Why are conceptualizations of advanced practice nursing important for students and practicing advanced practice nurses (APNs) to understand? The content may seem dry to students, who are otherwise excited about learning new ways of caring for individuals, through their APN education. Concepts, models, and theories seem remote from the real work of eliciting histories, performing physicals, planning treatment, evaluating outcomes, and otherwise helping patients and families improve their health, cope with illnesses, and die with dignity. Whether one does so consciously, all these advanced practice activities are guided by some model or framework. Novices may rely more frequently on rules and guidelines to accomplish their work. Expert APNs may not consult rules and guidelines for common problems, but can improvise new ways of thinking (models) when faced with novel situations. Regardless of years of experience, APNs rely on common processes and language in their communications with colleagues about patient care and recognize when they must explain a clinical situation to someone unfamiliar with the patient. Similarly, it is important for the nursing profession and for individual APNs to understand the language of advanced practice nursing to communicate with each other, clients, and stakeholders. Currently, converging forces in the United States are moving rapidly, requiring the profession to advance a common understanding of advanced practice nursing, which is likely to inform future conceptualizations of advanced practice nursing.

The development of a common language and conceptual framework for communication and for guiding and evaluating practice, education, policy, research, and theory

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is fundamental to sound progress in any practice discipline. Given the evolving changes in the U.S. health care system, such a foundation is particularly crucial at this stage in the development of advanced practice nursing. Since the last edition, a professional consensus on advanced practice nursing regulation has been reached in the United States—the Consensus Model for APRN Regulation (2008) and is being implemented. In addition, the Institute of Medicine (IOM) (2011) has called for integrating advanced practice nursing more completely into the U.S. health care delivery system. Other forces driving a common understanding of advanced practice nursing are the expansion of programs offering the Doctorate of Nursing Practice (DNP), the Patient Protection and Affordable Care Act (PPACA, 2010), accountable care organizations, and the promulgation of interprofessional competencies (Canadian Interprofessional Health Collaborative [CIHC], 2010; Health Professions Networks, Nursing and Midwifery, & Human Resources for Health, 2010; Interprofessional Education Collaborative [IPEC] Expert Panel, 2011) and education (see Chapters 12 and 22). Understanding what advanced practice nursing is, what APNs do, similarities and differences among APNs, and how APNs contribute to affordable, accessible, and effective care is central to the redesign of U.S. health care. It is important for readers to understand that because of the dynamic and evolving nature of health care reform and nursing organizations’ activities in this arena, nationally and globally, the content in this chapter is changing quickly. Readers are encouraged to consult the websites cited in this chapter for up to date information.

Internationally, there have been efforts to clarify, establish, and/or regulate advanced practice roles within the nursing profession in other countries (e.g., Canadian Nurses Association [CNA] 2007, 2008, 2009a, b; International Council of Nurses [ICN] (2009). In countries in which APN roles exist, in addition to studies of the distinctions among roles (Gardner, Chang, & Duffield, 2007; Gardner, Gardner, Middleton, et al., 2010), efforts are underway to establish educational programs (Wong, Peng, Kan, et al., 2009) or develop frameworks that clarify education, scope of practice, registration and licensing, and/or credentialing that are country-specific (e.g., Fagerström, 2009). Statements by national organizations such as the CNA and ICN and articles on conceptualizations of advanced practice nursing proposed by authors from other countries (e.g., Ball & Cox, 2004; CNA, 2007, 2008, 2009a, b; DiCenso, Martin-Misener, Bryant-Lukosius, et al., 2010; Gardner, Chang, & Duffield, 2007; Gardner et al., 2010; Mantzoukas & Watkinson, 2007; McMurray, 2011; Pringle, 2010) have been reviewed. Although contextual factors may differ from those in the United States, there are global opportunities for clarifying and advancing advanced practice nursing and these should be specific to a country’s culture, health system, professional standards, and regulatory requirements. Content from articles about advanced practice in other countries is used to present models or illuminate certain conceptual issues; they also inform the discussion of recommendations and future directions. For a more complete discussion of global perspectives on advanced practice nursing, see Chapter 6.

In reviewing the literature for this edition, searches were conducted using the terms advanced practice nursing, model, or theory, and the four APN roles. In addition, a search was done of the authors of models cited in the prior edition. Few new curricular models were identified (Fagerström, 2009; Perraud, Delaney, Carlson-Sabelli, et al., 2006; Wong et al., 2009), but several types of articles related to model development, model testing, and models used in advanced practice nursing were identified. These models may be characterized as follows:

- Curriculum models (e.g., Fagerström, 2009; Perraud et al., 2006; Wong et al., 2009)
- Administrative or organizational models (e.g., Ackerman, Mick, & Witzel, 2010; Scarpa & Connelly, 2011; Skalla & Caron, 2008)
- Models that differentiate among advanced practice roles (e.g., Gardner, Chang, & Duffield, 2007)
- Models of the nature of advanced practice nursing (e.g., Ball & Cox, 2003; Brown, 1998; Hamric, 1996, 2009, and see Chapter 3; Mantzoukas & Watkinson, 2007; Styles & Lewis, 2000)
- Models that differentiate between basic and advanced practice nursing (e.g., Calkin, 1984; Oberle & Allen, 2001)
- Models of role development of APNs (see Chapter 4)
- Models of APN regulation and credentialing (e.g., the APRN [Advanced Practice Registered Nurse] Consensus Model, 2008; CNA, 2007, 2008, 2009a, b; Stanley, Werner, & Apple, 2009; Styles, 1998)
- Models of interdisciplinary practice (Duphy & Winland-Brown, 1998; Duphy, Winland-Brown, Porter, Thomas, & Gallagher, 2011)
- Models that APNs would find useful include the following:

Application or testing of grand and middle-range theories to APN practice (e.g., Musker, 2011; Newcomb, 2010); Models of role implementation (Ball & Cox, 2004; Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004) and APN care delivery (Mahler, 2010; McAiney, Haughton, Jennings, et al., 2008; Duphy & Winland-Brown, 1998; Dungy, Winland-Brown, Porter, Thomas, & Gallagher, 2011; Carley, 1998; American Association of Critical Care Nurses, 2012)
• Models to evaluate outcomes of advanced nursing practice (see Chapters 23 and 24).

In addition, professional organizations with interests in licensing, accreditation, certification, and educational (LACE) issues regarding APNs can be viewed as operating from some conceptualization of advanced practice nursing, whether implicit or explicit. In this chapter, the following types of models will be discussed: those promulgated by APN stakeholder organizations, models that describe the nature of advanced practice and/or differentiate between advanced and basic practice, and selected models that APNs may find useful in practice.

In previous editions, problems associated with lack of a unified definition of advanced practice and imperatives for undertaking this important work were identified. When practicable, consensus on advanced practice nursing models should be beneficial for patients, society, and the profession. Although the APRN Consensus Model (2008) has brought needed conceptual clarity to regulation of advanced practice nursing in the United States, there is still work to be done with regard to other aspects of conceptualizing advanced practice nursing, such as APN competencies, differentiating basic and advanced nursing practice, and differentiating the advanced practice of nursing from the practices of other disciplines. This work has become more urgent given the impacts of other U.S. initiatives that are unfolding. I have reviewed published documents from national professional organizations and the literature and focused selectively on models of APN practice. This review is not exhaustive. For example, in limiting the scope of this chapter, statements on advanced practice nursing by specialty organizations have not been examined. Thus, the purposes of this chapter as follows:

1. Lay the foundation for thinking about the concepts underlying advanced practice nursing by describing the nature, purposes, and components of conceptual models.
2. Identify conceptual challenges in defining and operationalizing advanced practice nursing.
3. Describe selected conceptualizations of advanced practice nursing.
4. Make recommendations for assessing existing models and developing, implementing, and evaluating conceptual frameworks for advanced practice.
5. Outline future directions for conceptual work on advanced practice nursing.

Readers are invited to debate and enlarge on the models, issues, and thinking put forward in this chapter.

### Nature, Purposes, and Components of Conceptual Models

A conceptual model is one part of the structure, or holarchy, of nursing knowledge. This structure consists of metaparadigms (most abstract), philosophies, conceptual models, theories, and empirical indicators (most concrete; Fawcett, 2005). Traditionally, key concepts in the metaparadigm of nursing, which nursing theories are expected to address in their conceptual underpinnings, are humans, the environment, health, and nursing (Fawcett, 2005). Although some theorists have proposed additional or expanded concepts, Fawcett’s ideas inform this discussion. At this stage of the evolution, conceptual models of advanced practice nursing remain an appropriate focus.

- What is a conceptual model?
- What purposes does it serve?
- What are its components?

A number of answers to these questions are in the nursing literature. Fawcett (2005) has identified a conceptual model as “a set of relatively abstract and general concepts that address the phenomena of central interest to a discipline, the propositions that broadly describe these concepts, and the propositions that state relatively abstract and general relations between two or more of the concepts” (p. 16).

Fawcett (2005) also noted that a conceptual model is “a distinctive frame of reference…that tells [adherents] how to observe and interpret the phenomenon of interest to the discipline” and “provide alternative ways to view the subject matter of the discipline; there is no ‘best’ way.” Although there is no best way to view a phenomenon, evolving a more uniform and explicit conceptual model of advanced practice nursing is likely to benefit patients, nurses, and other stakeholders (IOM, 2011) and have practical benefits. It can facilitate communication, reduce conflict, ensure consistency of advanced practice nursing, when relevant and appropriate, across APN roles, and offer a “systematic approach to nursing research, education, administration, and practice” (Fawcett, 2005). Thus, conceptual models serve many purposes.

Models may help APNs articulate professional role identity and function, serving as a framework for organizing beliefs and knowledge about their professional roles and competencies, providing a basis for further development of knowledge. In clinical practice, APNs use conceptual models in the delivery of their holistic, comprehensive, and collaborative care (e.g., Carron & Cumbie, 2011; Dunphy & Winland-Brown, 1998; Dunphy et al., 2011; Musker, 2011). Models may also be used to differentiate among levels of nursing practice—for example, between staff nursing and advanced practice nursing (Calkin, 1984; ANA, 2010b). In research and other scholarly activities, investigators use conceptual models to guide research and theory development. An investigator could decide to focus on the study of one concept or examine relationships among select concepts to elucidate testable theories. For
example, research by Fenton (1985) and Brykczynski (1989) has elucidated new domains of practice for clinical nurse specialists (CNSs) and nurse practitioners (NPs), respectively. In education, faculty use conceptual models to plan curricula, identify important concepts and the relationships among them, and make choices about course content and clinical experiences for preparing APNs (Perraud et al. 2006; Wong et al., 2009).

Fawcett and colleagues (Fawcett, Newman, & McAllister, 2004; Fawcett & Graham, 2005) have raised additional conceptual questions about advanced practice:

- What do APNs do that makes their practice “advanced?”
- To what extent does incorporating activities traditionally done by physicians qualify nursing practice as “advanced?”
- Are there nursing activities that are also advanced?

Because direct clinical practice is viewed as the central APN competency, one could also ask: “What does the term clinical mean? Does it refer only to hospitals or clinics?” These questions are becoming more important given the APRN Consensus Model and given the role that APNs are expected to play across the continua of health care as a result of the PPACA and its reforms. From a regulatory standpoint, the emphasis on a specific population as a focus of practice will lead, when appropriate, to reconceptualizing curricula to ensure that graduates are prepared to succeed in new or revised certification examinations. Hamric (see Chapter 3) has noted that some APN competencies are likely to be performed by nurses in other roles but suggests that the expression of these competencies by APNs is different. For example, all nurses collaborate but a unique aspect of APN practice is that APNs are authorized to initiate referrals and prescribe treatments that are implemented by others (e.g., physical therapy). Innovations and reforms arising from the PPACA will ensure that APNs are explicitly engaged in the delivery of care across care settings, including in nursing clinics and palliative care settings, and as full participants in interprofessional teams. Changes in regulations and in the delivery of health care must and should lead to new or revised conceptualizations of advanced practice nursing, such as defining theoretical and evidence-based differences between APN care and the care offered by other providers and clinical staff, the role of APNs in interprofessional teams, and specialization and subspecialization in advanced practice nursing. This work will enable nursing leaders and health policy makers to design a health care system that delivers high-quality care at reasonable cost based on disciplinary and interdisciplinary competencies, outcomes, effectiveness, efficacy, and costs. Indeed, this textbook reflects a consistent effort to evaluate and revise the authors’ conceptualizations of advanced practice nursing based on current contextual factors. The conceptualization advanced in this text has been remarkably stable since it was first proposed in 1996 and has required modest modifications as APN roles and health care have evolved.

In addition to a pragmatic reevaluation of advanced practice nursing concepts based on the evolution of APN regulation and health care reform, writers in the United States and abroad are raising important theoretical questions about conceptualizations of advanced practice, including the following: the epistemologic, philosophical, and ontologic underpinnings of advanced practice (Arslanian-Engoren, Hicks, Whall, & Algase, 2005); the nature of advanced practice knowledge, discerning the differences between and among the notions of specialty, advanced practice, and advancing practice (Allan, 2011; Christensen, 2009, 2011; Macdonald, Herbert, & Thibeault, 2006; Thoun, 2011); and the extent to which APNs are prepared to study and apply nursing theories in their practices (Algase, 2010; Arslanian-Engoren, Hicks et al., 2005; Karnick, 2011).

In summary, questions arising from a changing health policy landscape and from theorizing about advanced practice nursing point to the need for well thought-out, robust conceptual models to help individuals answer important questions about the phenomenon—in this case, advanced practice nursing. The need for clarity about advanced practice nursing, what it is and is not, is becoming more important, not only for patients and those in the nursing profession but for evolving initiatives such as interprofessional education (CIHC, 2010; Health Professions Networks, 2010; IPEC Expert Panel, 2011), practice (American Association of Nurse Anesthetists, 2012), and creation of accountable care organizations, efforts to build teams and systems in which effective communication, collaboration, and coordination lead to quality care and improved patient, institutional, and fiscal outcomes.

Conceptualizations of Advanced Practice Nursing: Problems and Imperatives

Despite the usefulness and benefits of conceptual models, some difficulties are apparent in the literature when the clinical and professional issues inherent to advanced practice nursing are examined. Although there is increasing conceptual clarity about advanced practice nursing, five issues of conceptual confusion or uncertainty in the evolution of advanced practice nursing can still be identified.

Despite improvements in the area of regulation, the first issue remains the absence of well-defined and consistently applied terms of reference. A core stable vocabulary, a lingua franca, is needed for definition and model building. The lack of a consistent stable vocabulary can be seen
in the literature. Shuler and Davis (1993a) have stated that “One of the greatest barriers to using nursing models in [nurse practitioner] practice relates to vocabulary and communication.” Despite progress, this challenge remains. For example, in the United States, advanced practice nursing is the term that is used but the ICN and CNA use the term advanced nursing practice. Furthermore, the role and functions of APNs could be better conceptualized. Although the use of competency is becoming more common, concepts about APN work are variously termed roles, hallmarks, competencies, functions, activities, skills, and abilities. Few models of APN practice address nursing’s metaparadigm (person, health, environment, nursing) comprehensively. The problem in comparing, refining, or developing models is that terms are used with no universal meaning or frame of reference; occasionally, no definition is offered at all, or terms are used inconsistently. This instability and inconsistency are evident in many models cited in this chapter. It is rightly anticipated that conceptual models of the field and its practice change over time. However, the evolution of advanced practice nursing and its comprehension by nurses, policymakers, and others will be enhanced if scholars and practitioners in the field agree on the use and definition of fundamental terms of reference.

The second issue is that many attempts to articulate models of advanced practice nursing fail to consider extant literature that is directly relevant to such conceptualizing activities. In part, this may be a result of the lag between the conceptualizing effort and its ultimate publication, the knowledge explosion, and the role of the Internet and social media in the generation and dissemination of knowledge. For example, some recently published articles reviewed for this chapter cited work from the 1980s and 1990s; revised publications of these earlier cited works, although apparently available, were not cited. This caution should be considered when proposing, evaluating, or refining advanced practice nursing models.

The third issue is a lack of clarity regarding conceptualizations that differentiate between and among levels of clinical practice:

- Does the practice of APNs differ from the practice of registered nurses (RNs) who are experts by experience (i.e., no graduate degree in advanced practice)?
- How does the practice of an APN certified in a subspecialty such as oncology differ from the practice of a non–master’s prepared clinician who is certified at the basic level in the oncology subspecialty?
- With the definition of population foci and subspecialties influence the quality and outcomes of care?
- How does the care provided by an adult health NP with a subspecialty APN certification in oncology or critical care differ from one who is certified in adult health only?

Although many authors who write about advanced practice nursing cite Benner’s model of expert practice (1984), they rarely indicate that the model was derived from the study of nurses who were primarily experts by experience, not APNs. Certainly, Benner’s model is relevant to efforts to conceptualize advanced practice nursing, as demonstrated by Fenton’s (1985) and Brykczynski’s (1989) work. Given that clinical practice is why the profession of nursing exists and is central to advanced practice nursing, models that help the profession differentiate levels of practice are needed.

The fourth issue is the need to clarify the differences between advanced practice nursing and medicine (see Chapter 3). Graduate APN students struggle with this issue as part of role development (see Chapter 4). This lack of conceptual clarity is apparent in advertisements that invite NPs or physician assistants to apply for the same job. As noted in Chapters 21 and 22, organized medicine expends resources in trying to limit or discredit advanced practice nursing, even as some physician leaders work on behalf of advocating for APNs. Hamric, in Chapter 3, asserts that advanced practice nursing is not the junior practice of medicine, an assertion supported by the seven competencies of advanced nursing practice (Chapters 7 through 13). Fawcett, a well-respected nursing leader, has asked, “What does it mean to blend nursing and medicine?” (Fawcett et al., 2004; Fawcett & Graham, 2005). Finally, little is understood about the impact of APN-physician collaboration on practice or about strategies for matching the level of knowledge and skill to the needs of patient populations (Brooten & Youngblut, 2006; Calkin, 1984).

The fifth issue is interprofessional education and practice, a concept that is central to accountable, collaborative, coordinated, and high-quality care. The development of interprofessional competencies for health professionals (CIHC, 2010; Health Professions Networks, 2010; IPEC Expert Panel, 2011) suggests that the more important questions now are not about “blending” APN and physician practice, but questions such as “How do we ensure that despite differing disciplinary backgrounds, patients, colleagues, and other observers recognize the behavioral expressions of interprofessional competencies?” Also, how do we undertake the conceptual, curricular, credentialing, and other work that will be needed to make interprofessional practice and effective teamwork the gold standard of quality care? The existence of interprofessional competencies and emergence of promising conceptualizations of interprofessional work. (e.g., Barr, Freeth, Hammick,
et al., 2005; Reeves, Goldman, Gilbert, et al., 2011) are critical contextual factors for elucidating and advancing conceptualizations of advanced practice nursing. See Chapter 12.

Among many imperatives for reaching a conceptual consensus on advanced practice nursing, most important are the interrelated areas of policymaking, licensing and credentialing, and practice, including competencies. In the policymaking arena, for example, not all APNs are eligible to be reimbursed by insurers, and even those activities that are reimbursable are often billed incident to a physician's care, rendering the work of APNs invisible. The APRN Consensus Model (2008), the PPACA, and the IOM's call for changes to enable APNs to work within their full scope of practice (IOM, 2011), will make it easier for U.S. policymakers to recommend and adopt changes to policies and regulations that now constrain APN practice, eventually making the contributions of APNs to quality care visible and reimbursable. Agreement on vocabulary and concepts such as competencies that are common to all APN roles will maximize the ability of APNs to work within their full scope of practice.

Although some progress has been made, there are compelling reasons for continuing dialogue and activity aimed at clarifying advanced practice nursing and the concepts and models that help stakeholders understand the nature of APN work and their contributions. Reaching consensus on concepts and vocabulary will serve theoretical, practical, and policymaking purposes. As the work of health care reform and implementing interprofessional competencies, education, and practice moves forward, there will be opportunities for the profession to conceptualize advanced practice nursing more clearly. Clarification and consensus on conceptualization of the nature of advanced practice nursing will lead to the following outcomes:

1. Clear differentiation of advanced practice nursing from other levels of clinical nursing practice.
2. Clear differentiation between advanced practice nursing and the clinical practice of physicians and other non-nurse providers within a specialty.
3. Clear understanding of the roles and contributions of APNs on interprofessional teams, enabling employers to create teams and accountable care organizations that can meet institutions' clinical and fiduciary outcomes.
4. Clear delineation of the similarities and differences among APN roles and the ability to match APN skills and knowledge to the needs of patients.
5. Regulation and credentialing of APNs that protects the public and ensures equitable treatment of all APNs.
6. Clear articulation of international, national, state, and local health policies that do the following:

   a. Recognize and make visible the substantive contributions of APNs to quality, cost-effective health care, and patient outcomes.
   b. Ensure the public's access to APN care.
   c. Ensure explicit and appropriate mechanisms to bill and pay for APN care.
7. A maximum social contribution by APNs in health care, including improvement in health outcomes and health-related quality of life for the people to whom they provide care.
8. The actualization of practitioners of advanced practice nursing, enabling APNs to reach their full potential, personally and professionally.

### Conceptualizations of Advanced Practice Nursing Roles: Organizational Perspectives

Practice with individual clients or patients is the central work of the field; it is the reason for which nursing was created. The following questions are the kinds of questions a conceptual model of advanced practice nursing should answer:

- What is the scope and purpose of advanced practice nursing?
- What are the characteristics of advanced practice nursing?
- Within what settings does this practice occur?
- How do APNs' scopes of practice differ from those of other providers offering similar or related services?
- What knowledge and skills are required?
- How are these different from other providers?
- What patient and institutional outcomes are realized when APNs deliver care? how are these outcomes different from other providers?
- When should health care systems employ APNs and what types of patients particularly benefit from APN care?
- For what types of pressing health care problems are APNs a solution in terms of improving outcomes, quality of care, and cost-effectiveness?

Some conceptual models reviewed in this chapter are more narrowly focused than others. Some advanced practice models are more homogeneous and some are mixed with respect to the phenomenon studied. Some could be seen as micromodels in terms of the unit of analysis and others could be seen as metamodels, incorporating a number of conceptual frameworks. Some models explain systems; others explain relationships between and among systems. All these foci are important, depending on the purposes to be served. However, in the development of conceptual models, the phenomenon to be modeled must be carefully defined. For example, is the model intended to encompass the entire field of advanced practice nursing,
or is it confined to distinctive concepts such as collaborative practice between physicians and APNs? Is advanced nursing practice different from advanced practice nursing? If a phenomenon and its related concepts are not clearly defined, the model could be so inconsistent as to be confusing or so comprehensive that its impact will be diluted.

In addition to describing concepts and how they are related, assumptions about the philosophy, values, and practices of the profession should be reflected in conceptual models. The present discussion of conceptualizations of advanced practice nursing is guided by three assumptions:

1. Each model, at least implicitly, addresses the four elements of nursing’s metaparadigm—persons, health and illness, nursing, and the environment.
2. The development and strengthening of the field of advanced practice nursing depends on professional agreement regarding the nature of advanced practice nursing (a conceptual model) that can inform APN program accreditation, credentialing, and practice.
3. That APNs meet the needs of society for advanced nursing care.
4. Advanced practice nursing will reach its full potential to the extent that foundational conceptual components of any model of advanced practice nursing framework are delineated and agreed on.

In the next section, the implicit and explicit conceptualizations of advanced practice nursing promulgated by professional organizations concerned with defining APN practice and with clarifying particular APN roles are discussed. Organizations such as the Oncology Nursing Society and the American Association of Critical-Care Nurses (AACN) have addressed advanced practice nursing in their specialties. Although specialty models and standards are important to students and APNs, they are not addressed in this chapter. As students and readers consider their own APN practices, they may want to review the history of advanced practice nursing (see Chapter 1) and evolving advanced practice nursing roles (see Chapter 5) to inform their efforts to conceptualize their own practices.

Although not all the documents described in this section are conceptual models, many imply, describe, or reference a conceptual framework. The APRN Consensus Model (2008) represents a major step forward in promulgating a uniform definition of advanced practice nursing, for the purposes of regulation, in the United States. This accomplishment is informing efforts by other organizations; even so, some problems with the absence of a core vocabulary noted earlier are apparent as one reads the different approaches taken by other professional organizations; therefore, comparisons are difficult to make because terms of reference and their meanings vary. To help the reader appreciate the challenge of developing a common language to characterize advanced practice nursing, dictionary definitions of terms used in conceptualizations of advanced practice nursing are found in Box 2-1. In spite of differences in terminology, the efforts of the profession to deal with a definition of advanced practice nursing are evident in the documents reviewed here. Reflection on and discussion of the various terms used, and debate about interpreting terms such as roles, domains, and competencies, may contribute to the clarification of conceptual models and the emergence of a common language. The descriptions of each model in the following sections are necessarily limited. The reader is encouraged to refer to the original documents and organizations’ websites to understand advanced practice nursing as described by organizations and individual authors more fully. Website addresses for national APN organizations are found in Chapter 21. The APRN Consensus Model, the result of collaboration of many organizations, is described first, because it will continue to guide and influence conceptualizations of advanced practice, at least with regard to regulation and credentialing, for the near future.
**Consensus Model for Advanced Practice Registered Nurse Regulation**

In 2004, an APN Consensus Conference was convened, based on a request from the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties (NONPF) to the Alliance for APRN Credentialing. The purpose was to develop a process for achieving consensus regarding the credentialing of APNs (APRN Consensus Model, 2008; Stanley, Werner, & Apple 2009) and the development of a regulatory model for advanced practice nursing. Independently, the APRN Advisory Committee for the National Council of State Boards of Nursing (NCSBN) was charged by the NCSBN board of directors with a similar task of creating a future model for APRN regulation and, in 2006, disseminated a draft of the APRN Vision Paper (NCSBN, 2006), a document that generated debate and controversy. Within a year, these groups came together to form the APRN Joint Dialogue Group, with representation from numerous stakeholder groups, including AACN, NCSBN, and organizations representing APNs. The outcome was the APRN Consensus Model (2008).

The APRN Regulatory Model includes important definitions, the roles and titles to be used, and population foci. Furthermore, it defines specialties and describes how to make room for the emergence of new APRN roles and population foci within the regulatory framework. In addition, a timeline for adoption and strategies for implementation were proposed, and progress has been made in these areas (see Chapter 21 for further information; only the model is discussed here). Figure 2-1 depicts

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**FIG 2-1** Consensus model for APRN regulation. This model was based on the work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee. (From APRN Joint Dialogue Group. [2008]. Consensus Model for APRN Regulation. [http://www.aacn.nche.edu/education-resources/APRNReport.pdf]).

*The population focus Adult-Gerontology encompasses the young adult to the older adult, including the frail elderly. APNs educated and certified in the Adult-Gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APNs in any of the four roles providing care to the adult population (e.g., Family or Gender Specific) must be prepared to meet the growing needs of the older adult population. Therefore the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.*

†The clinical nurse specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

‡The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the Pediatrics and Adult-Gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is not setting-specific but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP roles. If programs prepare graduates across both roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles.
the components of the APRN Consensus Model, the four recognized APN roles and six population foci. The term *advanced practice registered nurse* (APRN) refers to all four APN roles. An APRN is defined as a nurse who meets the following criteria (APRN Consensus Model, 2008):

- Completes an accredited graduate-level education program preparing him or her for one of the four recognized APRN roles and a population focus (see discussion in Chapter 3)
- Passes a national certification examination that measures APRN role and population-focused competencies and maintains continued competence by national recertification in the role and population focus
- Possesses advanced clinical knowledge and skills preparing him or her to provide direct care to patients; the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals
- Builds on the competencies of RNs by demonstrating greater depth and breadth of knowledge and greater synthesis of data by performing more complex skills and interventions and by possessing greater role autonomy
- Is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis, and management of patient problems, including the use and prescription of pharmacologic and nonpharmacologic interventions
- Has sufficient depth and breadth of clinical experience to reflect the intended license
- Obtains a license to practice as an APRN in one of the four APRN roles

The definition of the components of the APRN Consensus Model begins to address some of the questions about advanced practice posed earlier in this chapter. An important agreement was that providing direct care to individuals is a defining characteristic of all APRN roles. This agreement affirms a position long held by editors of this text—that when there is no direct practice component, one is not practicing as an APN. It also has important implications for LACE and for career development of APNs.

Graduate education for the four APRN roles was described in the consensus document. It must include completion of at least three separate, comprehensive graduate courses in advanced physiology and pathophysiology, health assessment, and advanced pharmacology, consistent with requirements for the accreditation of APN education programs. In addition, curricula must address three other areas—the principles of decision making for the particular APN role, preparation in the core competencies identified for the role, and role preparation in one of the six population foci.

The Consensus Model asserts that licensure must be based on educational preparation for one of the four existing APN roles and a population focus; certification must be within the same area of study; and that the four separate processes of LACE are necessary for the adequate regulation of APRNs (APRN Consensus Model, 2008; see Chapter 21). The six population foci displayed in Figure 2-1 include the individual and family across the life span, including adult, gerontologic, neonatal, pediatric, women’s health, gender-specific, and psychiatric and mental health populations. Preparation in a specialty, such as oncology or critical care, cannot be the basis for certification. Specialization “indicates that an APRN has additional knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty area could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms (e.g., portfolios, examinations)” (APRN Consensus Model, 2008, p. 12). This was a critical decision for the group to reach, given the numbers of specialties and APN specialty examinations in place when the document was prepared.

With this brief overview of the APRN Consensus Model, one can ask how this model has advanced the conceptualization of advanced practice nursing. It is helpful for many reasons. First, for the United States, it affirms that there are four APN roles. Second, it is advancing a uniform approach to LACE and advanced practice nursing that will have many practical and policymaking effects, including better alignment between and among APN curricula and certification examinations. Although not comprehensively described, it begins to address the issue of differentiating between RNs and APNs and will be foundational to future efforts to differentiate among nursing roles. By addressing the issue of specialization, the model offers a reasoned approach for the following: (1) avoiding confusion that would arise from a proliferation of specialty certification examinations; (2) ensuring that because of a limited and parsimonious focus (four roles and six populations), there will be sufficient numbers of APNs for the relevant examinations to ensure psychometrically valid data on test results; and (3) allowing for the development of new APN roles or foci to meet society’s needs.

What are the limits of this conceptualization of advanced practice nursing? First, competencies that are common across APN roles are not addressed beyond defining an APRN and indicating that students must be prepared “with the core competencies for one of the four APRN roles across at least one of the six population foci” (APRN Consensus Model, 2008). However, as the Hamric Model suggests (see Chapter 3), there are core
competencies that all APNs should possess. In addressing specialization, the model also leaves open the issue of the importance of educational preparation, in addition to experience, for advanced practice in a specialty. Experience in an area is certainly a factor that leads to the emergence of new specialties, but will experience alone be sufficient for the APN who specializes in oncology or critical care (or another specialty) to achieve desired outcomes in timely and cost-effective ways? These are specialties in which the population's needs are many and complex and the scope of research knowledge is similarly broad and deep. These are important conceptualization questions that are probably best addressed by the ANA and specialty professional nursing organizations, rather than by a group with a regulatory focus.

Numerous efforts are underway to implement this model in the United States; NCSBN has an extensive toolkit to help educators, APNs, consumers, and policymakers implement the new APRN regulatory model (NCSBN, 2012; https://www.ncsbn.org/2276.htm). The work undertaken to produce the APRN Consensus Model (2008) illustrates the power of interorganizational collaboration and is a promising example of how a model can, as Fawcett (2005) has suggested, reduce conflicts and facilitate communication within the profession, across professions, and with the public.

American Nurses Association

As the “only full-service professional organization representing the interests of the nation’s 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates,” the American Nurses Association (ANA) and its constituent organizations have also been active in developing and promulgating documents that address advanced practice nursing. Two of these are particularly important as we consider contemporary conceptualizations of advanced practice nursing. Since 1980, ANA has periodically updated its Social Policy Statement (ANA, 2010a). Specialization, expansion, and advancement have consistently been identified as concepts that can differentiate advanced practice nursing from basic nursing practice. The most recent edition notes that specialization (“focusing on a part of the whole field of professional nursing”) can occur at basic or advanced levels and that APNs use expanded and specialized knowledge and skills in their practices. According to the 2010 statement, expansion, specialization, and advanced practice were defined as follows (ANA, 2010a):

Expansion refers to the acquisition of new practice knowledge and skills, including the knowledge and skills that authorize role autonomy within areas of practice that may overlap traditional boundaries of medical practice. Specialization is concentrating or delimiting one’s focus to part of the whole field of nursing such as ambulatory care, pediatric, maternal-child, psychiatric, palliative care, or oncology nursing.

Advanced practice is characterized by the integration of a broad range of theoretical, research-based, and practical knowledge that occurs as part of graduate education. Advanced practice registered nurses hold master’s or doctoral degrees and are licensed, certified, and/or approved to practice in their expanded roles (p. 9).

ANA’s definitions of specialization and advanced practice are consistent with the APRN Consensus Model.

ANA also establishes and promulgates standards of practice and competencies for RNs and APNs. In the second edition of their text, Nursing: Scope and Standards of Practice (ANA, 2010b), six standards of practice and 16 standards of professional performance are described. Of the 22 standards, one standard outlines additional expectations for APNs compared with RNs; Standard 5, “Implementation,” addresses the consultation and prescribing responsibilities of APRNs. Each standard is associated with competencies. It is in the description of the competencies that RN practice is differentiated from APNs and nurses prepared in a specialty at the graduate level. This document is must reading for APN students, practitioners, and others wishing to understand how basic, advanced, and specialized practice differ.

In addition to these documents, ANA, together with the American Board of Nursing Specialties (ABNS), convened a task force on CNS competencies. For many reasons, including the recognition that developing psychometrically sound certifications for numerous specialties, especially for clinical nurse specialists (CNSs), would be difficult as the profession moved toward implementing the APRN Consensus Model, the ANA and ABNS convened a group of stakeholders in 2006 to develop and validate a set of core competencies that would be expected of CNSs entering practice (National Association of Clinical Nurse Specialists [NACNS]/National CNS Core Competency Task Force, 2010). This group was charged with identifying core, entry-level competencies that are common in CNS practice, regardless of specialty. This work is discussed later in this chapter in the section on NACNS.

ANA continues to make numerous contributions to promoting clarity about all nursing roles, including advanced practice nursing. Its definitions of expansion, specialization, and advanced practice have remained consistent over time. ANA’s Nursing: Scope and Standards of
acknowledged that organizations representing APNs are expected to develop Essential VIII as it relates to specific advanced practice roles and “to develop competency expectations that build upon and complement DNP Essentials 1 through 8” (AACN, 2006, p. 17). These Essentials affirmed that the advanced practice nursing core includes the three Ps (three separate courses)—advanced health and physical assessment, advanced physiology and pathophysiology, and advanced pharmacology—and is specific to APNs. The specialty core must include content and clinical practice experiences that help students acquire the knowledge and skills essential to a specific advanced practice role. These requirements were reconfirmed in the Consensus Model (2008).

The DNP has been described as a “disruptive innovation” (Hathaway, Jacob, Stegbauer, et al., 2006) and a natural evolution for NP practice. Although the DNP remains controversial (Avery & Howe, 2007; American College of Nurse-Midwives [ACNM], 2012b; Dreher & Smith Glasgow, 2011; Irvin-Lazorko, 2011; NACNS, 2009a), the proposal to make the DNP required for entry

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**BOX 2-2  Essentials of Doctoral Education for Advanced Nursing Practice**

I. Scientific underpinnings for practice
II. Organizational and systems leadership for quality improvement and systems thinking
III. Clinical scholarship and analytical methods for evidence-based practice
IV. Information systems and technology and patient care technology for the improvement and transformation of health care
V. Health care policy for advocacy in health care
VI. Interprofessional collaboration for improving patient and population health outcomes
VII. Clinical prevention and population health for improving the nation’s health
VIII. Advanced nursing practice


**BOX 2-3  Essential VIII: Advanced Nursing Practice Competencies**

I. Conduct a comprehensive and systematic assessment of health and illness parameters in complex situations, incorporating diverse and culturally sensitive approaches.
II. Design, implement, and evaluate therapeutic interventions based on nursing science and other sciences.
III. Develop and sustain therapeutic relationships and partnerships with patients (individual, family, or group) and other professionals to facilitate optimal care and patient outcomes.
IV. Demonstrate advanced levels of clinical judgment, systems thinking, and accountability in designing, delivering, and evaluating evidence-based care to improve patient outcomes.
V. Guide, mentor, and support other nurses to achieve excellence in nursing practice.
VI. Educate and guide individuals and groups through complex health and situational transitions.
VII. Use conceptual and analytical skills in evaluating the links among practice, organizational, population, fiscal, and policy issues.

into advanced practice nursing is one of several national initiatives that have contributed to a broader discussion and may lead the profession to a clearer definition of advanced practice nursing. One outcome of the national DNP discussion is that APN organizations have promulgated practice competencies for doctorally prepared APNs (e.g., ACNM, 2011c; NACNS, 2009b) or have proposed a practice doctorate, even though it may not be the DNP (AANA, 2007). The National Organization of Nurse Practitioner Faculties (2012) now has one set of core competencies for NPs. Organizational positions on doctoral education are briefly explored in the discussion of APN organizations (see later). Readers can consult Chapters 14 through 18 and are urged to visit stakeholder organizations’ websites for the history and up to date information on organizational responses to AACN’s DNP position paper (AACN, 2004) and the DNP Essentials (AACN, 2006).

Although not a conceptual model per se, the AACN’s publication, DNP Essentials (2006) addresses concepts and content that are now evident in many other documents that address standards of APN practice and education. The fact that Essential VIII affirms a set of common competencies across APN roles is an important contribution to conceptual clarity about advanced practice in the United States. Because these Essentials, with the exception of Essential VIII, are intended to address DNP preparation for any nursing role, its contribution to conceptual clarity regarding advanced practice nursing specifically is limited. Eventually, the evolution of the DNP may lead to more conceptual clarity about advanced practice nursing and the role of APNs. However, it is possible that the rapid expansion of this degree may contribute to less clarity in the short term about the nature of advanced nursing practice and the centrality of direct care of patients to APN work, particularly because the DNP will prepare people for other, nonclinical nursing roles. In the next section, in addition to discussing the organizations’ conceptualizations of APN practice, the extent to which their responses to the DNP proposal might influence conceptual clarity on advanced nursing practice is addressed.

National Organization of Nurse Practitioner Faculties

The mission of the NONPF is to provide leadership in promoting quality NP education. Since 1990, NONPF has fulfilled this mission in many ways, including the development, validation, and promulgation of NP competencies. As of 2012, there is only one set of NP core competencies in use (NONPF, 2012); the 2002 and 2006 competencies are available on the website but are no longer active. A brief history of the development of competencies for NPs is presented, in part because their development has influenced other APN models.

In 1990, NONPF published a set of domains and core competencies for primary care NPs based on Benner’s (1984) domains of expert nursing practice and the results of Brykczynski’s (1989) study of the use of these domains by primary care NPs (Price et al., 1992; Zimmer et al., 1990). Within each domain were a number of specific competencies. Until the 2011 competencies were published, these validated domains and core competencies served as a framework for primary care NP education and practice.

After endorsing the DNP as entry level preparation for the NP role, and consistent with the recommendations in the APRN Consensus Model (2008), new NP core competencies were developed in 2011 and amended in 2012 (http://www.nonpf.com/displaycommon.cfm?an=1&subarticlenbr=14). Each of the nine core competencies is accompanied by specific behaviors that all graduates of NP programs, whether master’s or DNP-prepared, are expected to demonstrate. The document includes a glossary of key terms. Population-specific competencies for specific NP roles, together with the nine core competencies, are intended to inform curricula and ensure that graduates will meet certification and regulatory requirements.

From a conceptual perspective, these NP core and population-specific competency documents are notable for several reasons: (1) the competencies for NPs were developed collaboratively by stakeholder organizations; (2) empirical validation is used to affirm the competencies; (3) overall, the competencies are conceptually consistent with statements in the APRN Consensus Model, the DNP Essentials (2006), and ANA’s Nursing: Scope and Standards (2010); and (4) the revised competencies are responsive to society’s needs for advanced nursing care and the contextual factors that will shape NP practice for at least the next decade. In the amended 2011 NONPF competencies (2011, 2012), one also sees an appropriate emphasis on practice that is not in the APRN Consensus Model (2008)—patient-centered care, interprofessional care, and independent or autonomous NP practice, clearly responsive to health care reform initiatives, are addressed.

National Association of Clinical Nurse Specialists

The NACNS published the Statement on Clinical Nurse Specialist Practice and Education in 1998 and revised it in 2004. Although acknowledging the early conceptualization of CNS practice as subroles proposed by Hamric and Spross (1983, 1989), the authors of the NACNS statement believed that this conceptualization, although delineating competencies, failed to differentiate CNS practice from
that of other APNs and proposed their statement to resolve the ambiguity about this particular APN role. Three spheres of influence are posited: patient, nurses and nursing practice, and organization or system, each of which requires a unique set of competencies (NACNS, 2004; Fig. 2-2). In addition, the statement outlined expected outcomes of CNS practice for each sphere and competencies that parallel those of the nursing process. Thus, CNSs have sphere-specific competencies of assessment, diagnosis, intervention, and evaluation.

As work on the APRN Consensus Model neared completion, NACNS and the APRN Consensus Work Group asked the ANA and the ABNS to “convene and facilitate the work of a National CNS Competency Task Force...” using a standard process to develop nationally recognized education standards and competencies (NACNS/National Core Competency Task Force, 2010). The process of developing and validating the competencies is described in the document. Figure 2-3 illustrates the model of CNS competencies that emerged from this work, a synthesis of NACNS’ spheres of influence, Hamric’s seven APN competencies, and the Synergy Model. Subsequently, new criteria for evaluating CNS education programs were developed, based on the competencies (Validation Panel of the NACNS, 2011). It is important to note that the APRN Consensus Model, as discussed in Chapter 3, has had more impact on certification for CNS roles than for other APN roles.

The 2004 statement and the new CNS competencies are not entirely parallel. Some aspects of the 2004 statement were more comprehensive with regard to theoretical elements, such as the inclusion of assumptions and theoretical roots in nursing. The 2010 document has an appendix that includes definitions of key concepts such as nurses and nursing practice, spheres of influence, and competencies. An underlying assumption of the 2008 competencies, which has empirical validation (e.g., Lewandowski & Adamle, 2009; see Chapter 23), is that CNSs have an impact on patients, nursing practice, and institutional outcomes. From a conceptual standpoint, the CNS competencies document brought needed clarity on several fronts: (1) ensuring that all CNSs would be eligible for credentialing under the APRN Consensus Model so that CNSs could take a psychometrically valid examination on their core competencies, because these examinations could not be developed for every existing area of specialization; (2) advanced the work of NACNS in ensuring consistency among programs preparing CNSs; and (3) because CNSs’ work often looks very different from that of other APNs (e.g., fewer responsibilities for prescribing but more responsibilities for clinical and systems leadership) facilitated the profession’s ability to speak about what is common across APN roles. At least two areas will need further clarification. One is the relationship between the 2004 statement and the 2010 competencies, because both documents are available and CNS authors still refer to the 2004 statement. Both are being used, which is understandable; there is content in the statement that is not in the new competencies document, including, in addition to the 2004 competencies, relevant history, a description of CNS practice, and recommendations for graduate programs.

The second area will be the ongoing need for clarity regarding specialty as defined in the Consensus Model (the population focus, not specialization, is the basis for regulation). From a regulatory standpoint, it would seem that a CNS’s specialty is his or her population focus as defined in the Consensus Model.

In 2005, NACNS published a white paper on the DNP in which a number of concerns were raised and the leaders called for extensive dialogue with stakeholders. NACNS reaffirmed the position taken in 2005, which is “a position of neutrality [in which] the board neither endorses or opposes the DNP degree as an option for [CNS] education” (NACNS, 2009a). Recognizing that some CNSs would pursue advanced clinical doctorates, core competencies for doctoral level practice were published by NACNS; these are to be used in conjunction with the 2010 CNS competency document and the DNP essentials “to inform education programs and employer expectations” (NACNS’ CNS Practice Doctorate Competencies Taskforce, 2009b).
In 2012, NACNS published a Statement on the APRN Consensus Model Implementation, outlining a number of concerns and recommendations, in particular the importance of grandfathering currently practicing CNSs and monitoring implementation of the Consensus Model to ensure that adoption of the model does not negatively affect the ability of CNSs to practice. Although the details of the statement are beyond the scope of this chapter, the fact that there are concerns may have implications for a professional consensus on conceptualization of advanced practice nursing. For further information, see the NACNS website and Chapters 14 and 21.

American Association of Nurse Anesthetists and American College of Nurse-Midwives
Certified registered nurse anesthetists (CRNAs) and certified nurse-midwives (CNMs) have been recognized as APNs and are recognized as such in the APRN Consensus Model. Advanced practice competencies, as described in the DNP Essentials, ANA Scope and Standards, and APN competencies identified in this text, are evident in the official statements of the AANA (2010a, b) and the ACNM (2008, 2011a, b). These statements include scopes of practice, standards for practice, and ethics. See Chapters 17 and 18 for a thorough discussion of CNM and CRNA practice, respectively.

American Association of Nurse Anesthetists
The CRNAs scope of practice was defined in the most recent revision of the AANA’s Scope and Standards for Nurse Anesthesia Practice (2010a). The scope is followed by 10 items that can be characterized as clinical competencies or responsibilities (e.g., managing a patient’s airway)—the direct clinical practice of CRNAs. CRNAs have seven additional responsibilities that are within the CRNA’s scope of practice that can be characterized as leadership behaviors, including participation in research. Eleven standards and an interpretation for each are also listed. The purposes of the standards are as follows: (1) assist the profession in evaluating CRNA care; (2) provide a common foundation on which CRNAs can develop a
quality practice; (3) help the public understand what they can expect from CRNAs; and (4) support and preserve the basic rights of patients.

Initially, the AANA did not support the DNP for entry into CRNA practice and established a task force to evaluate doctoral preparation further. Subsequently, AANA issued a position statement (2007) requiring doctoral preparation for nurse anesthesia practice by the year 2025. The position statement did not specify the type of doctoral degree. This likely reflects the diversity of existing practice doctorates for nurse anesthesia practice in addition to the DNP, such as Doctor of Nurse Anesthesia Practice (DNAP) and Doctor of Management of Practice in Nurse Anesthesia (DMPNA) (Dreher & Smith Glasgow, 2011; Hawkins & Nezat, 2009). The Council of Accreditation (COA) of Nurse Anesthesia Educational Programs revised their 2004 accreditation standards for nurse anesthesia education (2012a). Notably, the standards include a requirement for the “three P” courses, consistent with requirements specified in the APRN Consensus document. The standards also distinguish between competencies expected for graduates of practice doctorate (referencing both DNP and DNAP as examples) and research-oriented doctorate programs. In addition, the first draft of accreditation standards have been developed for the practice doctorate in nurse anesthesia (COA, 2012b), which are expected to be effective in 2015 (personal communication, Barbara Farkas, MAEd, COA, July 5, 2012). Both the revised 2012 standards and the draft practice doctorate standards have competencies that align with those in the DNP Essentials. Although these are not cited in either document, throughout there is consistent reference to “commonly accepted national standards,” a phrase defined in the glossary.

American College of Nurse-Midwives
The scope of practice for CNMs (and certified midwives [CMs] who are not nurses) has been defined in four ACNM documents: “Definition of midwifery and scope of practice of CNMs and CMs” (ACNM, 2011a), the “Core competencies for basic midwifery practice” (ACNM, 2012a), “Standards for the practice of midwifery” (ACNM, 2011), and a “Code of ethics” (ACNM, 2008). The core competencies are organized into sixteen hallmarks that describe the art and science of midwifery and the components of midwifery care. The components of midwifery care include professional responsibilities, midwifery management processes, fundamentals, primary health care of women, and the childbearing family, within which are prescribed competencies. According to the definition, “CNMs are educated in two disciplines: nursing and midwifery” (ACNM, 2011a). Competencies “describe the fundamental knowledge, skills and behaviors of a new practitioner” (ACNM, 2012a). The hallmarks, components, and associated core competencies are the foundation on which midwifery curricula and practice guidelines are based.

In addition to the competencies, there are eight ACNM standards that midwives are expected to meet (ACNM, 2011b) and a code of ethics (ACNM, 2008). The standards address issues such as qualifications, safety, patient rights, assessment, documentation, and expansion of midwifery practice. Three ethical mandates related to its mission to promote the health and well-being of women and newborns in their families and communities are identified in the ethics code.

As of 2010, CNMs entering practice must earn a graduate degree, complete an accredited midwifery program, and pass a national certification examination (see Chapter 17 for detailed requirements; ACNM, 2011a); the type of graduate degree is not specified. ACNM does recognize the value of doctoral education as a valid and valuable path for CNMs, evidenced by a statement on a practice doctorate in midwifery, including competencies (2011c). Although not cited, these competencies are in alignment with those in the DNP Essentials; ACNM recognizes that there other paths for a practice doctorate in midwifery. ACNM does not support the DNP as a requirement for entry into nurse-midwifery practice because of the following: (1) midwifery practice is safe, based on the rigor of their curriculum standards and outcome data; (2) evidence is insufficient to justify the DNP as a mandatory requirement for CNM; and (3) the costs of attaining such a degree could limit the applicant pool and access to midwifery care (ACNM, 2012b, 2012c). Midwifery organizations have recently addressed the aspects of the 2008 Consensus Model that they support and identified those that are of concern (ACNM et al., 2011d).

International Organizations and Conceptualizations of Advanced Practice Nursing
International perspectives on advanced practice nursing are covered in Chapter 6. In this section, I highlight issues with regard to a common language and conceptual frameworks for advanced practice nursing.

In 2009, the ICN defined the NP-APN “as a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice.” A master’s degree is recommended for entry level (ICN, 2009). Based on the definition, key concepts include educational preparation, the nature of practice, and regulatory mechanisms. The statement is necessarily broad, given the variations in health systems, regulatory mechanisms, and nursing education programs in individual countries.
In 2008, the CNA published *Advanced Nursing Practice: A National Framework*, which defined advanced nursing practice, described educational preparation and regulation, identified the two APN roles (NP and CNS), and specified competencies in clinical practice, research, and leadership. In addition, they have issued position statements on advanced nursing practice (CNA, 2007), which affirm the key points in the national framework document and defined and described the roles and contributions to health care of nurse practitioners (2009a) and clinical nurse specialists (2009b). Furthermore, leaders have undertaken an evidence-based, patient-centered, coordinated effort (called a decision support synthesis) to develop, implement, and evaluate the APN roles of the CNS and NP in Canada (DiCenso, Martin-Meisener, Bryant-Lukosius, et al., 2010), a process different from the one used to advance APN roles in the United States. This process included a review 468 published and unpublished articles and interviews conducted with 62 key informants and four focus groups that included a variety of stakeholders. The purpose of this work was to “describe the distinguishing characteristics of CNs and NPs relevant to Canadian contexts,” identify barriers and facilitators to effective development and use of APN roles, and inform the development of evidence-based recommendations that individuals, organizations, and systems can use to improve the integration of APNs into Canadian health care.

**Section Summary: Implications for Advanced Practice Nursing Conceptualizations**

From this overview of organizational statements that clarify and advance APN practice, it is clear that nationally and internationally, stakeholders are engaged in a more active dialogue about advanced practice nursing and progress has been made in this area since the last edition. Progress includes global agreement that there is a type of clinical nursing practice that is advanced and builds on basic nursing education, requiring additional education and characterized by additional competencies and responsibilities. In the United States, the consensus on an approach to APRN regulation was critical for the following reasons: (1) clarifying what is an APN and the role of graduate education and certification in licensing APRNs; (2) ensuring that APNs are fully recognized and integrated in the delivery of health care; (3) reducing barriers to mobility of APNs across state lines; (4) fostering and facilitating ongoing dialogue among APN stakeholders; and (5) offering common language regarding regulation.

Although there may not be agreement on the DNP as the requirement for entry into advanced practice nursing, the promulgation of the document fostered dialogue nationally and within APN organizations on the clinical doctorate (whether or not it is the DNP) as a valid and likely path for APNs to pursue. As a result, each APN organization has taken a stand on the role of the clinical doctorate for those in the role and has developed or is developing doctoral level clinical competencies. In doing so, it appears that the needs of their patients, members, other constituencies, and contexts have been considered. Until the time when a clinical doctorate becomes a requirement for entry into practice for all APN roles, the development of doctoral level competencies for APN roles will help stakeholders distinguish between master’s- and doctorate-prepared APNs with regard to competencies.

MacDonald, Herbert, & Thibeault (2006) have suggested that a common identity for advanced practice nurses is worth pursuing. It will most likely be through regulatory mechanisms that a consistent definition of advanced practice nursing and authority to practice, in particular APN roles, will be established in the United States. However, it will be important to heed the caution of NACNS to ensure that the APRN Consensus Model is not implemented selectively (NACNS, 2012). Although important differences exist between roles and across countries, a common identity for APNs will most likely result from policy and regulatory initiatives and should facilitate communication within and outside the profession, consistent with assertions by Styles (1998) and Fawcett (2005) on the purposes of models. There are important differences among APN organizations regarding such issues as doctoral preparation, which is also consistent with Fawcett’s assertion that there is not one best model.

The level of consensus regarding regulation in the United States reflects considerable and laudable progress, paving the way for policies and health care system transformations that will enable APNs to be used fully to ensure access to health care and improve its quality. The processes that have led to this juncture in the United States have required openness, civility, a willingness to disagree, and wisdom. Finally, there are at least two different approaches (collaborative policymaking in the United States and an evidence-based approach in Canada) to determine how best to assess contributions of APNs and develop ways to integrate them into health care infrastructures and to maximize benefits to patients and populations. The global APN community can examine these processes for insights on how to adapt them to suit their particular context.

In conclusion, the organizational models described enable the reader to understand who engages in advanced practice nursing and the nature of the respective APN practices. These models primarily address professional roles, licensing, accreditation, certification, education, competencies, and clinical practice, some of the purposes
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The descriptive statements about APN roles and competencies demonstrate that common elements exist across all APN roles. These include a central focus on and accountability for patient care, knowledge and skills specific to each APN role, and a concern for patient rights. Using Hamric’s Model of primary criteria and the seven competencies, Table 2-1 was constructed based on the content of official statements of the AANA, ACNM, NACNS, and NONPF to illustrate commonalities across the four roles. The published definitions, standards, and competencies offer models against which differences among APN roles and practices can be distinguished, educational programs can be developed and evaluated, knowledge and behaviors can be measured for certification purposes, practitioners can understand, examine, and improve their own practice, and job descriptions can be developed. As advanced practice nursing moves forward in the United States and globally, the profession will continue to have opportunities to define those situations in which a conceptual consensus will serve the public and the profession and those situations in which alternative conceptualizations are needed for the same reasons—serving the public and our profession.

### Conceptualizations of the Nature of Advanced Practice Nursing

The APN role-specific models promulgated by professional organizations naturally lead to the following questions:

- What is common across APN roles?
- Can an overarching conceptualization of advanced practice nursing be articulated?
- How can one distinguish among basic, expert, and advanced levels of nursing practice?

Some authors have attempted to discern the nature of advanced practice nursing and address these questions. The extent to which they considered all existing APN roles is not always clear; some authors have considered only the CNS and NP roles.

In this section, the focus is on those frameworks that address the nature of advanced practice nursing. The term role is used loosely and variably, sometimes seeming to describe functions (e.g., management, teaching, research, consultation) and sometimes taking a psychological or sociologic perspective on developing social roles in relation to environment. Dictionary definitions add to the confusion by using the terms role, function, occupation, and duties to define one another. For example, role is generally used to refer to titles appearing in legal documents, certification programs, or job descriptions. From this perspective, the CNS, NP, CNM, and CRNA designations represent advanced practice roles. From the present review of a number of frameworks, domain and competency may be the most commonly used concepts in explaining nursing practice and advanced practice nursing. However, meanings are not consistent. Hamric’s Model, which uses the terms roles and competencies, is the only one that is integrative—that is, it explicitly considers all four APN roles. Because it is integrative, it has remained relatively stable since 1996, has informed the development of the DNP Essentials and CNS
comparabilities, and is widely cited, it will be discussed first, enabling the reader to consider the extent to which important concepts are addressed by other models. Otherwise, the models are discussed in chronological order. In most cases, new literature on the models discussed here were not found in literature searches in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), which included using the "cited references" function.

Hamric's Integrative Model of Advanced Practice Nursing

One of the earliest efforts to synthesize a model of advanced practice that would apply to all APN roles was developed by Hamric (1996). Hamric, whose early conceptual work was done on the CNS role (Hamric & Spross, 1983, 1989), proposed an integrative understanding of the core of advanced practice nursing, based on literature from all APN specialties (Hamric, 1996, 2000, 2005, 2009; see Chapter 3). Hamric proposed a conceptual definition of advanced practice nursing and defining characteristics that included primary criteria (graduate education, certification in the specialty, and a focus on clinical practice with patients) and a set of core competencies (direct clinical practice, collaboration, guidance and coaching, evidence-based practice, ethical decision making, consultation, and leadership). This early model was further refined, together with Hanson and Spross in 2000 and 2005, based on dialogue among the editors. Key components of the model (Fig. 2-4) include the primary criteria for advanced nursing practice, seven advanced practice competencies with direct care as the core competency on which the other competencies depend, and environmental and contextual factors that must be managed for advanced practice nursing to flourish.
The revisions to the Hamric Model since 1996 highlight the dynamic nature of a conceptual model; at the same time, the fact that essential features remain the same demonstrates the inherent stability and robustness of Hamric’s Model, particularly when many potentially transformative advanced practice nursing initiatives are being developed. Models are refined over time according to changes in practice, research, and theoretical understanding. This model forms the understanding of advanced practice nursing used throughout this text and has provided the structure for each edition of the book. Using Hamric’s Model, some contributors to this text have further elaborated on the specific competencies proposed (see Chapter 3) by describing and graphically depicting concepts relevant to the specific competency. These include guidance and coaching (Spross, 2009; see Chapter 8), consultation (see Chapter 9), and ethical decision making (see Chapter 13). In addition, as noted, it has informed the development of the DNP Essentials and the revised CNS competencies and is widely cited in the advanced practice literature, evidence of its contribution to conceptualizing advanced practice nursing.

Integrative reviews of the literature provide further support for Hamric’s integrative conceptualization of advanced practice nursing. The purpose of the review by Mantzoukas and Watkinson (2007) was to identify “generic features” of advanced nursing practice. They identified seven generic features: (1) use of knowledge in practice; (2) critical thinking and analytic skills; (3) clinical judgment and decision making; (4) professional leadership and clinical inquiry; (5) coaching and mentoring; (6) research skills; and (7) changing practice. The first three generic features are consistent with the direct care competency in Hamric’s Model; three of the seven characteristics seem directly related to clinical practice, which supports the notion that direct care is a central competency. The remaining four features are consistent with the three competencies of leadership, guidance and coaching, and evidence-based practice competency in Hamric’s Model.

An integrative review of the literature on CNS practice (Lewandowski & Adamle, 2009) similarly affirmed direct care, collaboration, consultation, systems leadership, and coaching (patient and staff education) competencies in the Hamric Model. Ten countries were represented in their review, which included 753 anecdotal articles, 277 research articles, and 62 dissertations or theses. Their findings were organized using NACNS’s three spheres of influence. Within the first sphere, management of complex or vulnerable populations, they found three essential characteristics—expert direct care, coordination of care, and collaboration. In the sphere of educating and supporting interdisciplinary staff, substantive areas of CNS practice were education, consultation, and collaboration. Within the system sphere of influence, CNSs facilitate innovation and change. These findings lend support for the integration of the Hamric Model with the NACNS model in the CNS core competencies (2008).

**Fenton’s and Brykczynski’s Expert Practice Domains of the Clinical Nurse Specialist and Nurse Practitioner**

Fenton’s and Brykczynski’s studies of APNs were based on Benner’s model of expert nursing practice (1984). To appreciate the contributions of Fenton (1985) and Brykczynski (1989) to the understanding of advanced practice, it is important to highlight some of Benner’s key findings about nurses who are experts by experience. Although many have used Benner’s seminal work (1984), From Novice to Expert, in their conceptualizations of advanced practice nursing, it is important to note that Benner has not studied advanced practice nurses. Fenton’s and Brykczynski’s studies represent an appropriate extension of Benner’s findings and theories to advanced practice nursing. Benner and colleagues continue to study how nurses (not APNs) acquire clinical expertise; these findings are interesting and APNs are likely to find them useful. However, because APNs were not subjects, the later findings are not presented here (Benner, Tanner, & Chesla, 2009).

The early work of Benner and associates informed the development of the first NONPF competencies, graduate curricula in schools of nursing, models of practice (e.g., the Synergy Model, discussed later) and the standards for clinical promotion (APNs may be identified at senior levels in these schema by employers). Most importantly, as the authors noted, this early work “put into words what they had always known about their clinical nursing expertise but had difficulty articulating” (Benner, et al., 2009). It is perhaps this impact that has led to the sustained integration of Benner’s studies of experts by experience into the APN literature, including descriptions and development of competencies.

Through the analysis of clinical exemplars discussed in interviews, Benner derived a range of competencies that resulted in the identification of seven domains of expert nursing practice. Within this lexicon, these domains are a combination of roles, functions, and competencies, although the three were not precisely differentiated. The seven domains are as follows (Benner, 1984): the helping role, administering and monitoring therapeutic interventions and regimens, effective management of rapidly changing situations, diagnostic and monitoring function, teaching and coaching function, monitoring and ensuring the quality of health care practices, and organizational and work role competencies.

Fenton (1985) and Brykczynski (1989) each independently applied Benner’s Model of expert practice to APNs,
Calkin's Model of Advanced Nursing Practice

Calkin's model (1984) was the first to distinguish explicitly the practice of experts by experience from advanced practice nursing as practiced by CNSs and NPs. Calkin developed the model to help nurse administrators differentiate advanced practice nursing from other levels of clinical practice in personnel policies, and proposed that this could be accomplished by matching patient responses to health problems with the skill and knowledge levels of nursing personnel. In Calkin's model, three curves were overlaid on a normal distribution chart. Calkin depicted the skills and knowledge of novices, experts by experience, and APNs in relation to knowledge required to care for patients whose responses to health care problems (i.e., health care needs) ranged from simple and common to complex and complicated (Fig 2-6). A closer look at Figure 2-6, A, shows, as one would expect, that there are many more human responses (the highest and widest curve) than a beginning nurse would have the knowledge and skill to manage. The impact of experience is illustrated in Figure 2-6, B. The highest and widest curve is effectively the same, but because of experience, expert nurses have more knowledge and skill; the curves are higher and somewhat wider, but their additional skill and knowledge do not yet match the range of responses that they may encounter in the patients for whom they care. In Figure 2-6, C, APNs, by virtue of education and experience, have knowledge and skills that enable them to respond to a wider range of human problems. The three curves in Figure 2-6, C, parallel each other; this suggests that even as less common human responses arise in clinical practice, APNs have the knowledge and skill to respond creatively and effectively to these unusual problems.

Calkin used the framework to explain how APNs perform under different sets of circumstances—when there is a high degree of unpredictability, new conditions, new patient population, or new sets of problems, and a wide variety of health problems requiring the services of “specialist generalists.” What APNs do in terms of functions were also defined. For example, when patients' health problems elicit a wide range of human responses with continuing and substantial unpredictable elements, the APN should do the following (Calkin, 1984):

- Identify and develop interventions for the unusual by providing direct care.
FIG 2-5 Fenton’s and Brykczynski’s expert practice domains of the CNS and NP. (From Fenton, M.V., & Brykczynski, K.A. [1993]. Qualitative distinctions and similarities in the practice of clinical nurse specialists and nurse practitioners. Journal of Professional Nursing, 9, 313–326.)
FIG 2-6 Calkin’s model of advanced nursing practice. Patient responses correlated with the knowledge and skill of beginning practitioners (A), experienced nurses (B), and APNs (C). (From Calkin, J. D. [1984]. A model for advanced nursing practice. Journal of Professional Nursing, 14, 24–30.)
The model has been left for others to test; although Calkin’s thinking remains relevant, no new applications of the work were found. However, Brooten’s and Youngblut’s work (2006) on the concept of nurse dose, based on years of empirical research, offers a similar understanding of the differences among beginners, experts by experience, and APNs. They proposed, as did Calkin, that one needs to understand patients’ needs and responses and the experience, education, and expertise of nurses to match nursing care to the needs of patients, but they did not cite Calkin’s work. Similarly, the Synergy Model in critical care is based, in part, on an understanding of patient and nurse characteristics consistent with Calkin’s ideas.

Brown’s Framework for Advanced Practice Nursing

Brown (1998) developed a conceptual framework for the entire field of advanced practice nursing, including the environments that surround and impact upon practice (Fig. 2-7). Studies were synthesized to propose a conceptual framework that included 4 main and 17 specific concepts (specific concepts are in parentheses): environments (society, health care economy, local conditions, nursing, advanced practice community); role legitimacy (graduate education, certification, licensure); advanced practice
nursing (scope, clinical care, competencies, managing health care environments, professional involvement in health care discourse); and outcomes (patient, health care system, the nursing profession, individual APN outcomes).

The central concept, conceptually and visually, is advanced practice nursing. Brown (1998) proposed a definition of advanced practice nursing: “professional health care activities that (1) focus on clinical services rendered at the nurse-client interface, (2) use a nursing orientation, (3) have a defined but dynamic and evolving scope, and (4) are based on competencies that are acquired through graduate nursing education.”

This comprehensive model is one of the few that explicates the relevant components of a conceptual framework, as described in the beginning of this chapter. Brown defined the concepts or building blocks of the model, articulated assumptions, and proposed linkages among concepts that could be tested. The model is comprehensive in that it addressed the nature of the practice and the context in which the practice occurs. The importance of a nursing orientation was noted, particularly when APNs perform activities traditionally done by physicians. Brown noted that scope is “defined but dynamic and evolving,” an observation that reflects the rapidity with which knowledge accrues and practice changes. The model is sufficiently explicated that it could be used for all the purposes that conceptual models can serve—differentiating practice, designing curricula, and evaluating advanced practice. Like the early NONPF competencies, Brown used domains and competencies to describe the work of APNs. Brown's model has been cited in later theoretical and research investigations on advanced practice (e.g., Gardner et al., 2007).

**Strong Memorial Hospital’s Model of Advanced Practice Nursing**

APNs at Strong Memorial Hospital developed a model of advanced practice nursing (Ackerman, Clark, Reed, et al., 2000; Ackerman, Norsen, Martin, et al., 1996; Mick & Ackerman, 2000). The model evolved from the delineation of the domains and competencies of the acute care NP (ACNP) role, conceptualized as a role that "combines the clinical skills of the NP with the systems acumen, educational commitment, and leadership ability of the CNS" (Ackerman et al., 1996, p. 69). The five domains are direct comprehensive patient care, support of systems, education, research, and publication and professional leadership. All domains have direct and indirect activities associated with them. In addition, necessary unifying threads influence each domain, which are illustrated as circular and continuous threads in Figure 2-8:


collaboration, scholarship, and empowerment (Ackerman et al., 1996). These threads are operationalized in each practice domain. Ackerman and colleagues (2000) noted that the model is based on an understanding of the role development of APNs; the concept of novice (APN) to expert (APN) is foundational to the Strong Model (see later).

Direct comprehensive care includes a range of assessments and interventions performed by APNs, including history taking, physical assessment, requesting and/or performing diagnostic studies, performing invasive procedures, interpreting clinical and laboratory data, prescribing medications and other therapies, and case management of complex, critically ill patients. The support of systems domain includes indirect patient care activities that support the clinical enterprise and serve to improve the quality of care. These activities include consultation, participating or leading strategic planning, quality improvement initiatives, establishing and evaluating standards of practice, precepting students, and promoting APN practice. The education domain includes a variety of activities, such as evaluating educational programs, providing formal and informal education to staff, educating patients and families, and identifying and disseminating educational resources. The research domain addresses the use and conduct of research. The publication and professional leadership domain includes those APN functions involved with disseminating knowledge about the ACNP role, participating in professional organizations as a member or leader, influencing health and public policy, and publishing. APNs are expected to exert influence within and outside their institution.
The unifying threads of collaboration, scholarship, and empowerment are attributes of advanced practice that exert influence across all five domains and characterize the professional model of nursing practice. Collaboration ensures that the contributions of all caregivers are valued. APNs are expected to create and sustain a culture that supports scholarly inquiry, whether it is questioning a common nursing practice or developing and disseminating an innovation. APNs support the empowerment of staff, ensuring that nurses have authority over nursing practice and opportunities to improve practice.

The Strong Model is a parsimonious model that has many similarities with other advanced practice conceptualizations. For example, its domains are consistent with the competencies delineated in the Hamric Model. Unlike the Hamric Model, which posits direct care as the central competency that informs all other advanced nursing practice competencies, all domains of practice in the Strong Model, including direct care, are considered “mutually exclusive of each other and exhaustive of practice behaviors” (Ackerman et al., 1996). Like the Synergy Model, discussed later, role development is incorporated within the model (novice to expert). As described in the original article, the Strong Model emerged from consideration of the ACNP as a combined CNS-NP role. It is notable that this model was the result of a collaborative effort between practicing APNs and APN faculty members. One could infer that such a model would be useful for guiding clinical practice and planning curricula, two of the purposes of conceptual models outlined earlier in this chapter. The Strong Model has informed studies of advanced practice nursing in critical care since its publication (e.g., Mick & Ackerman, 2000; Becker, Kaplow, Muenzen, & Hartigan, 2006; Chang, Gardner, Duffield, & Ramis, 2010). More recently, Ackerman and coworkers (2010) have proposed an administrative model for managing APNs.

Oberle and Allen: The Nature of Advanced Practice Nursing

At the time that they wrote, Oberle and Allen (2001) asserted that conceptualizations of advanced practice nursing were limited; particular gaps were the lack of clear distinctions between the expert practice of experienced nurses and of APNs, as well as the lack of nursing theories to address such levels of practice. The authors noted that, although the literature on expert nursing is mostly focused on expertise as it unfolds in the context of relationships, the literature on advanced practice nursing seems to focus more on expertise as “skills acquisition and critical thinking abilities.”

According to Oberle and Allen (2001), any conceptualization of advanced practice nursing should be embedded in a conceptual understanding of nursing, so the authors first proposed a conceptualization of nursing practice. They refer to practice by the term praxis, which captures the values-oriented, reflective, and creative nature of the work of nurses. They conceive of nursing as a dialectic (back and forth) process between the nurse’s knowledge and his or her experiences and relationships with patients. In this process, the nurse considers general and particular knowledge, synthesizes this knowledge, and generates options for care that can be offered to the patient. By this, they mean that experiences with patients (and, presumably, reflection on these experiences) extend nurses’ knowledge, this new knowledge informs their practice with subsequent patients, and experiences with applying the new knowledge gained from experience and reflection again inform and extend their thinking, a dialectic process that occurs repeatedly. As nurses accumulate experience, this dialectic process that occurs in relationships with patients contributes to developing expertise.

The conceptualization of advanced practice nursing proposed by Oberle and Allen (2001) is illustrated in Figure 2-9. Each of the elements in the model is described in Box 2-4. Oberle and Allen (2001) differentiated between experts by experience and APNs as follows: “The inherent difference between expert and advanced practice is that the expert nurse’s knowledge base is largely experientially acquired, whereas the APN has a greater store of theoretical knowledge acquired through graduate study” (p. 151).

Although Figure 2-9 is meant to illustrate advanced practice nursing, the elements in the model are the same as those used for the authors’ textual description of experts by experience; there are no separate illustrations of the two levels of practice. Differences between experts by experience and APNs are described in the text. Oberle and Allen (2001) proposed that graduate education is a process in which students (presumably experts by experience) have experiences that lead to transformations in self and in practice, a dialectic process that results in “transformative practice.” Although the notion of transformative practice is provocative and likely to resonate with students and faculty, neither the model nor the text helps the reader understand the nature of this transformative practice and how it differs from the practice of experts by experience.

Oberle and Allen (2001) acknowledged that they did not consider the specifics of advanced practice and thus did not address environment or contexts of practice, which is a limitation of their model. Environment is a significant theoretical concept for nursing in general and for advanced practice nursing in particular, a concept that is addressed, for example, in Brown’s and Hamric’s models. Another limitation of Oberle and Allen’s model is the assumption of significant practical experience in nursing prior to graduate school. With more and more career changers...
entering nursing through direct-entry programs that prepare APNs, future conceptualizations of advanced practice nursing will need to take into account how non-nursing experience helps graduate nursing students experience the dialectic process that is at the heart of praxis and helps them develop the practical wisdom essential to effective nursing practice. Graduate APN students who do not have nursing experience prior to graduate school are encouraged to reflect and expand on this model, considering how their life and professional experiences account for their experience of transformation and their mastery of advanced practice nursing.

Shuler’s Model of Nurse Practitioner Practice

This model is complex and the review for this edition found no additional reports using this model. Because of its historical importance as an early NP model, the Shuler model (Shuler & Davis, 1993a) is briefly discussed. Readers should refer to the original article to see the full model.

Shuler’s experience integrating nursing and medical knowledge skills into the NP role led to the development of a conceptual model that would make apparent the unique contributions of NPs, purposefully addressing the need for a model that reflects the acquisition of expertise by the NP in two health care disciplines, nursing and medicine. Shuler’s Nurse Practitioner Practice Model is a complex systems model that is holistic and wellness-oriented. It is definitive and detailed in terms of how the NP-patient interaction, patient assessment, intervention, and evaluation should occur (Shuler & Davis, 1993a). It is complex and its value for understanding NP practice may not become clear until one is in practice. Table 2-2 outlines key model constructs and related theories, many of which should be familiar to students. Knowing that these familiar concepts are embedded in this comprehensive model may help readers appreciate its potential usefulness.

Shuler’s model is intended “to impact the NP domain at four levels: theoretical, clinical, educational, and research” (Shuler & Davis, 1993a). A close review of the model indicates that it addresses important components of a model of advanced practice nursing, such as the following: (1) nursing’s metaparadigm (person, health, nursing, and environment); (2) the nursing process; (3) assumptions about patients and nurse practitioners; and (4) theoretical concepts relevant to practice. The model could be characterized as a network or system of frameworks.

Clinical application of the Shuler Model is intended to describe the NPs’ combined functions (i.e., nursing and medicine), benefits for practitioner and patient, and a framework whereby NP services can be evaluated (Shuler & Davis, 1993b). Shuler and Davis (1993b) published a lengthy template for conducting a visit. Although it is difficult to imagine ready implementation into today’s busy
CNSs, and clinical nurse consultants—a term used in Australia for those in CNS-like positions (Ball & Cox, 2003, 2004). Subjects (N = 36) from the United States, Canada, United Kingdom, and Australia participated; they were required to be master’s-prepared or graduate students preparing for an advanced practice role. The investigators conducted interviews and made observations of the participants over a 3-year period. The theory of legitimate influence emerged from this study (Fig. 2-10). The figure illustrates the range of activities in which APNs engage to “enhance patient stay” and “improve patient outcomes.” This study provided empirical support for many of the competencies described in the models reviewed in this chapter. For example, findings from their work are consistent with the competencies in Hamric’s model (Table 2-3). Ball and Cox’s work suggests that the activities of APNs, in this case NPs and CNSs, are strategic and focused and that some activities involve direct service to patients, whereas others are aimed at communication and system issues.

Section Summary: Implications for Advanced Practice Nursing Conceptualizations

When one considers conceptualizations of advanced practice nursing described by professional organizations and individual authors, similarities and differences emerge. Many conceptual models address competencies that APNs must possess. All are in agreement that the direct care of patients is central to APN practice. Most models affirm two or more competencies identified by Hamric and some models emphasize some competencies more than others. Some models (e.g., the Calkin and Strong models) address the issue of skill mix as it relates to APNs, an issue of concern to administrators who hire APNs. A notable difference across models is the extent to which the concept of environment as it relates to APN practice is addressed. In the next section, selected models, which APNs may find useful as they develop and evaluate their own practices, are described. Models of APN role development are explored in Chapter 4.

Models Useful for Advanced Practice Nurses in Their Practice

American Association of Critical-Care Nurses’ Synergy Model

The American Association of Critical-Care Nurses created the Synergy Model (2003; Fig. 2-11) to link nursing practice with patient outcomes (Curley, 1998). Components of the model are patient’s characteristics, nurse’s competencies, and patient, nurse, and system level outcomes. Patients’ capacity for health and their vulnerability to

Box 2-4

Elements of Oberle and Allen’s Conceptualization of Advanced Practice Nursing

Patient-client presenting concern—problem or potential problem for which an individual needs nursing care

General and particular knowledge—nurses move back and forth between global knowledge (e.g., the features of an illness or the nursing care that usually works for a particular problem) and specific knowledge (specifies about the individual patient or situation).

General Knowledge
- Theory—know what and know why.
- Pattern recognition—know what.
- Practical knowledge—know how.

Particular Knowledge
- Client’s meanings, desired outcomes, and acceptable actions—know who.
- Dialectic—the process whereby nurses consider general and particular knowledge and synthesize this information to generate options and propose actions to the patient to move the patient toward his or her goals.
- Synthesis—know that (a particular action is called for in a specific situation).
- Practical wisdom—know when (a particular action ought to be taken). The dialectic process and experience with synthesis, informed by praxis, lead to the development of practical wisdom.
- Telos—human flourishing (the object of nursing care, of which health is a part—health is a resource for human flourishing.
- Options—possibilities for actions identified by nurse.

PART I  Historical and Developmental Aspects of Advanced Practice Nursing

FIG 2-10  Ball and Cox’s theory of legitimate influence. (From Ball, C., & Cox, C. L. [2003]. Restoring patients to health: Outcomes and indicators of advanced nursing practice in adult critical care, Part 1. International Journal of Nursing Practice, 9, 356–367.)

TABLE 2-2  Model Constructs and Underlying Theoretical Concepts Included in Shuler’s Model of Nurse Practitioner Practice

<table>
<thead>
<tr>
<th>Model Constructs</th>
<th>Holistic Patient Needs</th>
<th>Nurse Practitioner–Patient Interaction</th>
<th>Self-Care</th>
<th>Health Prevention</th>
<th>Health Promotion</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying theoretical concepts</td>
<td>Basic needs, Wellness activities, Health and illness, Psychological health, Family, Culture, Social support, Environmental health</td>
<td>Contracting Role modeling, Self-care activities, Teaching, learning, Contracting Culture, Family, Social support Environmental health</td>
<td>Wellness activities, Preventive health activities, Health promotion activities, Compliance, Problem solving, Teaching, learning, Contracting Culture, Family, Social support Environmental health</td>
<td>Primary prevention, Secondary prevention, Tertiary prevention, Preventive health behavior, Family, Culture, Environmental health</td>
<td>Health promotion behavior, Wellness, Family, Culture, Environmental health, Social support</td>
<td>Self-care activities, Wellness activities, Disease prevention activities, Health promotion activities, Family, Culture, Social support, Environmental health, Spirituality, Contracting, Teaching/learning</td>
</tr>
</tbody>
</table>

illness are influenced by biologic, genetic, psychological, and socioecologic determinants. The Synergy Model posits a unique cluster of personal characteristics that arise from these determinants and exist along a continuum that parallels health and illness states—stability, complexity, predictability, resiliency, vulnerability, participation in decision making and care, and resource availability (Table 2-4). An important function of the nurse is to ensure the patient’s safe passage through the health care system.

Nursing competencies are derived from the needs of patients and also exist along a continuum. The eight nursing competencies are clinical judgment, advocacy and moral agency, caring practices, facilitation of learning, collaboration, systems thinking, diversity of responsiveness, and clinical inquiry (Table 2-5). These range from competent (level 1) to expert (level 5). However, a discussion of the interpretation of these levels is beyond the scope of this chapter. The reader is referred to the American Association of Critical-Care Nurses website (http://www.aacn.org) and other publications (American Association of Critical-Care Nurses, 2012; Curley, 1998).

![FIG 2-11](image-url) American Association of Critical-Care Nurses Synergy Model. The Synergy Model delineates three levels of outcomes—those derived from the patient, those derived from the nurse, and those derived from the health care system. (From Curley, M. A. Q. [1998]. Patient-nurse synergy: Optimizing patient’s outcomes. American Journal of Critical Care, 7, 64–72.)
Outcomes are conceptualized as being derived from the patient, nurse, and/or system. For example, trust of the caregiver and patient satisfaction are patient outcomes that arise or are derived from the patient. Physiologic outcomes are derived from the nurse (i.e., the nurse’s interventions). Systems level outcomes are derived from the hospital or insurer (e.g., readmission to the hospital for a preventable complication).

The model is interesting for several reasons. From the perspective of patient-centered care, the model recognizes the importance of nurse-patient relationships and patients’ trust in their caregivers. Certification examinations, including those for APNs, are based on the conceptualization of levels of competency and represent conceptual coherence between the nature of the practice and how a person’s knowledge of the practice is tested. The model has shown considerable stability, informing practice (a regular column in their publications) and changes in certification. As can be seen, there is overlap between the Synergy Model and Hamric Model, both of which have been integrated into the new CNS competencies.

Finally, the model has been used to document differences among critical care APN roles (Becker et al., 2006). Like the NACNS, Hamric, and DNP conceptualizations, the Synergy Model addresses the patient, nurse, and system. Since the last edition, there have been several publications using the Synergy Model, often by APNs, about basic and advanced practice to explain a patient's knowledge of the practice is tested. The model has shown considerable stability, informing practice (a regular column in their publications) and changes in certification. As can be seen, there is overlap between the Synergy Model and Hamric Model, both of which have been integrated into the new CNS competencies.

TABLE 2-4  The Synergy Model: The Seven Continua of Patient Characteristics

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimally resilient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highly resilient</td>
</tr>
<tr>
<td>Highly vulnerable</td>
<td></td>
<td></td>
<td></td>
<td>Minimally vulnerable</td>
<td></td>
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<tr>
<td>Minimally stable</td>
<td></td>
<td></td>
<td></td>
<td>Highly stable</td>
<td></td>
</tr>
<tr>
<td>Minimally complex</td>
<td></td>
<td></td>
<td></td>
<td>Highly complex</td>
<td></td>
</tr>
<tr>
<td>Not predictable</td>
<td></td>
<td></td>
<td></td>
<td>Highly predictable</td>
<td></td>
</tr>
<tr>
<td>Few resources available</td>
<td></td>
<td></td>
<td></td>
<td>Many resources available</td>
<td></td>
</tr>
<tr>
<td>No participation in decision making and care</td>
<td></td>
<td></td>
<td></td>
<td>Full participation in decision making and care</td>
<td></td>
</tr>
</tbody>
</table>


TABLE 2-5  The Synergy Model: The Eight Continua of Nurse Characteristics and Nursing Competencies

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical judgment</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Advocacy, moral agency</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Caring practices</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Systems thinking</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Response to diversity</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Clinical inquiry or innovator, evaluator</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
<tr>
<td>Facilitator of patient and family learning</td>
<td>Competent</td>
<td></td>
<td></td>
<td></td>
<td>Expert</td>
</tr>
</tbody>
</table>

Advanced Practice Nursing Transitional Care Models

There are several models of transitional care in which care is provided by APNs; some of these are discussed in Chapter 8. Early work by Brooten and colleagues (1988) continues to inform these models of APN care (e.g., Partiprajak, Hanucharurnkul, Piasue, et al., 2011). Brooten's model is important because it illustrates how a theory of clinical care can be studied to obtain a better understanding of the work of APNs; it is a model that has evolved but has resulted in steady contributions to understanding and improving APN practice. This theoretical and empirical steadfastness has had a significant influence on the new policies evolving as the United States undergoes health care reform.

Brooten and colleagues (1988) used a conceptual framework proposed by Doessel and Marshall (1985). They integrated this framework into their evaluation of outcomes of APN transitional care with different clinical populations. APN transitional care was defined as “comprehensive discharge planning designed for each patient group plus APN home follow-up through a period of normally expected recovery or stabilization” (Brooten et al., 2002). Brooten's model was intended to address outlier patient populations (e.g., those whose care, for clinical reasons, was likely to cost more). Across all studies, care was provided by NPs and/or CNSs whose clinical expertise was matched to the needs of the patient population. In these studies, APN care was associated with improved patient outcomes and reduced costs (see Chapters 8 and 23).

Research by Brooten, Naylor (e.g., Bradway, Trotta, Bixby, et al., 2012), and others who have studied transitional care by APNs has provided empirical support for several elements important to a conceptualization of advanced practice nursing. In a summary of the studies conducted, the investigators identified several factors that contribute to the effectiveness of APNs: content expertise, interpersonal skills, knowledge of systems, ability to implement change, and ability to access resources (Brooten, Younghblut, Deatrick, et al., 2003). This finding provides empirical support for the importance of the APN competencies of direct care, collaboration, coaching, and systems leadership.

Two other important findings were the existence of patterns of morbidity within patient populations and an apparent dose effect (i.e., outcomes seemed to be related to how much time was spent with patients, how many interactions APNs had with patients, and numbers and types of APN interventions; Brooten et al., 2003). Subsequently, based on this finding of a dose effect, Brooten and Younghblut (2006) proposed a conceptual explanation of nurse dose. Their explanation suggests that nurse dose depends on patient and nurse characteristics. For the nurse, differences in education and experience can influence the dose of nursing needed.

The concept of nurse dose, which has empirical support, may enable the profession to differentiate more clearly among novice, expert, and advanced levels of nursing practice. Taken together, findings from this program of research suggest that characteristics of patients and characteristics and dose of APN interventions are likely to be important to any conceptualization of advanced practice nursing, an idea consistent with the relationships posited in the Synergy Model. Finally, the fact that this program of research has used NPs and CNSs to intervene with patients provides support for a broad conceptual model of APN practice that encompasses APN characteristics, competencies, patient factors, environment, and other concepts that can inform role-specific models.

Although there have been other studies of APNs providing transitional care (see Chapter 8), Brooten's work is highlighted because of the additional analyses that were done and the ultimate influence on health policy of this program of research (e.g., Naylor, Aiken, Kurtzman, et al., 2011). The findings help us understand the APN characteristics and interventions that have contributed to the success of the interventions and a model of care that evolved from the skilled care provided by APNs.

Dunphy and Winland-Brown's Circle of Caring: A Transformative, Collaborative Model

A central premise of Dunphy and Winland-Brown's model (1998) is that the health care needs of individuals, families, and communities are not being met in a health care system that is dominated by medicine and one in which medical language (i.e., the International Classification of Disease Codes [ICD-10-CM]) is the basis for reimbursement. They proposed the "Circle of Caring: A Transformative Model" to foster a more active and visible nursing presence in the health care system and to explain and promote medical-nursing collaboration. Dunphy and Winland-Brown's transformative model, which has been slightly revised since its original publication (Dunphy, Winland-Brown, Porter, et al., 2011; Fig. 2-12) is a synthesized problem-solving approach to advanced practice nursing that builds on nursing and medical models (Dunphy & Winland-Brown, 1998).
When first proposed, the authors argued that a model such as theirs was needed because nursing and medicine have two different traditions, with the medical model being viewed as primarily reductionistic and nursing being regarded as primarily humanistic. Neither model, by itself, provided a structure that allowed APNs to be recognized for their daily practice and the positive patient health outcomes that can be attributed to APN care. The model’s authors viewed the development of nursing diagnoses as an attempt to differentiate nursing care from medical care, but because few nursing diagnoses are recognized by current reimbursement systems, the nursing in APN care was rendered invisible.

The Circle of Caring Model was proposed to incorporate the strengths of medicine and nursing in a transforming way. The conceptual elements are the processes of assessment, planning, intervention, and evaluation, with a feedback loop. Integrating a nursing model with a traditional medical model permits the following to occur:

- The assessment and evaluation are contextualized, incorporating subjective and environmental elements into traditional history taking and physical examination.
- The approach to therapeutics is broadened to include holistic approaches to healing and makes nursing care more visible.
- Measured outcomes include patients’ perceptions of health and care, not just physiologic outcomes and resource use.

The assessment-planning-intervention-evaluation processes in linear configuration are encircled by caring. Caring is actualized through interpersonal interactions.
with patients and caregivers to which NPs bring patience, courage, advocacy, authentic presence, commitment, and knowing (Dunphy & Winland-Brown, 1998; Dunphy, et al., 2011). Conceptual definitions of these terms would add to the understanding of how these processes interact with and affect the caregiving of APNs. The authors suggested that the model promotes the incorporation of the lived experience of the patient into the provider-patient interaction, and that the process of caring is a prerequisite to APNs providing effective and meaningful care to patients.

The Circle of Caring is an integrated model of caregiving that incorporates the discrete strengths of nursing and medicine. This is an important concern for many graduate students. They struggle with integrating their nursing expertise and philosophy with new knowledge and skills that were traditionally viewed as medicine. Although the authors regard the concept of caring as a way to bridge the gap between advanced practice nursing and medicine and raise awareness, the model provides no clear guidance on how faculty can help students or how students themselves can use the model to bridge the gap.

Several issues remain to be considered. For example, if one goal of proposing the model is to resolve differences about the diagnostic language used by medicine and nursing to obtain reimbursement, no specific mechanism is offered for APNs to resolve this issue using the model. The model does not seem to be described in enough detail to guide policymaking. The conceptual significance of encircling the four practice processes with the six caring processes is unclear, although their recent work devotes a chapter to caring in the nurse practitioner role (Boykin & Schoenhofer, 2011). Given today's health policy context, the value of this model, with its emphasis on the APN-patient relationship and caring processes, could inform practice evaluation and research on APN practices. Since it was first proposed, it is only recently that publications informed by this model have appeared. For example, the Circle of Caring Model has been used for the development of an online risk assessment of mental health (McKnight, 2011), evaluation of medication adherence (Palardy & March, 2011), and neonatal transport (Thomas, 2011). In addition, their primary care textbook (Dunphy, Winland-Brown, Porter, & Thomas, 2011) is informed by their Circle of Caring Model.

Given the emphasis on interprofessional education and efforts to distinguish advanced practice from medical practice, empirical testing of this model is warranted. This testing would help determine whether the model has the following features: (1) applicability to all advanced practice nursing roles; (2) potential to be used to distinguish expert by experience practice from advanced practice; (3) viewed by other disciplines as having an interdisciplinary focus that would promote collaboration; and (4) result in more visibility for NPs and other APNs in the health care system.

**Recommendations and Future Directions**

It is understandable that students may feel confused by the variety of conceptualizations and inconsistency in terminology. The challenge for students and practicing APNs is to find a model that works for them, that enables them to understand and evaluate their practices and attend to the profession's efforts to create a coherent, stable, and robust conceptualization of advanced practice nursing.

**Conceptualizations of Advanced Practice Nursing**

This review of extant models of advanced practice nursing is necessarily cursory, primarily focused on U.S. literature, and may be incomplete. It is more a survey or overview than a review of the literature. Although there is some agreement on selected elements of advanced practice, there has generally been no comprehensive synthesis of existing work and limited evidence that new conceptualizations have built on earlier work. To promote a unified conceptualization of advanced practice nursing, I suggest that the following be undertaken:

1. A rigorous content analysis of the statements published by national and international professional organizations that describe the advanced practice nursing of recognized APNs (CNMs, CNs, CRNAs, CNPs). This would be a natural evolution of the work done by the APRN Consensus Work Group, NCSBN APRN Advisory Committee, and CNA, among others, to inform future work. As part of this analysis, an assessment of the extent to which nursing's metaparadigmatic concepts are integrated into the statements about advanced practice that organizations make about the nature of advanced practice nursing should be undertaken.
2. A similar content analysis of statements that address advanced practice nursing promulgated by specialty organizations.
3. A review of recent role delineation studies of the four APN roles.
4. A comprehensive integrative review of the advanced practice literature (building on the work of Mantzoukas and Watkinson [2007] and Lewandowski and Adamle [2009]). This could be modeled on the work of Reeves, Goldman, Gilbert, et al. (2011) and their work on the conceptualization of interprofessional education, identifying
concepts and relationships that need further development.

5. Based on recommendations 1 through 4, a synthesis of results should be generated that could be used to propose a definition of the phenomenon—advanced practice nursing.

6. Informed by these analyses, a common structure for organizational statements about APNs could be developed that ensures common nursing concepts are included, such as the following:
   - Definition of nursing and advanced practice nursing
   - Specification of assumptions
   - Incorporating the metaparadigmatic elements of persons, health and illness, nursing, and the environment, into scopes and introductions to key documents
   - Referencing documents such as ANA’s social policy statement and ICN’s statements on nursing

7. Evolving a similar structure for developing statements that define advanced practice nursing would make clear the foundational and philosophical underpinnings of each organization’s approach to defining advanced practice nursing.

8. Using the results of 1 through 5 to inform revisions of the DNP Essentials, standards, and other documents that address APN LACE issues for existing and new APN roles. Future revision of documents regarding APNs should be informed by a clear conceptualization of advanced practice nursing and empirical evidence.

9. Because the terms advanced practice nursing and advanced nursing practice are being used to refer to APN work, revisit the work on definitions of these terms done by Styles (Styles & Lewis, 2000; Styles, 1998) and clarify these definitions as they relate to APNs.

Consensus Building Around Advanced Practice Nursing

A collaboratively developed conceptualization of advanced practice nursing and what is common across APN roles is a prerequisite for building consensus among APNs, stakeholder organizations, and policymakers; this is a priority for the profession. This work is critical to ensuring that patients will continue to benefit from advanced practice nursing. The APRN Consensus Model represents substantial progress in the area with regard to regulation. Studies are underway worldwide (see Chapter 6) that could inform efforts to refine conceptualizations of advanced nursing practice. Ongoing development of consensus on advanced practice nursing should involve the following:

- Now that there is a common language regarding the regulation of U.S. advanced practice nursing, periodic updates on the progress of nationwide implementation of the regulatory model—successes and challenges—will be important (note that NCSBN periodically updates state by state maps on its website).
- Because U.S. nurse anesthetists and nurse-midwives operate under different accrediting and certification bodies and mechanisms than CNSs and NPs, their experience may be helpful in countries in which nurses and midwives are regulated separately, or where nurse anesthesia is not a practice role.
- Define common terms used in documents describing APN practice. It is evident from this review that there is still a need for common language to describe advanced practice nursing. There is no clear articulation of the differences among terms such as essentials, competencies, hallmarks, and standard of care as they are used by various organizations. Such clarity would be helpful to those in the profession and other stakeholders.

The responses of NACNS, NONPF, ACNM, and AANA to the DNP initiative and concerns about selective implementation of the APRN Consensus Model are likely to influence the evolution of advanced practice nursing in the next decade. The extent to which we reach agreement within the profession will affect policy related to advanced practice and whether the public recognizes and requests the services of APNs. Disagreement on the nature and credentialing of advanced practice nursing should be resolved by continued efforts to foster true consensus by the following:

- Addressing the legitimate concerns of these organizations (e.g., impact on access to care, concerns about certification or grandfathering existing APNs)
- Establishing priorities for negotiation and resolution by stakeholder groups and initiating a process to find common ground and address disagreements.
- In the face of disagreements, working toward agreement on a common identity to facilitate public understanding of APN roles.

These consensus-building efforts are needed if our profession is to remain attractive to new nurses and new APNs and make room for evolving APN roles.

Consensus on Key Elements of Practice Doctorate Curricula

With the promulgation of AACN’s DNP essentials and the increasing numbers of practice doctorate programs in nursing, there may be less disagreement on the need for APNs prepared at the doctoral level, but disagreements
about elements of the curricula are emerging. Several authors have expressed concern that the DNP may not be demanding enough with regard to theory and research methods, which may be just as important for evaluating practice and testing practice models as they are in nursing PhD programs. Although NACNS and ACNM do not support the practice doctorate for entry into practice and AANA has delayed doctoral preparation for entry into practice until 2025, APN organizations have prepared doctoral level competencies that are consistent with those proposed in the DNP. One question that will need to be addressed is whether regulations will specify which type of nursing practice doctorate will be needed when, and if, a doctorate becomes the entry level credential for APNs because, as Dreher and Smith Glasgow (2011) have noted, there are other practice doctorates in nursing.

**Research on Advanced Practice Nurses and Their Contributions to Patient, Team, and Systems Outcomes**

Theory-based research on APNs’ contributions to improved patient outcomes and cost-effectiveness is needed to inform and validate the conceptualizations of advanced practice nursing. Increased knowledge about advanced practice nursing is critical (see Chapter 24). The worth of any service depends on the extent to which practice meets the needs and priorities of health care systems, the public policy arena, and society in general. In addition to research that links advanced practice nursing with outcomes, I recommend the following:

1. Promising conceptual models of advanced practice nursing should be refined based on research that validates key concepts and tests theoretical propositions associated with these models.

2. Research on APNs should examine the interpersonal processes used in the course of coaching patients and collaborating with colleagues within and across disciplines; across many of the models reviewed in this chapter, the APN’s skill in communication and collaboration is considered important. I hypothesize that advanced communication skills contribute to APNs’ effectiveness (Spross, 2009; see Chapter 8). APNs can contribute descriptive data on the interpersonal strategies that they use in practice through case studies and other practice analyses to enable researchers to examine links between these less tangible aspects of APN care and patient outcomes.

3. Studies should be undertaken to examine advanced practice nursing across APN roles and between physician and APN practices with regard to processes and outcomes. The studies conducted across APN roles can determine whether the assumption that a core set of competencies is used by all APNs is valid, and the activities that differentiate one APN role from another. The studies of APNs and physicians can identify the factors that distinguish APNs from physicians as a basis for understanding differences in outcomes and developing proposals for the health of our society.

4. As conceptualizations of interprofessional teams evolve, the roles and contributions of APNs and their interdisciplinary colleagues to outcomes should be studied.

When there is a better empirical understanding of the similarities and differences across APN roles and between physicians and APNs, this knowledge must be packaged and presented to colleagues in other disciplines, policymakers, and the public. This information is important to educating physicians, consumers, and policymakers about the meaning and relevance of advanced practice nursing and the health needs of society.

For a further discussion of research directions relevant to advanced practice nursing, see Chapter 23.

**Summary**

Conceptual models serve many purposes for the fields that they seek to describe. If the nursing profession can achieve consensus on a conceptual model of advanced practice nursing, considerable progress will have been made. The future of advanced practice nursing depends on the extent to which practice meets the needs and priorities of society, health care systems, and the public policy arena. A stable robust model of advanced practice nursing will serve to guide the development of advanced practice nursing and ensure that patients will have access to APN care.

I have identified problems and imperatives related to conceptualizing advanced practice nursing, reviewed a number of models, and made some recommendations for future work on conceptualizing advanced practice nursing that address problems and imperatives. The nursing profession, nationally and internationally, remains at a critical juncture with regard to advanced practice nursing. In each country in which APNs practice, the need to move forward with one voice on this issue is urgent if APNs and the nursing profession as a whole are to fulfill their social contract with the individuals, institutions, and communities we serve. A unified conceptualization of advanced practice nursing focuses the efforts of the profession on preparing APNs, promulgating policies, and fostering research to enable the realization of the outcomes stated at the beginning of this chapter, including maximizing the social contribution of APNs to the health needs of society and promoting the actualization of APNs.
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Journal of Nursing Studies, 48, 403–408. doi: 10.1016/j.jinurstu.2010.09.003
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