health care practitioner who examines people that have common medical problems. PCPs may also provide preventive care, teach healthy lifestyles choices and refer to medical specialists when necessary (U.S. National Library of Medicine, 2018).

Chapter Summary

This chapter discussed the role of advanced practice nurses and Nightingale's foundational nursing constructs of holistic care and explored the phenomenon of the expanding role of the nursing profession in a fast-paced, cost-conscious changing health care environment. The recommendation to increase NPs to address the ongoing shortage of primary care providers presents an opportunity to explore their lived experiences as their roles evolve. As NPs face issues regarding efficiency, limitations, and consequences related to the care they provide, are they able to apply the holistic foundation as they were prepared? Do NPs maintain a professional identity as holistic primary care practitioners as they satisfy the critical need for health care providers in rural New York State?

The landscape of health care and the nurse practitioner has evolved significantly over the past 10 years. The purpose of this study is to explore the practice experience of NPs, who have participated in the field for no less than 3 years, to reflect upon how they have seen their role evolve in the shifting environment of health care. The major question is the impact on NPs' ability to practice holistically as they were prepared to in the evolving health care industry.

Chapter 2 will explore a review of the empirical literature related to the work of NP's as primary care practitioners and the holistic practice of nursing while Chapter 3 will discuss the research design and methodology that was utilized to answer the research questions. Chapters 4 and 5 present research results and a summary of findings with recommendations.

Chapter 2: Review of the Literature

Introduction and Purpose

This chapter provides a brief description of the dissertation topic, the research problem, and an analysis of supporting research literature. The evaluation of literature includes research-based, peer-reviewed primary sources which clarify the research problem. Research papers reviewed include quantitative, qualitative, and a meta-analysis. Ultimately at the center of all health care research is the patient. Exploring if patients are treated holistically by NPs in a hectic, demanding work environment will add to the pool of information related to the positive effect of holistic patient centered care.

Governing Professional Organizations

In order to understand the role of a nurse practitioner, it is necessary to review professional role competencies. Nurse practitioner professional competencies are health care areas NPs are required to apply competently in practice (NONPF, 2014). A review of these competencies reveals that nurse practitioners' practice, under a philosophy of holistic care includes providing spiritual care to patients (NONPF, 2012). Existing research includes examinations of patient expectations, nurse practitioner role competencies, foundations of education, and gaps in practice. Nurse practitioners are providers of holistic care and ideally are capable and comfortable in this realm (NONPF, 2014). Yet, instructional programs should be designed so that NPs become knowledgeable and skilled in offering spiritual and holistic care in practice (Hubbell, Woodard, Barksdale-Brown, & Parker, 2006). The expectation of holistic care has

existed for over 100 years (Nightingale, 1860) as part of the professional role; nurses are expected to recognize the spiritual dimension of individuals. However, the development of the role of nurse practitioners is relatively new to the overall profession of nursing.

Development of the Nurse Practitioner Role

In 1965, the NP role was created in response to a shortage of primary care physicians in rural areas of the United States (Henderson, 1964). Gould et al. (2007) investigated the role performance and experiences of nurse practitioners (NPs) after 1 year of practice and identified three themes:

1. NPs' holistic philosophy of nursing care is different from a philosophy of medical care.
2. NPs experienced difficulties were encountered in the establishment of the nurse practitioner professional role.
3. Despite challenges, a sense of pride was expressed by the NPs who were also concerned about future preservation of their holistic philosophy due to multiple new role expectations.

Concerns regarding the evolution of the NP role led to additional studies such as Chikotas' (2009) work exploring the experience of NPs who had been educated through problem-based learning pedagogy. The findings determined that classroom information could be directly applied to practice, with a resulting holistic perspective of care (Chikotas, 2009). Carron and Cumble (2011) addressed the need for a conceptual nursing model for the implementation of spiritual care by nurse practitioners. The desire for nurses to provide holistic care is well documented (Pesut & Sawatzky, 2006;

Timmins, Murphy, Neill, Begley, & Sheaf, 2015), and is an important element from the perspective of the patient.

Holistic Nursing Care

Nurse leaders have documented the need to value a holistic perception of humans which includes the mind, body, and spirit (Henderson, 1964; Nightingale, 1860; Watson, 1985). Providing holistic care requires nurses to participate in lifelong learning regarding holistic professional knowledge and skills of caring (Tsai, Wang, & Chow, 2015). A spiritual education foundation is provided for professional nurses in their undergraduate program, but this remains a neglected element of practice from the associate degree nurse to the doctoral-prepared advanced practice nurse. To be healthy, people need more than a current state of being disease free. Maintaining a healthy status includes prevention of illness and disease. Prevention requires an environment supportive of health including fresh food, clean water, and air, adequate shelter, employment/income, and opportunities. These social, economic, and environmental factors are referred to as social determinants of health (Hacke & Gaskins, 2019). Assessing beyond the immediate physical state of a patient has long been recognized by nursing as the practice of holistic health care.

The goal of the Affordable Care Act (ACA) is to stress a holistic perspective in clinical care with interventions on the social determinants of health have the greatest potential public health benefit. In June 2018 the American Medical Association House of Delegates, the U.S. Surgeon General, Jerome Adams, urged physicians to resist responding to national health with clinical solutions alone (Health Affairs, 2016). Adams was supported by the American Medical Association (AMA) recommendation that patients be questioned regarding their home and work environments to improve their care

experience, and amenability to medical treatments (American Medical Association, 2019).

Spiritual care. Stranahan (2001) conducted a study to examine the associations among spiritual views, attitudes, and practices by nurse practitioners. Nurse practitioners are the largest group of non-physician primary care providers in the US who believe in providing spiritual care; however, they face potential barriers through reimbursement issues, time constraints, and specific direction.

In a study of spirituality and health in older women by Knestruck and Lohri-Posey (2005), the findings reinforced the need for a holistic view of patients and supported nursing as a holistic practice while encouraging the development of educational programs in spiritual care. Standardized direction regarding spiritual care was identified as illusive by the nurse participants. Hubbell et al. (2006) explored whether and how nurse practitioners integrated spiritual care into their practices. Participants identified the frequency with which they utilized spiritual care practices, specific spiritual interventions, and their definitions of spiritual care. The two-part study concluded that even though the majority of the NPs believed spiritual care was an important part of nursing practice, they did not provide spiritual care to their patients.

Quality patient care. Frost, Currie, Northam, and Cruickshank's (2017) research supported the belief that patient-centered care is an indicator of high-quality primary health care. Evaluation of patient-centered care and its connection to individual patient enablement demonstrated positive patient outcomes when there was a strong relationship between NPs and their patients. Enablement was defined as an indicator of a patient's ability to understand, manage, and cope with his or her illness. Research results

demonstrated enablement increased with continuity of care and development of the NP-to-patient relationship supported quality health care.

Patient-centered care enhances patient outcomes and relationships within the health care system (Vincensi & Solberg, 2017). Incorporating spiritual care into practice is one intervention NPs can use to promote a patient centered care practice model.

Attard, Baldacchino, and Camilleri (2014) identified three areas of concern incorporating spiritual care into practice. They are the potential application of a medical model of care by advanced practice nurses, the current shift of attention to technological advances in health care, and the impact of experience and educational level between the nurses on spiritual care competency.

To further understand the role of NPs in the primary care provider role (PCP), Andregard and Jangland (2015) sought to identify and evaluate elements affecting the position. A meta-ethnography technique was used to assess and synthesize completed research elements. The four themes that emerged from this study which affect the success of the NP role are professional boundary concerns, NPs were seen as an added resource, the need for increased autonomy, and control. Collaboration within the health care team, in addition to the new skills and responsibilities, challenged NPs to maintain their foundation in holistic nursing.

In exploring nurses' levels of spiritual well-being, it was also found as a nurse's work experience increased there was a demonstrated higher ability to handle conflicts and collaborate; however, the age of the nurse and years of clinical experience were not related to their spirituality score. Overall the nurses reported average levels of spiritual well-being (Koren et al., 2009). Evidence supporting the interpersonal advance practice

model of care verses a strong technical medical model of care was validated indicating continued need for a relationship-based caring model to promote positive patient outcomes (Brunton & Beaman, 2000).

Benefits of holistic care. O'Brien (2018) found addressing the spiritual needs of patients is linked to positive health-related outcomes and provides better client-centered service. Social workers Hodge and Horvath's (2011) meta-synthesis of clients' perspectives on spiritual needs in health care settings identified spiritual issues as a concern and a desire for health care practitioners to address their needs. Identified needs included reflection upon meaning, purpose, and hope, relationships with God, spiritual practices, religious obligations, interpersonal connection, and professional staff interactions. These six interrelated themes support the practice of conducting a brief assessment related to the need for spiritual care and stressed that a strong relationship between the patient and the practitioner is needed. Taking a client's spiritual needs into account is an integral component of holistic service which directly facilitates positive health outcomes (Dossey et al., 2005).

Draper (2012) conducted a mixed-methods systematic review of quantitative approaches and a meta-synthesis of qualitative research regarding current spiritual care assessments and related professional implications. The importance of spiritual care as a part of health care is supported by the World Health Organization, National Institutes of Health, and the Department of Health and Human Services. Specific findings identified were the need to develop and test instruments to identify spiritual needs related to the six overarching categories of spiritual needs regarding the nature of spirituality and specific domains needed for assessment.

Not all research supports the growth of spirituality as a topic in the nursing literature. Critics of spiritual care have indicated the emergence of new categories of spiritual need and are an attempt by nursing to carve out a territory for itself (Paley, 2001). However, Narayanasamy (2006) stated that spiritual need of each patient is an essential aspect of holistic care, which is a philosophical framework of the nursing profession.

Measuring the value of holistic care. The nurse theorist Jean Watson has established a tool to measure the nontangible holistic elements. The Watson Caritas Patient Score (WCPS) survey instrument proved to be a valid tool to compare caring staff behaviors, healing environments, and patients' subjective perception of helping to trust professional staff relationships (Brewer & Watson, 2015). The quality of life for elderly nursing home patients is positively affected by spirituality, therefore a means to measure spiritual well-being is beneficial (Haugan, 2015).

An empirical study conducted in Norway evaluated two construct tools utilized to measure indicators of quality of life. The study determined the newly developed and improved tool had stronger validity; however, the original tool provided a better reliability (Haugan, 2015). A study limitation was some quality of life indicators, such as the role of meaning and peace, were unclear revealing a low reliability (Haugan, 2015). Both tools demonstrated usefulness; however, each quality of life indicator measured should be evaluated carefully for unclear meaning or differing definitions.

Spiritual care, the role of holistic care, and patient centered care as an indicator of best practice, found nurses wish to provide spiritual care at end of life; however, it was frequently not accomplished (Balboni et al., 2014). A look at barriers to provisions of

spiritual care for terminal patients identified three issues namely lack of privacy, not enough time, and inadequate training regarding spiritual care. The response rate for the study was high, but selection bias and applying the findings to the diseases or stages of illness inappropriately were two noted potential limitations.

At the graduate level of nursing care, there is limited research addressing the provision of spiritual care by nurse practitioner as patient primary care providers even as NPs are currently expanding their role in care coordination, medical management, psychosocial support, and patient education (Deitrick et al., 2011). Determinants of health go beyond an individual's physiological makeup. A theoretical framework for advanced practice nurses is supported by Watson's conceptual model, providing a guide for caring as a foundation of holistic practice which is inclusive of the mind, body, spirit, and environment (Hemsley, Glass, & Watson, 2006).

As primary care providers NPs have the potential to effect changes related to the social determinants of health, which demonstrate connections between social conditions, environmental factors, health equity, social justice, and health care policy (Davis & Chapa, 2015). Data from a long-term care facility determined NPs provided client and family-centered care, improved the quality of care, and established caring relationships assisting in end of life decisions (Ploeg et al., 2013). NPs establishing caring relationships and providing emotional support helped facilitate residents' participation in end of life decisions. Residents and families also perceived the NP as improving availability and timeliness of care thereby helping to prevent unnecessary hospitalization. As holistic care providers, the evidence indicates NPs need to continuously update

knowledge on the spiritual dimension in care and improve self-awareness regarding their role in spiritual care (Baldacchino, 2011).

The Hodge and Horvath (2011) evaluation of 11 studies revealed six overarching categories of spiritual needs and suggested a significant importance of spiritual assessment in health care settings. These categories are meaning, purpose and hope, relationship with God or the transcendent, spiritual practices, religious obligations, interpersonal connection, and professional staff interactions. Rykkje, Eriksson, and Raholm, (2018) metasynthesis of spirituality identified inner space at the center of spirituality connecting others, community, nature, and a higher power. However, a literature review of quantitative approaches to spiritual assessment revealed there is a limited number of quantitative instruments available to measure the spiritual state of patients (Draper, 2012).

Research completed in Sweden explored the role transition of NPs in a medical model of care and evaluated their integration as primary care providers and members of the health care team (Andregard, 2014). Cockell and McSherry (2012) reviewed 80 research papers on spiritual care in nursing, over a quarter of the studies (21 of 80) noted a correlation between the spirituality of nurses and their spiritual care. A correlation also identified provision of spiritual care, the potential to address issues of poor care delivery, and staff motivation to provide spiritual care was limited by a strong medical-systems approach to care. Common themes of dignity, holistic care, relationships/connections, meaning/purpose, hope/ coping, and existential distress was present across the studies. The final analysis stated spiritual care of patients is associated to the care and value given

to nurse practitioners. When NPs felt valued and cared for, they delivered holistic meaningful care.

Curricula related to holistic care. Boswell, Cannon, and Miller's (2013) study of nursing students identified issues regarding spiritual care. Their research indicated a significant gap in curricula with little direction regarding how, when, or what to provide in relation to a patient's spiritual care needs. Within a year of Boswell et al's (2013) study, nursing students and nurse practitioners voiced discomfort in providing spiritual care. An evaluation of nursing curricula and the development of tools to teach nurses spiritual care competency was undertaken by Attard et al. (2014). The research noted that those who completed an educational course scored higher in spiritual care competence indicating education influences competency. Wu, Tseng, and Liao (2016) investigated undergraduate nurses' willingness to provide spiritual care and found that 88% of the respondents felt insufficiently educated to provide spiritual care.

The profession of nursing is cemented in holistic care and holistic nursing care cannot exist without recognizing the spiritual/religious aspects of care (Ruder, 2013). A significant amount of research associated with undergraduate nursing care has identified issues surrounding application of spiritual care in daily practice. The issues identified include lack of clarity regarding the definition of spirituality, lack of comfort in providing care, limited educational preparation, barriers associated with care priorities, limited time to establish a strong nurse- patient relationship, and unclear regulatory requirements (Timmins et al., 2015).

Nursing textbooks did not provide content related to spirituality, direction for providing spiritual care, or consistency in the definition of spiritual care, and yet

approximately a third advocated for assessment of patient spiritual needs (Timmins et al., 2015). Highly significant positive correlations were found among nurses whose basic nursing educational programs focused on spiritual care and the nurses' comfort level, knowledge, and patient interventions connected to supporting spiritual care (Ruder, 2013). Exploration of tools to measure spiritual assessment by NPs and how such care might affect patient outcomes were tested and validated by Vincensi and Burkhart (2016). Advanced practice graduate nursing faculty has opportunities to develop the content to educate NPs in providing patients good end of life care (Shea, Grossman, Wallace, & Lange, 2010). As NPs assist a patient's journey towards health, the NPs too experienced struggles.

When investigating nursing students' perceptions of spiritual care, the data indicated experience, education, and personal career interest, regardless of gender, affected the students' perceptions of spirituality (Wu, Liao, & Yeh, 2012). A small study sample evaluated the effect in comfort regarding providing spiritual care after completing an educational model (Hubbell, Kauschinger, & Oermann, 2017). The results concluded that nurses comfort level and application of spiritual care increased following the educational activity. Regardless of the small sample, post educational program evaluations indicated the nurses increased frequency of addressing the spiritual needs of patients. Some confusing results indicated nurses were not to address patient beliefs and may have been due to the placement and use of pronouns in the survey which directed nurses not to push their own beliefs.

The findings of a qualitative study revealed nurses continue to value holistic care yet remain uncomfortable and ill prepared to provide spiritual care (Graham, Brush, &

Andrew, 2003; Ozan, Okumus, & Lash, 2015; Tanyi, McKenzie, & Chapek, 2009). Results of quantitative research demonstrated that education and experience influenced comfort level addressing spiritual care but did not affect provision of spiritual care in daily practice (Cockell & McSherry, 2012). Meta-synthesis research revealed a growth of evidence that has an impact upon curriculum development in nursing education (Narayanasamy, 2006). Spiritual care research pertaining to the undergraduate and nursing student level is vast. The literature identifies difficulties regarding direct patient care nurses providing spiritual care as unresolved and complex. Specific criticism describes quantitative studies of caring results as no more than knowledge of things said (Paley, 2001). Paley (2001) presented an analysis of research indicating the provision of holistic care by the nurses is not value added. However, several empirical studies have identified spiritual care improves patient outcomes and patient satisfaction thereby providing best practice (Ring, Malcolm, Coull, Murphy-Black, & Watterson, 2005).

Vincensi and Solberg (2017) identified a lack of education on spiritual care as a barrier to incorporating it in NP practice, thus affecting the patient-centered care model. Even though competency in spiritual care is expected at the baccalaureate level of nursing, concepts for inclusion in graduate education were suggested based on the findings (Vincensi & Solberg, 2017).

Chapter Summary

Results of multiple studies demonstrated that patients who receive holistic care report improved outcomes (Brewer & Watson, 2015; Dossey, 2010; Hodge, & Horvath, 2011). Ensuring that a patient's holistic needs are met is a professional nurse's responsibility (American Association of Colleges of Nursing, 2008; American Nurses

Association, 2019) however spiritual care continues to be a neglected area of practice (Balboni et al., 2014). NPs provide services under a holistic health care philosophy. In their role as primary care providers, nurse practitioners care for patients across the life span; this opens an opportunity to apply spiritual care in practice.

The literature review provided multiple empirical studies regarding an education based in a holistic preparation related to care of the mind, body, spirit, and environment as a value in multiple levels of nursing curricula. However, limited studies were identified regarding implementation of spiritual care in practice by the advance practice nurses. A modest amount of research regarding the provision of spiritual care provided in end of life situations was located but not connected to routine non-acute outpatient health care settings. The search supported data has documented a steady increase in the number of NPs in practice and their application of safe medical patient outcomes supported by evidence-based care (Melnyk, 2011). Yet a gap in the literature exists regarding exploration of a nurse practitioner's educational foundation in holistic care and application of this foundation to practice.

Chapter 3 will review the research design and methodology for this study including the research context, participants, and instrument used to answer the research questions. Chapters 4 and 5 will present data results, summary of outcomes and recommendations for future research.

Chapter 3: Research Design Methodology

Introduction

The Institute of Medicine (2010) predicted a shortage of primary health care providers due to a decrease of physicians specializing in family or internal medicine and tasked nursing to fill the gap with nurse practitioners. Then in 2015, the Association of American Medical College report validated a current shortage of physicians and predicted a continued decrease of available physicians to provide primary care. As the provision of health care is increasingly provided by nurse practitioners, the impact of a holistic care philosophy has yet to be fully evaluated (Blasdell et al., 2002). The NP's roles are changing, and the purpose of this study was to explore their experiences as practitioners and their ability to apply their holistic nursing foundation as they were prepared. The primary research question explores, from the viewpoint of a nurse practitioner, how and if the NP role has changed in the current health care system focused on efficiency and if there are limitations or consequences related to the ability to provide holistic health care.

The purpose of this research was to investigate the holistic practice behaviors of nurse practitioners (NPs) as primary care providers (PCPs). The profession of nursing is a unique mixture of art and science which presents the opportunity to explore the application of knowledge in practice (Carson, 1989). Nursing is a profession which provides care to every patient according to a holistic model that views people as biological, psychological, social, and spiritual beings. Holistic health care treats humans

as complex creatures whose health and wellness are multifaceted and a person's overall health is based on a balance of our entire beings not merely a person's physiological well-being (Dossey, 2010). This comprehensive holistic practice philosophy was explored by descriptive phenomenology.

A phenomenological technique aided in discerning the meaning NPs place on the activity of holistic health care. A qualitative study helps to understand a human experience (Creswell, 2013). The goal of this exploratory qualitative study was to describe how NPs feel about the application of holistic care and their key lived experiences of NPs as providers of health care in a non-acute setting (Gliner, Morgan, & Leech, 2017). The qualitative interviews sought knowledge and did not quantify the data. The application of a descriptive qualitative interview inspired the participants to describe what they have experienced, how they felt, and responded to the philosophy of holistic health care in practice. An examination of the participants experiences and why they act as they describe was assessed (Brinkmann & Kvale, 2015).

Research Context

The study location was rural New York State. The distribution of NPs practicing in New York varies widely by regions with the majority caring for the urban population, the 29 regions of Central New York receive care by NPs with 28.6 active NPs per 100,000 people (Martiniano, Wang, & Moore, 2017). NPs provide the predominantly underserved rural communities of New York State with an extensive range of health care services including, primary care, illness prevention, counseling, physical assessments, and the management of acute and chronic health issues (Martiniano et al., 2017). The population served are adults who frequently have multiple comorbidities which require

long-term health care management. The situational demographics are the non-acute care settings. Non-acute care settings are non-inpatient settings such as physician offices, walk-in clinics, hospital-based outpatient health care clinics, and public health clinics. Eligible clinics do not provide acute care but may be independent practices or associated with larger health care organizations. The practice settings may be for profit or not for profit.

Research Participants

All participants had no less than 3 years' experience as NPs, practiced in rural New York State, and provided primary care. All participants have practiced as primary care providers for no less than 3 years in a rural setting. All participants are currently employed and working as primary care providers and are licensed nurse practitioners. Of the four participants, three have a Doctorate in nursing and the fourth participant has a Master of Science in nursing and a doctorate in chiropractic care. The study participant population was primary care nurse practitioners who have completed a program accredited by the New York State Board of Regents and the Commission on Collegiate Nursing Education (CCNE) which is registered by the University of the State of New York and the State Education Department. Participants must be listed in the Office of the Professions, Division of Professional Licensing Services and have successfully completed the American Academy of Nurse Practitioner national certification examination. The nurse practitioners' degree-granting institution must be accredited and recognized by the Middle States Commission on Higher Education through the U.S. Secretary of Education and the Council for Higher Education

A suggested sample size for a qualitative phenomenological study is four to six participants (Creswell, 2013). According to Mason (2010), a guiding principle to sample

size in qualitative research is the concept of saturation. Guest, Bunce, and Johnson (2006) determined that studies where there is a high level of homogeneity among the population, six participants may be sufficient to develop meaningful themes.

Convenience sampling is a nonprobability sampling method based on data collection from a participant population that is convenient to access by the researcher (Saunders, Lewis, & Thornhill, 2012). Convenience sampling was selected for this study due to the researcher having an extensive professional network as a nurse educator. Participants willing and available to be interviewed provides selection based on the easiest access with minimal limitations (Flick, 2014). A convenience sample is a selection of participants who have a basic understanding of the central phenomenon of the research (Flick, 2014). The substantial sample criteria strategy was applied due to specific sampling elements defined beforehand. Dimensions of the eligibility criteria includes current New York state licensed nurse practitioners who practice in the non-acute care setting and have practiced for no less than 3 years as NPs. Recruitment was completed using the application of convenience sampling through professional networking to acquire participants. This method allowed the researcher to identify participants who are educated about the phenomenon being studied and are readily accessible (Flick, 2014).

The researcher is employed by a college in Upstate New York in an accredited nursing division which educates nurses to become nurse practitioners. In addition, several of the researchers' colleagues are practicing nurse practitioners. The researchers' professional network of practicing nurse practitioners, nurse practitioner educators, and collegial associates from the American Nurses Association and New York Organization

of Nurse Executives and Leaders provide a network for potential participants. To diminish bias, participants who are not personally known to the researcher were sought.

Snowball sampling was also used as a recruitment technique. Snowball sampling, otherwise known as serial referral sampling, is where participants are asked to assist in identifying other potential subjects who met the study criteria (Creswell, 2013). The associate known to the researcher reached out to another who meets the criteria and inquire regarding willingness to participate. If the person is willing to participate, then and only then will the associate provide the researcher with an email to contact the potential participant.

The researcher first communicated with potential participants via email to ascertain interest in participating in an interview (Appendix B). When the potential participant expressed interest, the researcher emailed or called the participant to arrange a mutually agreed upon location to conduct the interview. Participants who met the listed requirements were chosen based on availability and willingness to participate. To avoid bias or indication of coercion, a general inquiry email was sent to known colleagues only once providing notification the researcher was seeking participants. Only participants who responded and expressed interest had follow-up contact (Appendix C). No additional contact was initiated to pursue participants who did not respond to the initial request. The disadvantage to convenience sampling is that there is no guarantee that the individuals interviewed are representative of the population and are not biased (Saunders et al., 2012). The sample was limited to interested NPs to best allow answers to the research questions which provides meaningful data relevant to the question (Flick, 2014). The

participants that were chosen were knowledgeable about the phenomenon of interest and able to express their thoughts and share their experiences.

Participants were required to meet the following inclusion criteria: (a) employment for no less than 3 years as a nurse practitioner, (b) graduated from an accredited NP program and have an active license in NY state, and (c) current employment as a nurse practitioner in a non-acute setting.

Once the candidates were established, they prepared for the study through provision of clear expectations. The expectations included one hour of uninterrupted time for an interview, agreement the interviews will be recorded, a review of the purpose of the interview, a review of the voluntary status of their participation, and their ability to stop at any points in time. The final provision was the assurance confidentiality for the protection of all participants and in an effort to establish a rapport with the interviewees (Flick, 2014). Enrollment in the study required a witnessed signed proof of consent by each participant (Appendix D). Participants were provided and acknowledged understanding of research approval by the St. John Fisher College Institutional Review Board (IRB) (Appendix E). Protection of participant identity was accomplished by the removal of names and all work locations from the study. In addition, there was secure maintenance of all data on a password encrypted computer in a password protected file. The handwritten notes and tape recordings were locked in a private file cabinet. Participant names were removed, and each interviewee was assigned a number to reference their input. A full explanation allowing participants to end contributing at any point in time was provided.

Instruments to be Used in Data Collection

A face to face interview was conducted with each individual following a predetermined protocol guide. The data was transcribed verbatim then coded and assessed to determine themes in the participant responses. The data instrument applied was the semi-standardized interviews aimed at comprehending themes of the nurse practitioners' daily practices regarding the application of holistic care (Brinkmann & Kvale, 2015). Verbal data was collected via interviews seeking narrative experiences and concrete situations told during focused semi-structured one-on-one meetings. The interviews started with open-ended questions followed by descriptive questions for deepening the issue (Flick, 2014). Content structured questions followed for clarifying unspoken information.

To guide the interview process, application of Brinkmann and Kvale's (2015) multiple forms of interview questions were applied. The questions are progressive in nature and are in the following order: introductory, follow-up, probing, specifying, direct, indirect, structuring, silence, and interpreting questions (Brinkmann & Kvale, 2015).

The nurse practitioners were asked descriptive questions to describe their feelings, experiences, and actions regarding their practice. Also, the interviewees were asked to describe detailed practice situations and actions related to holistic care to go beyond a general opinion question (Brinkmann & Kvale, 2015). The primary task accomplished by specific descriptive questions was the collection of data which explores what the subjects believe and apply in their practice. Descriptive questions are utilized to inspire a stream of information (Flick, 2014). As the interview progressed, previously prepared questions were asked of each participant to keep the interview focused (Flick, 2014).

Specific themed questions to control the interview were presented to elicit the interviewees personal opinions (Brinkmann & Kvale, 2015).

Procedures for Data Collection

Interviews were tape-recorded and field notes were completed immediately following each meeting. During the interview process, note taking was kept at a minimum to decrease distraction and increase open dialogue. First person phenomenology supported the gathering of qualitative issues related to their experience including but not limited the participant's sense of self-identity, sense of professional embodiment, their relationship to others, and activities which drive or motivate them (Eberle, 2014). The semi-structured, face to face interview questions were open-ended allowing participants to describe their experiences. According to Flick (2014), audio-recording the interviews will provide accurate information. Limiting the visual presence of the recording equipment may help the participants forget they are being documented allowing for a natural flow of conversation and thoughts.

All interview questions were reviewed by a doctoral-prepared nurse practitioner as a planned quality indicator and interview questions were sequenced to assist in establishing a rapport with the interviewee (Appendix F). Each interview started with general questions as icebreakers, progress to the sharing of information, followed by questions with stronger direction and thought (Brinkmann & Kvale, 2015).

Data Analysis

Descriptive coding was utilized to determine themes providing a personal account of the phenomena. (Creswell, 2013). Completed analysis of the data describes the

phenomenon focusing on comparing individuals to determine what they have in common in addition to identifying differences (Flick, 2014).

The analysis was completed in three steps. During the initial step, the researcher read and assessed the interview transcripts to establish a comprehensive understanding of the content. All data was organized and analyzed to explore the range of the nurse practitioners' knowledge and application of holistic health care. The qualitative analysis of the interviews focused on non-numerical distribution of the nurse practitioners' views and life experiences in their role as NPs.

The second step was application of a descriptive coding procedure to the data to identify trends and possible themes. The coding summarizes the issue of a section of qualitative data and recognize themes which will provide areas for further investigation (Saldana, 2012). This thematic analysis includes coding and content examination to identify reported patterns within the data (Flick, 2014). As outlined by Flick (2014) the data was scrutinized to find repetitive patterns of meaning to gain a rich description of identified themes or codes. The chunking of information gathered was compared line-by-line and side-by-side to determine possible themes.

The third and final step was the clustering of codes to generate themes for the review of the profession during its evolution and possibly add substance to the research completed by Gould et al. (2007) regarding the evolution of the role of the NP. The coding method selected was in vivo Coding which is a straightforward method to categorize data (Saldana, 2016). In vivo coding allowed for basic meanings and provided themes. The final step in the interview process of interpreting questions adds to the reliability when rephrasing, and clarification is sought (Brinkmann & Kvale, 2015). All

noted relevant quotes or data points were listed equally to prevent any indication of prioritization.

Trustworthiness. The application of structured procedures included standardized field notes which were written as soon as possible after the interview and documentation of impressions of the interaction supported the research trustworthiness (Flick, 2014). Dependability is increased through the use of standardized abbreviations making it possible to check the data interpretation. In addition, trustworthiness was supported by assigning an initial code as the interview data is transcribed and maintaining a research reflective journal with critical memos (Saldana, 2016). In addition, trustworthiness is indicated by deep intense data (Lobiondo-Wood & Haber, 2018). Finally, acknowledgment of self-identified epistemology and personal experience with the topic to avoid prejudices was accomplished (Creswell, 2013).

Chapter Summary

The research explored the lived experiences of nurse practitioners related to the application of holistic health care practice. The research method selected is descriptive phenomenology allowing each participant to provide a personal description of their reality or circumstance related to holistic health care (Creswell, 2013). This phenomenological research investigated NPs' feelings, lived experiences, and thoughts to discover a greater understanding of the evolving role of NPs as primary care providers (Flick, 2014). The methodology chosen provides a framework to explore individual nurse practitioner's experience related to care of their patient's mind, body, spirit, and environment in the shifting landscape of health care. Reflection upon the data analysis

and research finding are presented in Chapter 4 followed by a conclusion with potential suggestions in Chapter 5.

Chapter 4: Results

Introduction

This study explored the lived experiences of nurse practitioners' application of holistic health care in an evolving health care industry. A total of four female nurse practitioners were interviewed. The research supported previous studies as outlined in Chapter 2, inclusive of barriers to holistic practice, novice to expert care provision, and conflicts associated with having to bridge the medical model of health care and the holistic nursing model of health care. As outlined in Chapter 1, nurse practitioners are quickly becoming the primary care providers for adults in rural United States. As the number of NP providers grows these care givers are evolving their role as they maintain a philosophy of holistic health care.

Research Questions

The purpose of the study was twofold. The study first explored how a nurse practitioner applies a holistic philosophy in practice. This was followed by an examination of how the nurse practitioner role has changed over the practitioner's practice tenure with regards to holistic care. The goal was to address the following research questions from the perspective of a nurse practitioner:

1. How does the nurse practitioner apply a holistic philosophy in his/her practice?
2. How has the nurse practitioner role changed with regards to holistic care?

Data Analysis and Findings

The participants were educated in different nursing and graduate programs yet expressed common foundations for the provision of holistic health care. In addition, common themes were expressed by all four participants related to provision of holistic care and challenges related to the professional role of nurse practitioners. All participants expressed a desire to provide holistic health care and identified reasons why holistic health care is not consistently provided. The NPs voiced concern related to the personal impact of the evolving role of the NP, being used as a “dumping ground” by physicians, feeling of exhaustion, and being discouraged by patient expectations. However, participants expressed a sense of hope and positivity related to the role’s evolution and the future of the profession. Table 4.1 presents an overview of the three emerged categories and the themes associated with each of the categories.

The study addressed two research questions from the lens of a nurse practitioner. The first research question sought to determine how a nurse practitioner applies a holistic philosophy in practice followed by an investigation into how the NP’s role has changed since starting practice as an NP with regards to holistic care.

Research Question 1: *From the perspective of a nurse practitioner, how has the role changed since you started practicing with regards to holistic?*

The data revealed three categories related to the provision of holistic care by nurse practitioners and each category presented three distinct themes.

Table 4.1

Summary of Categories and Themes

Category	Theme
1. Holistic values and beliefs	1.1 Desire and passion to practice holistic care
	1.2 Lack of spiritual care
	1.3 Moving from novice to expert
2. Broken system	2.1 Time- Restraints/restrictions
	2.2 Evidence-based research
3. Impact on role of NP professional satisfaction and expectations	3.1 Burnout
	3.2 Patient and NP interactions
	3.3 Hope for the future

Holistic values and beliefs. Holistic values and beliefs emerged as Category 1 from the data analysis. All participant interviews discussed their holistic health care philosophy and its effect on their practice as NPs. Each participant expressed a belief which supports there is value added by assessing clients holistically and held strong opinions that patients will have healthier outcomes if treated holistically. NP2 stated,

We are a whole. We're not these separate entities, and you can see it. I mean physiologically, you can see that if the mind and spirit, are in a good place, the body will follow . . . if we addressed what we needed to in terms of mind and spirit, we might not have to have those very expensive medications with side effects and potentially harmful interventions.

NP4 stated,

My roots are the same that I believe that what happens in our body is sometimes affected by things that are happening in our mind or when our spirits are low, sometimes it affects the minds and eventually the body . . . I do think that our environment has an impact on both caregivers and to our patients, it's all affected by . . . So, it's really something that can't be separated.

Three subthemes developed when participants expressed a consistent desire to practice holistic care. The first theme was a desire and passion to practice holistic care and placed equal value on all four elements associated with holistic health care, yet each provider presented instances where they did not provide spiritual care. In addition, the participants reflected upon how their practice has developed with a greater focus on holism as they have moved from novice to expert. (Brenner, 1984).

Desire and passion to practice holistic care. NP2 stated, regarding holistic health care,

I do more now than as a novice clinician. I think as a novice clinician, a lot of the focus is on making sure that you're getting all the important information from the patient that you need from the history and the physical exam, and that you're coming to the correct diagnoses, and that they understand the treatment plan. With the treatment plan being . . . more focused on here's what's going on, and here's what we're going to do . . . not as focused on the assessment of areas [outside of the body] . . . as a novice clinician the body is more than the environment, mind and spirit.

Similarly, NP3 stated,

I believe that what happens in our body is affected by things that are happening in our mind or when our spirits are low, it affects the mind and eventually the body.

I think the environment impacts both caregivers and patients, and we are affected holistically . . . it's really something that can't be separated, although I feel the pressure in today's health care environment to separate them.

NP2 stated, "the topic of providing holistic care really comes in for me because that is something there is an immense need for."

Lack of spiritual care. Lack of spiritual care was exposed regardless of the NP's values or beliefs. NP3 went on to state,

I want to feel like when I interact with my patients that we kind of touch on all these things, more or less, just because that's kind of my background, but I don't see every patient every day. When I'm getting pulled into dealing with families, or labs, or reading notes and that stuff, I don't necessarily touch on all that stuff.

Even with the expressed acknowledgement of a strong belief that holistic care consists of all four spheres, mind, body, spirit, and environment, each participant self-identified a lack of providing spiritual care. The contradiction between expressed value related to spiritual care and the application of spiritual care continues as identified in Chapter 2 literature review. NP1 stated,

I'll be honest, I don't know if I really think about that as much as that I just try to live that. And I wait for patients to give cues that that is something that's a big part of their life.

NP1 went on to share a recent exchange when a fellow NP sought her guidance and questioned how to add spiritual care to her practice. The experienced NP advised her novice colleague,

Unless that patient wants you to. I don't think it's appropriate for us to initiate that. I think it's appropriate for the patient to initiate it or for us to have a better understanding of what's important the patient before we bring spirituality out.

One practitioner expressed discomfort related to spiritual care stating,

We don't talk a lot about. It's really hard to talk about because, when it comes to spirituality, I feel like it's kind of a touch subject . . . one of those things you don't necessarily want to touch on because you don't want to offend people. You're afraid to say the wrong thing.

NP3 went on to state "It's not even a quantifiable, tangible thing that I can really truly assess and help support sometimes, it is very elusive, the mind, body, and environment are concrete and easy to assess."

Moving from novice to expert. The third theme identified an increase in the provision of holistic health care as each NP moved from novice to expert. NP4 recounted a recent experience when she was with a patient and, "The doctor's yelling at me . . . Please hurry up." She continued and completed a holistic assessment on her patient and added that, "when I had less experience under my belt, I would have been inclined to keep it sweet, keep it short in response to pressure. There were times I have not provided holistic care."

NP3, compared her educational foundation and how once she gained experience, she was able apply holism, yet continues to struggle as she practices alongside physicians.

During school they talk about the holistic approach to things but, we do focus on the medical model, and we get stuck into the evidence based practice and treating what is right in front of us, not everything else that's potentially affecting the person . . .you're forced to learn the evidence based medical model, because unfortunately, when you work in the field, you work with doctors who work on the medical model, who to be quite honest, don't want to hear about the mind and the spirit, and the other portions that we are taught to question and look at as nurses . . . We kind of get stuck . . . we've got one foot in each world.

NP2, specifically stated she practices more holistically now than she did as a novice NP.

I think as a novice clinician, a lot of the focus is on making sure that you're getting all the important information from the patient that you need from the history and the physical exam, and that you're coming to the correct diagnoses, and that they understand the treatment plan which solely focuses on, what's going on, and what we're going to do about it.

As an experienced NP, NP2 stressed as the health care industry is evolving many nurse practitioners hope for a change to a more holistic model which is prevention focused.

As NP2 gained professional experience she credited her personal growth as moving her into a stronger holistic practice model. She described a personal experience

with the application of holistic care interventions which helped manage anxiety and stress in lieu of medications. This successful attention beyond the body convinced her to practice holistically and not see holistic care interventions as a secondary additive.

A broken system. A broken system category developed from statements expressed from all interviewees. This second category presented with two separate themes. The NPs consistently reported a desire to provide optimum health care through the application of a holistic framework but felt pressured by a system which does not support their philosophy. The system was described as a medical model focused solely on the body's state of illness or disease. The participants described the pressure to "treat and release" which does not provide for health maintenance, illness prevention, or overall health. Examples were provided of patients who were not able to pay for their medications or follow up care who would go without until they were ill again and able to, "come back into the system and get care up to speed" (NP3).

The participants interviewed expressed concerns related to practicing in a medical model of health care. For example,

Everything is evidence based for the most part. . . during school they talk about the holistic approach to things but, we do sometimes focus on the medical model, and we get stuck into the evidence based practice and treating what is right in front of us, not everything else that's potentially affecting the person. The doctors aren't taught on that model and aren't as perceptive or willing to incorporate that into care of a patient. So, a lot of times as a nurse practitioner you add some of those things in, against the medical doctor that you're working with advice. I feel like we talk about it a lot in nursing school, and we push it a lot in nursing school,

but when it comes to the real world and how you practice, unfortunately, most of the medical field works on the medical model. I want to incorporate those things in, but you get push back from the medical community. We work on a medical model. We don't work on a nursing model. . . So, I feel like there is a little bit of a disconnect. Unfortunately, we work where a medical model dominates. (NP3)

NP2 reflected on her practice as a primary care provider in the Veteran Administration caring for patients with both mental and physical health issues. She stated the providers were very distinct entities and cared for only the area related to their specialty, psychiatrists dealt exclusively with the psych realm and medical physicians dealt with the physical realm. The NP found this frustrating because she did not really consider them as separate and it went against her belief in holistic care.

NP3 stated,

We're not really accepted as a doctor, because we're not but, we're not really accepted as a nurse anymore because you're the nurse practitioner, so you get stuck having to play this middle role, I want to incorporate those things in but you get push back from the medical community, because that's how the medical world works, right? We work in a medical model. We don't work in a nursing model.

Time. During the data collection the comment to “treat and release” was stated multiple times. This concept is related to the compartmentalization of humans into separate elements such as the mind and the body. It directs a care provider to complete a focused assessment based on an identified complaint, illness, or disease. The care provider must determine a medical diagnosis, prescribe a treatment (medication, therapy or test), then discharge the patient. Frustration was expressed by all participants related

to the limited amount of time allowed per patient. In the health care industry time is money, as the more patients that are seen the more billable visits. NPs described difficulty practicing holistically related to the restricted time scheduled per patient.

NP4 stated,

I am expected to see between 16-20 patients a day which allows for approximately 15-20 minutes per patient in an 8-hour day with no breaks.

Where's the research that says 20 minutes is perfect? That shows us that that's the usual period of time that patients take.

Productivity requirements and time constraints were concerns were echoed by NP1 who shared, "to be honest, in 15 minutes there's no way that I am going to be able to take care of the whole patient, 15 minutes allows for minimal care."

A change to the 15-minute ruling was identified in order to establish an environment to provide holistic care. NP4 described a brief scenario where a patient asked questions regarding an issue other than the reason for the visit and her inability to address the issue due to limited time. NP4 also complained limited time was the biggest restraint on establishing a therapeutic relationship with the patient. In addition, she commented when patients are requested to return for follow up for additional issues they frequently do not come back.

Evidence-based research. NP4 complained that,

...instead of following evidence-based research we follow the money and the rules don't always follow along with the patient. And compared it to, we kind of got lost in the sauce there, you know. Nursing and medical care are both driven by evidence-based research. However, the professions focus on different sets of

research. Evidence based research is utilized to diagnose and treat disease and illness; however, evidence-based research also supports the importance holistic care to maintain a healthy state of being or for a person to be at their optimum level of wellness.

NP4 also stressed that a negative environment weighs on the mind and eventually affects the spirit and the body because a person can't feel good when everything's out of control. This negative environment can lead to physical changes in the body especially with blood sugars and infections which becomes a vicious cycle.

The health care industry is developing changes related to pay for performance which are designed to see outcomes that are better for the patient. NP4 described these changes as evidence-based research which are better aligned with the holistic health care model. Evidence-based research provides more than treatment options for health care providers as NP2 stated, "Anytime you can decrease the cortisol level, you're going to put the body in a less stressful situation," which promotes health.

Impact on nurse practitioners. Impact on the nurse practitioners was the third category of issues identified. This category noted several items which impact upon the NPs professional satisfaction, role expectations, and outlook for the future.

Burnout. Dealing with the position, expectations, barriers, and philosophical conflicts a burnout theme emerged. NP2 specifically expressed concern that NPs did not personally practice holistic health care and should add interventions to stimulate balance thereby promoting personal health.

What we do is high stakes. Which is why our stress levels are there and why we need to be doing more yoga and teaching our clinician students that they need to

be doing it too. I mean, like in the curriculum we should have a course that really . . . I mean, it should be integrated in our courses and is. You look at the textbooks, and you look at the lesson plans, and you go, “Oh yes. There’s this piece about complementary alternatives.” But it’s like, it’s not complementary or alternative. It is the answer!

NP4 stated,

Interestingly enough as a nurse, as an RN, I felt that I had more autonomy to kind of direct different cares than I do with being a nurse practitioner. When you’re a nurse practitioner, the model in the system today is . . . see them. See them, see them fast, see them in volume.

NP3 expressed concern regarding collegiality and teamwork. She stated some doctors look down on NPs and she told a story about a fellow NP and a physician who were going back and forth over a patient concern when one of the nurse practitioners said, “Your colleague is trying to explain something to you.” And the doctor looked at her and said, “You are not my colleague!” She went on to explain all the providers present had doctorate degrees but only the physician was allowed by hospital policy to use the title doctor. Additional information was provided indicating a lack of teamwork and a system with a strong hierarchy preventing an optimum functioning health care team. The hierarchy is reinforced by the terms invented by insurance companies and applied by health care organizations such as mid-level provider. The term indicates there are high-level, (physicians) mid-level, (nurse practitioners) and low-level (nurses) providers instead of health care team members who each bring a different expertise to the table.

NP3 described how in theory NPs were to care for the less clinically complex patients; however many NPs have become a “dumping ground” for physicians who want a “minion” to complete the “dirty work” they don’t want to do and to care for patients that have difficult families noting far too often, “the docs offload their patients.” The stress of an evolving role compounded by a system which does not support their professional values, education, and contributions has contributed to NP burnout.

Patient and NP interactions. NP1 addressed how the patient can be focused on a medical model of treat and release,

I always thought that I would be able to support people to a better way of life and not always through medications. Because I really don’t like putting people on medications, but I’m always surprised how many people want antibiotics . . . patients truly push to have that prescription before they leave my office.

My end goal, for every visit that a patient is with me, is to have them be the healthiest they can be. Many patients are resistant to that and some of it could actually be financial . . . other times the patients themselves are part of the barrier because, they’re unwilling to accept the help or accept their diagnosis to be able to get the right kind of care, or accept their situation.

NP1 expressed a sense of defeat due to lack of patient motivation to be their best selves and that the “harsh” reality is as health care providers we can teach and attempt to educate in an effort to get patients to change negative life styles but many patients are not motivated to change. NP1 stated that in fact motivation to change

. . . is not where many patients are, they are existing, and this [appointment] is just a small part of their life, that they don't have time to be sick because they have other things that they want to do in life.

NP3 expressed concern that patient perception and compliance was a source of frustration.

Unfortunately, we have patients that come here that are non-compliant that don't want to listen to the things that you tell them . . . and the patients willingness to accept help is sometimes a barrier because they're unwilling to accept the help or accept their diagnosis to be able to get the right kind of care, or accept their situation . . . and accept a holistic approach of fixing what happens to them to be able to make them better . . . non-compliance . . . would be my other barrier.

Patient feedback can be stressful when a provider does not know how receptive the patient will be suggestions NP4 shared,

Sometimes you get feedback from the patients that you were not terribly successful . . . I know a lady got really mad at me . . . because I was pretty straight with her and she took offense, after that she completely shut down. I felt bad about that . . . but she was in a position of doing better and I think that we needed to do better, but she's very reluctant to try anything new . . . didn't want to try anything new, so sometimes you get frustrated.

Hope for the future. It is noteworthy that regardless of the obstacles and difficult work situations all interviewees expressed optimism related to the role of nurse practitioners and society's current evaluation of the health care industry. NP3 shared

I think that some of the more recent literature points to the social determinants of health and the impact of the social determinants of health. There are some creative solutions are being brought forward to address the fact that it's very difficult if your only grocery store is a convenience store that you're not going to be able to get healthy food for your family.

Regarding health care reform, NP4 stated, "We're on the cusp . . . we're going to be turning over to pay for performance . . . we're going to have to be accountable for good outcomes for patients," and predicted this is opening a window of opportunity to improve care and increase holism.

NP4, additionally works as an educator and expressed,

Sometimes we teach toward the ideal and I can't imagine teaching any differently, but I think it's also important to make sure the students know that there's the real and that you're not a bad person if you have to deviate from the ideal sometimes . . . and it takes a while to get that judgment. I think that we're working in a model of thinking that is very different than the nursing model of thinking and bridging the two is a challenge.

NP2 stated,

Honestly, I feel like nurse practitioners are kind of a bastion of hope in the sense of getting to the right place because nurse practitioners and primary care particularly have a wonderful . . . opportunity. They're going to be needed because physicians as they graduate medical school have horribly, ungodly loans they cannot afford to be family practitioners, they have to specialize to pay off their loans. So, there's a huge gap, and nurse practitioners coming into that gap,

working with families in rural areas in primary care, making those connections, there's going to be numbers. In mass, those numbers and their experiences are going to have a voice. They're going to have public trust, and I think it's going to take time, but ultimately I think those are all things that will kind of cause a change that otherwise might have taken longer to get there if nurses weren't in primary care roles.

The NPs expressed a belief in being role models and accumulating data to drive policy change towards a holistic preventative health care model. Specifically, to provide education and to,

Make sure that what we teach our patients in the clinic, but also teach our students in the classroom, education has a real opportunity to influence change . . . to practice holistically . . . the only way to influence a change in the system is . . . through education, really influencing young people that there's a better way to do it than we're doing it, and empowering them to do that . . . and build on that kind of research, advocate . . . get involved. (NP2).

Nurse practitioners presented a sense of hope and empowerment citing,

We are in a great place because we're the most trusted profession, and have been for decades, so when we bring the data and we talk the talk that all the number crunchers understand, and we sit at the table and say, "Look, how are you not going to address that we have identified this?" Then they have to . . . While at the same time, there's more and more people who grow up with it enter that world and then you know it can create that nice perfect storm that will cause the changes that have to happen. (NP2)

Summary of Results

In summary the data revealed three categories of concern and each category presented thematic issues. Category one was a shared value and belief in holistic health care practice. The NPs expressed belief generated three themes; first and foremost a desire to practice holistic health care, second a noted lack of addressing spiritual care and third an increased ability to provide holistic care as they transitioned from novice to expert.

The second category identified is a broken health care system. This category revealed two themes. The first theme identified was time restraints in the practice setting. The second theme recognized in the broken health care system was the application of evidence-based research.

The third category involved the impact on role of NP professional satisfaction and expectations. Category three presented three themes. The themes are burnout, patient, and nurse practitioner's interactions and hope for the future. All three identified themes influence and impact the role of an NP.

Chapter 5 will discuss the implications of the results as well as recommendations for professional organizations, schools and colleges, and nurse practitioners.

Chapter 5: Discussion

Introduction

The United States health care system continues to evolve as it attempts to improve patient outcomes through health care reform. Research shows the amount of money spent on health care is greater than any other nation and yet our outcomes lag. The lack of value added to lives based on the current system expenditures presents an opportunity for support of holistic health care. This corresponds with the increase of NPs with a holistic philosophy to provide primary care. Research supports people have multiple needs which directly affect their health which go beyond the physical body. Lifelong positive health outcomes are promoted and maintained by a healthy mind, body, spirit, and environment. To support a healthy state of being a primary care provider is encouraged to go beyond a person's physical condition and assess the status of a patient's mind, spirit, and environment. As the number of primary care nurse practitioners grow and the number of physicians practicing primary care diminishes implications related to philosophical care foundations will evolve.

The purpose of this qualitative, phenomenological study was to explore the lived experiences of primary care nurse practitioners as holistic care providers in rural New York State. Interviews were conducted with four practicing NPs with no less than 3 years' experience in their positions.

Implications of Findings

The completed exploration into the lived experiences of nurse practitioner's application of holistic health care revealed a common desire to provide holistic care for their patients. The participants expressed a professional belief that holistic care adds value and improves patient outcomes; however, each element of holism was not practiced equally. The professional philosophies supported Watson's theory of caring yet taking the time to re-center and apply a strong caring relationship with patients was not expressed. The NPs practice focused on the body, mind, and occasionally the environment but seldom assessed patient spiritual needs. The practitioners described different levels of comfort related to spiritual care and noted it was not always assessed due to discomfort and not wanting to impose a belief on the patient. Specifically, the NPs alleged the word spirituality was too linked to religion which does not have a universal belief. NPs taking a moment to self-center and focus prior to each patient contact is a simple yet effective method to increase caring in the provision of health care (Watson, 2012).

The participants collectively noted barriers to providing holistic care were the health care system functioning on a medical model of care and restrictions implemented by the health care industry productivity requirements. The NPs identified frustrations related to the health care industry hierarchy, patient expectations, and lack of compliance. One provider identified that the system is broken, noting the current health care industry addresses disease and illness and provides no rewards related to prevention. NP2 strongly complained, "we do this ass backwards," and stressed a focus on prevention would produce a healthy society.

Despite frustration with the health care industry, lack of patient participation, and working in a demanding environment, all the participants were still hopeful the role of the nurse practitioner will remain holistic. All participants identified that they continue to value and apply holistic care whenever possible. In addition, the NPs expressed an ability for increased holistic assessments and interventions as they gain experience in their role. Each participant provided a real-life example where they provided holistic care and were able to accomplish a positive patient outcome by looking beyond the patient's immediate physical needs. NP2 expressed a desire to educate nurse practitioner students to participate in health care reform to address policy changes, patient advocacy, and an increased focus in curricula supporting the importance of holistic care.

Several implications were found related to previous research. The literature review provided a rich database of completed research related to holistic health care. Multiple approaches were found related to the value, foundation, expectations, definitions, and application of holistic health care. To streamline and provide a direct connection to the participants expressed data, the literature was narrowed to five aligned bodies of research and publications.

Literature findings were significant and were narrowed down to the following authors. First the definition and philosophy of holistic care was supported by Watson (1985) and Nightingale (1860). Known as the mother of the profession of nursing, Nightingale's (1860) notes on nursing included the elements which constitute nursing care today. In her extensive documentation and evaluation of nursing practice Nightingale (1860) recognized the need for nurses to care holistically for the entire patient including their environment. The first professional school of nursing was

established by Nightingale (1860) with a curriculum that included care for a patient's mind, body, and spirit as the nursing students were taught to address preventative, maintenance and healing elements of health care as outlined in her notes on nursing. Nursing textbooks steadily addressed the need for nurses to provide holistic health care and a philosophical belief that nurses regardless of practice level are to assess and treat a person's mind, body, spirit, and environmental issues (Timmins et al., 2015) Watson's (2012) caring theory describes professional caring as a method which helps healing and supports the nature of holistic nursing practice. Watson (2012) encouragement of caring is seen as part of a professional nurses' role and is a distinct part of the profession. The inclusion of caring applied in a holistic framework provided compassion which eased patients' suffering and contributed to the establishment of a practice of wholeness (Watson, 2012). Patients benefit from care provided in a professional caring environment (Vandenhouten, Kubsch, Peterson, Murdock, & Lehrer, 2012).

Current evidence-based publications supporting nurses as holistic care providers was identified in research and publications by Dossey et al. (2005). Historically and by current standards, nursing is a holistic practice focused on the rebuilding and promotion of health which supports a state of harmony and wellbeing (Dossey et al., 2005). Even though evidence-based research indicates that holistic care has a positive impact on patient outcomes such as improved response to treatment, improved physical condition, prevention of depression, a decrease in the length of hospitalization, and a quicker recovery it remains under supported by the current health care system (Jasemi et al., 2017). An added benefit to providing holistic care is the feelings of personal development which makes nurses feel satisfied, and consequently influences nurses to

stay in their profession. Evidence-based practice focused on scientific research to direct all decisions remains the gold standard for health care service delivery yet not all evidence is awarded the same value. Evidence-based medicine was developed to change medical care decisions determined by what residents were taught to do to a scientific method where medical care was provided based on the scientific evidence and is intended to include all empirical evidence (Smith & Rennie 2014).

The next literature connection identified was barriers outlined by research findings of Gould et al. (2007) to the provision of holistic care. Their 2007 study identified barriers which included NPs philosophy of care verses a medical model philosophy, fee for service billing, teamwork and a developing role. Challenges related to team work and differing models of care delivery were also noted as barriers to holistic care by NPs in a later study by Poghosyan and Liu (2016). Pressure related to payment policies, professional tensions and a health care system established to provide intermittent reactive care prevents NPs ability to provide holistic patient centered care (Carryer & Yarwood 2015). Balboni et al. (2014) completed research which indicated a desire by NPs to provide holistic care but were prevented due to lack of time, private space, and adequate preparation and comfort related to spiritual care.

Even though all the participants expressed belief in the importance of holistic health care provision, Timmins et al. (2015) identified barriers and a consistent lack of spiritual care by NPs. The lack of spiritual care provision was supported by Narayanasamy (2010) regardless of their professional belief in the importance of providing care and addressing all elements of holism equally. Spiritual care remained integral to holistic care yet research conducted by Narayanasamy from 1993 to 2010

extensively evaluated the application of spiritual care by the nursing profession and documented a lack of preparedness, comfort, consistency, and adequate provision of spiritual care.

A final element identified from the literature review which must be noted is Paley (2001) who completed a study which indicated patients desire physical care but do not desire the full arena of care required by the holistic health care model. However, no follow up studies were located to support Paley's finding. Paley (2001) contended caring and the application of spiritual care provision was difficult to measure, and the concepts were illusive and unique to each individual preventing clear direction and outcome measurements.

Limitations

The limitations related to the research include potential bias of the interviewer due to a strong foundation as a holistic health care provider and the lack of participant diversity. All four participants were Caucasian and female. An exploration of NPs providing primary care in urban locations may present a different list of concerns. In response to potential bias, the researcher made a conscious effort to contain expectations and actively reflected upon personal experience in holistic health care.

Recommendations

Recommendations that have arisen from this research are directed towards professional nursing organizations, educating institutions of nurse practitioners, and the nurse practitioners themselves. It should be noted there was an unintended finding related to lack of patient willingness to make personal lifestyle changes to improve health outcomes. The identified resistance to change is a barrier to holistic health care

application and indicates a need for education related to the positive benefits of holistic health care.

Recommendations for professional organizations. To increase the influence of nursing on the provision of health care and to combat identified barriers to holistic care, involvement by the profession's governing bodies is recommended. This recommendation is for continued development of a leadership role by the nursing profession in the changing health care industry. The American Nurses Association, The National Leagues of Nurses (NLN), the American Association for Nursing Leadership (AONL), and the American Association of Colleges of Nursing (AACN) all offer opportunities to promote health by increasing the voice of nursing in the health care industry through nursing leadership (AACN, 2019; AONL, 2019; NLN, 2019). Accessing the current resources supports research related to the importance of holistic health care and barriers to application. Professional organizations are encouraged to increase participation and advocacy in policy development, legislative changes, and leadership directed towards the improvement of health outcomes.

The American Nurses Association (ANA) has established programs to assist in the expansion of evidence-based practices offering an opportunity to validate the holistic health care model in the current practice environment. Potential changes to the philosophy of nursing exist based on the professions continued avoidance of spiritual health assessments and care. The definition of spirituality remains elusive to practitioners and yet the philosophy of holism continues opening an opportunity for research related to current holistic philosophies. The interpretation of holistic health care compared to the World Health Organization's research on the social determinants of

health may offer a unified definition or verbiage to address spirituality. In addition to the ANA, The American Organization of Nursing Leadership (AONL) has educational and leadership opportunities related to political advocacy in an effort to influence the future of nursing and health care (AONL, 2019).

Recommendations for schools and colleges. The American Association of Colleges of Nursing (AACN) is the nationwide voice for academic nursing. AACN sustains several leadership networks for nursing school's development, which includes instructional development, research, and organizational leadership. AACN establishes standards for nursing education, supports schools in applying those standards, and encourages nursing to improve health care, support education, research, and practice. Some of the AACN programs include curriculum standards, health policy advocacy, leadership development, and grant-funding special projects by nurse educators. The AACN has ability to increase emphasis on holism as a standard of nursing practice. Supporting a special project by nurse educators to add case studies with practical application of all four elements of holistic health care would produce practical tools to add to nurse practitioner curricula. The case studies should be developed to address the current health care system's drive towards efficiency, quality, and financial concerns while maintaining elements related to Watson's caring theory.

In addition, the organization has two independent programs. The first program is the Commission on Collegiate Nursing Education (CCNE). It is an organization recognized by the U.S. Secretary of Education as a national accreditation agency and is the leading accrediting agency of certified nurse practitioner programs. The second program is the Clinical Nurse Leader Certification Program (CNL) which identifies

people who have become skilled at specialized standards and knowledge through certification (AACN, 2019).

The National League for Nursing (NLN) is credited with being the voice of nursing education and supports nursing leadership through their Leadership Institute. The institute provides opportunities across all nursing career paths. The programs assist in the development of professional leaders prepared to address advocacy, public policy, and competency in nursing educations (NLN, 2019).

The AACN, NLN, and the ANA's programs offer opportunities to develop adaptation strategies for NPs as they practice in the current medical model of care. These organizations are in a position to advocate for the provision to continue working with the Institute of Medicine as nursing grows as primary care providers in the US.

Recommendations for nurse practitioners. Providers are in a unique position to address the application of holistic care during their daily practice. As front-line care providers NPs can assess work environments to identify methods to improve efficiency to support time for holistic assessments. Providers can propose the addition of a spiritual assessment tool such as the George Washington Institute of Spirituality Tool which addresses four areas of a person's spirituality; their faith and beliefs, how important spirituality is in their life, are they part of a spiritual community and do they desire these issues be addressed in their health care (Puchalski & Romer, 2000). It is recommended that NPs maintain professional organizational memberships to stay current with health care changes, advocacy, and nursing research.

Nursing established holistic health care as a foundation to nursing practice under Florence Nightingale in 1860 which was formalized by the American Holistic Nurses

Association (AHNA) in 1980 and supported by nurse theorists Jean Watson (1979) and Barbara Dossey (1998) research promoting a holistic philosophy of care (Covington, 2003). If nursing is to continue promoting a philosophy of holistic care which values each element equally then the lack of spiritual care must be addressed. Otherwise it is time for the profession to redetermine the essentials which generate health and an optimum level of wellness.

Recent development of the Academy of Integrative Health and Medicine supports a model based on a holistic philosophy combined with modern medicine (American Board of Physician Specialties, 2019). Promotion of similarities between physician-based primary health care and nurse practitioner-based primary care would support unified practice goals. Encouraging an alliance with the integrative medicine model bridges the two professions. However, there remains reimbursement issues associated with all applications of a holistic philosophy due to the U.S. health care system attempts to decrease health care costs and to increase efficiency (Riley et al., 2018).

Recommendations for future research. Specific future research or actions based on the findings include an investigation into the application and need for spiritual care. Nursing has a history of difficulty providing spiritual care and assessing spiritual needs. Research has demonstrated a continued discomfort associated with the word spirituality and its definition indicating the term continues to be defined as synonymous to religion. A nursing literature review identified eight different definitions of spirituality (Blasdell, 2015) creating confusion regarding spiritual care provision. NANDA International (NANDA-I) is the nursing professions' organization which regulates terminology into nursing practice and clinical decisions (Herdman & Kamitsuru, 2017).

Even though NANDA-I does not provide a definition of spirituality, it does provide guidance related to the need to provide spiritual care. Nurses are expected to assess for spiritual distress which is defined as a, “state of suffering related to the impaired ability to experience meaning in life through the connections with self, others, the world and a superior being,” (Herdman & Kamitsuru, 2017, p. 375). Nurses are also expected to evaluate patients for overall spiritual well-being which is, “a pattern of experiencing and integrating meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself, which can be strengthened” (Herdman & Kamitsuru, 2017, p. 377). Based on the multiple definitions and lack of standardization professional nursing governing body’s definition, further research is suggested to determine how and where spirituality exists to provide solid guidance. One potential research area is comparing the multiple elements of spirituality as defined by NANDA-I to the social determinants of health. Integration of the holistic health care model with the social determinants of health has the potential to establish standardized goals and the essential elements required to obtain an optimum level of wellness and health. The World Health Organization currently supports the philosophy that health is strongly influenced by specific social determinants inclusive of race/ethnicity, income, community infrastructure, education, housing, environment, and food (WHO, 2016),

Conclusion

Nurses are expected to focus on the whole person when providing and planning care. A foundation for holism was established by Florence Nightingale yet the profession established a connection to Western medicine. By the 1970s nurse theorists labeled the profession devoted to the whole person (Klebanoff & Hess, 2013). During the 1980s

Dossey created a nursing theory built upon a holistic base (Dossey et al., 2005). The number of nurse practitioners as primary care providers is expanding combining a nursing philosophy and a Western medical model of care. Nurse practitioners face challenges in an evolving health care industry which demands high quality, productivity, and patient care expectations.

This study explored the application of holistic health care by four NP primary care providers. The providers reported several challenges but remain devoted to the provision of holistic quality care. The participants devotion to holism remains intact and their ability to provide holistic care has grown as they have gained experience. Yet, all participants revealed hesitancy and or a lack of addressing spiritual care. Research has established a lack of comfort assessing spiritual care in the nursing profession. When questioned regarding assessment for spiritual needs, the participants expressed concern with the word spirituality. As they each reflected upon the provision of spiritual care, participants added a desire to see a connection to elements of the social determinants of health and the developing integration of holism medical health care model.

Three categories emerged which are, a shared value and belief in holistic health care, the current health care system is broken and is not supportive, and as the nurse practitioners provide care there are conflicts which impact upon them. First and foremost, all participants expressed a desire and passion to practice holistic care yet lacked the provision of spiritual care in their daily practice. The participants noted their application of holistic care increased as they moved from novice to expert. A desire to increase the provision of spiritual care was only identified by one participant.

The second category specified a broken health care industry. The themes established focused on a medical model of care, productivity expectations, and evidence-based research linked solely with diagnosis and treatment of disease. A desire for increased evidence-based research connecting patients outcomes with holistic care was articulated. The NPs desire a health care industry focused on the whole person, supported by research, and directed towards illness prevention.

The third category identified the impact of practice on the nurse practitioners. The effects were inclusive of experiencing burnout, negative patient interactions, and their ability to maintain a hope for the future of NPs. Rigorous practice demands such as productivity, hierarchy issues, and limited teamwork contributed to feelings of stress. An unexpected theme developed indicating a lack of patient accountability and ownership to their personal health care. The participants expressed frustration connected to patient expectations and perceptions. Two of the four stated that patients frequently ask for a prescription or treatment to fix their health concerns and do not want to expend the effort needed to generate their optimum level of health. Patient education, maintenance of health, and time to encourage patient participation were identified.

Regardless of the frustration and concerns, participants expressed a strong hope for the evolving role of the NP. Several positive ideas were presented to support continued development of their profession. The suggestions included increased holistic care content to NP curricula, supporting research related to holistic care and patient outcomes, and an increase in nurse leadership in health care policy and legislative.

In summary NPs support the application of holistic health care but face multiple challenges in the provision of holistic care. The role of the NP is evolving, and their

numbers continue to grow as primary care providers in rural areas. Novice nurse practitioners struggle to hold onto their nursing foundation as they practice with one foot in the profession of nursing and the other in the Western medical profession. NPs felt more empowered to practice holistically as they transitioned from novice to expert. Developing models of health care, patient expectations, distribution of resources, and an evolving health care industry provide a rich environment for additional research.

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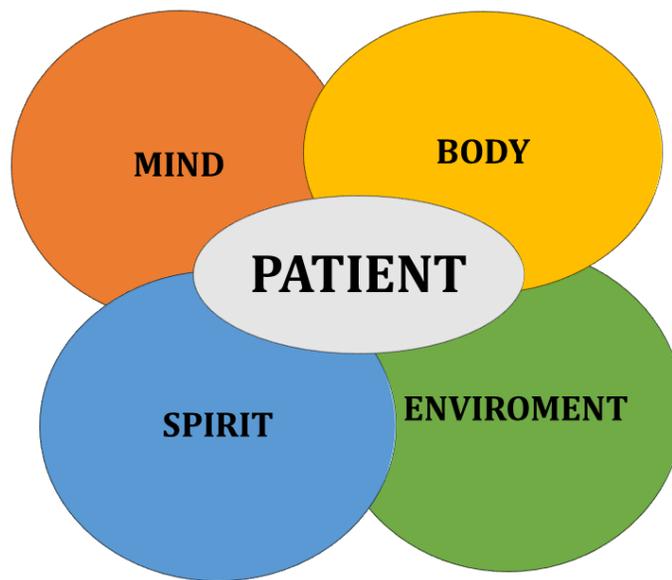
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Appendix A

Holistic Nursing Care Model



Author Reproduction Cindy E. Stevens

Appendix B

Introduction Letter to Participants

Dear Colleague,

I am a doctoral candidate in the Ed. D Program in Executive Leadership at St. John Fisher College in Rochester, NY. I am in the process of writing my dissertation, and my plan is to conduct my research in April-July of 2019.

I am contacting you as a potential participant because my study explores the lived experiences of nurse practitioners (NPs) providing nonacute care in rural central New York State and to investigate their lived experience regarding holistic health care. The number of NPs providing primary care has grown exponentially in the past five years as the demand for care providers has increased. The results from the study will contribute to the research available on the evolving role of the NP in a fast-paced demanding health care industry. My research will consist of interviewing nurse practitioners who meet the criteria described below.

In the study, the criteria for a nurse practitioner are the following: (a) employment for no less than three years as a nurse practitioner in a nonacute setting, (b) have completed an accredited New York State Board of Regents and Commission of Collegiate Nursing Education, have successfully completed the American Academy of Nurse Practitioner national certification, and hold a current license with the NYS Division of Professional Licensing Services. (c) current employment in the role of nurse practitioner.

I am requesting a one-hour interview, at the time and location of your convenience to be scheduled within the next four weeks.

St. John Fisher College Institutional Review Board (IRB) has reviewed and granted permission to conduct the study. All participation in the study is voluntary. To protect confidentially, any personal identifying information will not be disclosed at any point in the study.

If you would like further information or are willing to participate, please email me at my St. John Fisher address: cs08745@sjfc.edu

Sincerely,
Cindy E. Stevens

Appendix C

Sample Email

Dear Jane Doe,

It was nice talking to you the other day about my research project. As you know I am a doctoral student at Saint John Fisher College, and I am exploring the role of nurse practitioners as holistic health care providers. I appreciate your interest and I would like to add you as a participant to the study. I will arrange the one on one interview at the location of your choice. As I explained participation is completely voluntary; the interview will last approximately one hour, and all information will be kept confidential. Don't forget you may stop participating at any time during the process.

I look forward to hearing from you as soon as you are able. Simply respond to this email and I will be in touch. I am also enclosing my cell phone number for your convenience in case you have any additional questions or would prefer to talk this over.

Again, thank you for your time, it is greatly appreciated,

Cindy Stevens

Appendix D

St John Fisher Informed Consent Form

Title of study: An Exploratory Study of Nurse Practitioners as Holistic Care Providers

Name of researcher: Cindy E. Stevens

Faculty Supervisor: Dr. Kim VanDerLinden, PhD.

Email: kvanderlinden@sjfc.edu

Phone and email for further information: Cindy E. Stevens

Email: cs08745@sjfc.edu

Purpose of study: The purpose of this study is to explore the lived experiences of nurse practitioners who practice in rural Central New York State as primary care providers. This study will add to research surrounding the application of holistic care by recently established nurse practitioners.

Place of study: Nonacute Care Settings in Upstate in New York

Length of participation: 1 hour

Risks and benefits: The expected risks and benefits of participation in this study are minimal to no expected harm to the participants in this study. Participants' risks include that you may experience emotional/philosophical conflict during the study you discuss and reflect on their role as NPs provision of holistic health care. If you experience any discomfort, you may skip any questions that you do not wish to answer. You may also end the interview at any time.

The results of this study will contribute to research available in the area of the role development of NPs as primary care providers.

Method for protecting confidentiality/privacy: All interview transcriptions, audio recordings, field notes, and results will be stored on the researcher's personal laptop computer that is password protected and stored in a password protected file. All paper transcripts, field notes, and data collection tools will be kept in a locked container and will be destroyed after three years. Participant names will not be used in any documents, and no identifying information will be used in any publications. An additional step to ensure participants anonymity will be the use of assigned numbers to each participant in lieu of any personal

identification and no disclosure of specific work environments.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a question without penalty.
4. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name (Participant)

Signature

Date

Audio

Tape Release Form I voluntarily agree to

be audio taped during the interview.

Print name (Participant)

Signature

Date

Cindy E. Stevens _____

(Investigator)

Signature

Date

The Institutional Review Board (IRB) of St. John Fisher College has reviewed this project. If you have any additional questions or concerns, you can contact them at email at: irb@sjfc.edu.



Appendix E

IRB Approval

April 30, 2019

File No: 4010-041819-02

Cindy Stevens
St. John Fisher College

Dear Ms. Stevens:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "An Exploratory Study of Nurse Practitioners as Holistic Care Providers."

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at irb@sjfc.edu.

Sincerely,



Eileen Lynd-Balta, Ph.D.
Chair, Institutional Review Board

ELB: jdr

Appendix F

Interview Protocol

1. Please tell me a little about your professional background, for example, where did you go to school, and what type of nursing have you practiced?
2. Please describe your understanding of holistic care and explain to me your education and professional philosophy related to holistic health care. In day to day practice do you able to assess all four elements and if not, which areas are not addressed?
3. I'm interested to know if you had different expectations from nursing school related to your professional role compared to how it is today.
4. Can you describe any miss matches in the relationship to holistic care between your education and your practice?
5. Is there a specific experience you can recall where you applied holistic care? Tell me about it. What impact do you believe spirituality has on a person's overall health?
6. Tell me about any reasons you may or may not provide holistic care?
7. How has your perception of the role of a nurse practitioner changed during your years of experience?
8. Is there anything else you would like to share?