WHAT ACTIONS CAN NOVICE NURSE PRACTITIONERS TAKE TO DEVELOP AND MAINTAIN THERAPEUTIC RELATIONSHIPS WITH ADULT PATIENTS IN PRIMARY CARE?

By

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Abstract

Therapeutic relationships between health care providers and patients can have wide effects on patients' health outcomes. There is a significant body of literature that has investigated therapeutic relationships in nursing and medicine. However, there is a lack of literature investigating therapeutic relationships between nurse practitioners and patients in primary care. The purpose of this integrative literature review is to identify actions that novice nurse practitioners can take to develop and maintain therapeutic relationships with adult patients in primary care. Using an integrative literature review approach, actions related to competence and knowledge, valuing and affirming exchanges, patient engagement and reciprocity, and appreciating context were identified. Engaging in these actions may help novice nurse practitioners develop and maintain therapeutic relationships with patients in primary care. Focusing on the British Columbian practice environment, this review makes recommendations related to professional identity, solidarity, role ambiguity, patient empanelment, complex patients, and transitions in care.

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It is not the brains that matter most, but that which guides them–the character, the heart, generous qualities, progressive ideas (Fyodor Dostoyevski, The Insulted and Injured, 1861)

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To my grandmother, Anna Kushner, and late grandfather, Carl Kushner, for their strength, spirit, humour and authenticity, and for inspiring my nursing career.

What we know cures; who we are heals (Kuhl, 2013, p. 1).

Chapter One

Introduction

In British Columbia, about 34% of nurse practitioners are employed in community health centres, home care agencies, nursing stations, and public health units (Canadian Institute for Health Information [CIHI], 2015), where primary care is provided to patients with a variety of conditions and concerns. In primary care, patients most value the communication they have with their primary care provider and care that is consistent with their preferences and values (Laberge et al., 2014). These patient values are not directly related to the technical aspects of medical care, like disease management, but rather reflect the importance of therapeutic relationships. There is a significant body of literature that has investigated therapeutic relationships in nursing and medicine. However, there is little research that directly investigates therapeutic relationships between nurse practitioners and patients in primary care, or how the challenges experienced by novice nurse practitioners affect their ability to develop and maintain therapeutic relationships with patients in primary care. Researchers have observed that therapeutic relationships between health care providers and patients can have positive effects on patients' health outcomes (Greenfield, Kaplan, Ware, Yano, & Frank, 1988; Griffin et al., 2004; Hojat et al., 2011; House, Landis, & Umberson, 1988; Kaplan, Greenfield, & Ware, 1989; Kelley, Kraft-Todd, Kossowsky, & Riess, 2014; Krumholz et al., 1998; Mohammadi, Abedi, Jalali, Gofranipour, & Kazemnejad, 2006; Mumford, Schlesinger, & Glass, 1982; Peplau, 1997; Street & Voight, 1997; Ward et al., 2003). Without developing and maintaining therapeutic relationships, novice nurse practitioners may not be able to fully achieve a wide variety of positive health outcomes with their patients.

Nurse practitioners are a relatively new type of primary care provider in British Columbia, with nurse practitioners first becoming regulated in the province in 2005 (College of Registered Nurses of British Columbia [CRNBC], 2017). This literature review focuses on the

practice environment of novice nurse practitioners in primary care in British Columbia and the specific considerations related to the current state of integrating nurse practitioners in this location. In adapting to their new role in the context of primary care in British Columbia, novice nurse practitioners in particular may require targeted support to develop and maintain therapeutic relationships. The purpose of this integrative literature review is to identify actions that novice nurse practitioners can take to develop and maintain therapeutic relationships with adult patients in primary care.

The second Chapter explores the context of primary care; the influence of therapeutic relationships on patient outcomes; the history and present context of therapeutic relationships between patients and nurses, physicians, and nurse practitioners; and challenges for novice nurse practitioners that may impact how they are able to develop and maintain therapeutic relationships in primary care. The third Chapter outlines the approach to this project, describing the literature review method. The fourth Chapter describes the findings from the critical analysis and evidence synthesis of the literature. Finally, the fifth Chapter reviews the key findings and implications for practice, and provides recommendations for clinical practice and research.

Chapter Two

Background and Context

There are many definitions of therapeutic relationships, depending on discipline. Nursing, medicine, physiotherapy, psychology, sociology, philosophy, and other fields describe therapeutic relational processes, provider competencies, and relational outcomes similarly. Regardless of professional group, patients expect a therapeutic relationship or rapport to develop between them and their health care provider (Kitson, Marshall, Bassett, & Zeitz, 2013). A therapeutic relationship can be simply defined as the interpersonal connection that occurs as the result of the interaction between a health care provider and a patient (College of Family Physicians of Canada, 2016). Since education, experience, focus, and context differ across professions (e.g., nursing and medicine), there are likely to be variations in how members of different professions approach or conduct the interpersonal process between themselves and their patients.

Nurse practitioners are a newer type of primary care provider in British Columbia, with nursing and advanced practice nursing education and experience. Accordingly, nurse practitioners approach therapeutic relationships with patients from two different health care perspectives. Thus, it is important to explore the theoretical and historical bases of therapeutic relationships for nurses, physicians, and nurse practitioners in order to determine how developing and maintaining therapeutic relationships in primary care may be different for novice nurse practitioners. In addition, potential practice challenges associated with the integration of nurse practitioners may impact how they interact with patients. Hence, it is important to explore practice challenges of novice nurse practitioners. Furthermore, the context of professional specialties (e.g. oncology and primary care) can impact therapeutic relationships due to differences in the purpose of the visit and temporal aspects of the relationship (Squier, 1990).

Thus, it is important to explore the context of primary care. This chapter is divided into three sections to discuss the context of primary care and the influence of therapeutic relationships on patient outcomes; the history and present context of therapeutic relationships between patients and nurses, physicians, and nurse practitioners; and the challenges for novice nurse practitioners that may impact how they are able to develop and maintain therapeutic relationships in primary care. This chapter concludes with a summary.

It is important to first acknowledge that patient characteristics (age, gender, ethnicity, socio-economic, culture) and personal preferences can influence how patients interact with providers (Greenhalgh & Heath, 2010). Physical setting and environmental context can also influence how patients and health care providers interact (Bentley, Stirling, Robinson, & Minstrell, 2016). For example, health care providers may work in a clinic room where their desk can only be positioned facing the wall, forcing them to position themselves with their back to their patient during at least part of the interaction. Health care providers generally cannot change patient characteristics and preferences, and may not be able to change the physical environment. Instead, providers may aim to interact with patients in a way that is respectful and consistent with the patient's values (Wiechula et al., 2015). Novice nurse practitioners may be able to take actions to develop and maintain therapeutic relationships with patients in primary care that may be used with any patient and/or context.

Therapeutic Relationships in Primary Care and Patient Outcomes

The interactions and relationships between health care providers and patients in acute care, specialty medical care, and surgery are typically time-limited. Thus, the understanding of patient preferences and values of providers within those settings is limited to the time the patient is actually in those settings. In addition, the relationship between health care providers and patients in tertiary care may end when a certain goal is met. For example, an endocrinologist

may refer care back to the primary care provider after a patient with diabetes has been stabilized on a new medication regimen. Primary care providers care for patients in a comprehensive way, without intentions to terminate the relationship after a certain time period or after a certain target has been achieved. Specific aspects of care may be referred to different providers or services, but primary care providers continue to provide care for their patients, with repeated contact over time (College of Family Physicians of Canada, 2016). Thus, relationships between providers and patients in primary care are longitudinal. As new primary care providers, novice nurse practitioners may not have practiced in a setting where they had the opportunity to have longitudinal relationships with their patients. Consequently, novice nurse practitioners may benefit from more information regarding what actions they can take to develop and maintain therapeutic relationships with patients in primary care over longer periods of time.

Many events occur over time that impact both providers and patients and the relationship between them. Squier (1990) argues that the longitudinal relationship between primary care providers and patients can make a significant difference in patients' ongoing quality of life and ability to cope with chronic and/or recurrent illness. Continuity of primary care is associated with better health, improved provider-patient communication, decreased emergency department visits, and greater uptake of preventive and health promotion strategies (Burge et al., 2011; Laberge et al., 2014). Difficult times and events that occur throughout patients' lives highlight the importance for providers to actively and thoughtfully take action to develop and maintain the therapeutic relationship between themselves and their patients in primary care.

In a pan-Canadian report describing patient and physician perspectives on the quality of and satisfaction with primary care, patients' most highly rated values in primary care were related to communication, continuity, coordination, and providing care that is consistent with their preferences (Laberge et al., 2014). Values that were important to patients include being

known to their provider, being treated as a person and not just a medical problem, being listened to attentively, being understood, being involved in decision-making about treatments; and having a provider who is knowledgeable about their medical history, has their medical records at hand, and knows when to refer to a specialist (Laberge et al., 2014). Having continuity with one most responsible provider was not rated as highly (Laberge et al., 2014), suggesting that patients are open to other providers, as long as these providers are knowledgeable about them personally. As new primary care providers, novice nurse practitioners may benefit from connecting these values to actions they can take to develop and maintain therapeutic relationships with patients in primary care.

Discussing relationship quality is largely subjective, as is examining professional virtues such as loyalty, honesty, and integrity, or mutual qualities of the therapeutic relationship like respect, positive regard, and trust (Greenhalgh & Heath, 2010). Even though these qualities and virtues are not easily measurable, their absence is very obvious, especially to patients who are ill or vulnerable (Greenhalgh & Heath, 2010). In psychotherapy, Lambert (1992) estimated that the nature of the therapist-patient relationship accounts for approximately 45% of the effectiveness of therapy. The therapeutic relationship "may be the primary intervention to promote awareness and growth and/or to work through difficulties… [or] may be more in the background, serving as the intervention through which comfort, support, and provision of care are facilitated" (Registered Nurses Association of Ontario, 2002, p. 11). For example, a health care provider discussing prognosis with a patient recently diagnosed with terminal cancer may rely more heavily on the therapeutic relationship compared to a health care provider taking a history from an otherwise healthy patient who presents with symptoms of a respiratory tract infection. Nonetheless, the therapeutic relationship underlies every interaction between provider and patient.

Even though the influence of therapeutic relationships on health outcomes is difficult to measure, Kelley et al. (2014) found that that the provider-patient relationship has a small but statistically significant (p=.02) effect on health care outcomes such as general quality of life, pain relief, depression/anxiety and other psychosocial outcomes, functioning, weight loss, reconsultation rate, asthma quality of life, blood pressure, and smoking quit rate. Therapeutic relationships have been found to confirm self-worth, provide a connection to others, and support self-esteem (Peplau, 1997). Therapeutic relationships have also demonstrated measurable improvements in many other health parameters (Griffin et al., 2004; Kelley et al., 2014), such as improved diabetic management (Hojat et al., 2011), improved recovery from surgery and myocardial infarctions (Mumford et al., 1982), decreased morbidity (Krumholz et al., 1998; Ward et al., 2003), decreased mortality (House et al., 1988), improved quality of life in breast cancer patients (Street & Voight, 1997), increased treatment adherence (Mohammad et al., 2006), improved general health status (Kaplan et al., 1989) and generally improved clinical outcomes (Greenfield et al., 1988). Overall, the above research findings demonstrate the diffuse effects that therapeutic relationships can have on patients' health. In addition, these health outcomes emphasize the importance of developing and maintaining therapeutic relationships with patients in primary care.

Therapeutic Relationships Between Patients and Nurses, Physicians, and Nurse Practitioners

There are historical differences in the focus of nurse-patient relationships and physician-patient relationships. There has been significant research in nursing about nurse-patient relationships, which have been described as therapeutic relationships, and alternately as caring relationships. As it is beyond the scope of this paper to describe each theory, the work of one prominent nursing leader and pioneer will be featured here. Peplau, a psychiatric nurse, was the

first nursing theorist to identify the nurse-patient relationship as being central to all nursing care (Peden, Staal, Rittman, & Gullett, 2015). Along with other nurse leaders that followed, Peplau helped to shift the pre-20th century focus of nursing from performance of tasks to engagement in therapeutic relationships designed to facilitate patients' health and healing (Peden et al., 2015). Peplau (1992) believed that the work of nursing is to engage the patient in therapeutic relationships that move them toward greater health, and to do this nurses have to engage patients rather than allowing patients to be passive recipients of nurse-directed care. In other words, Peplau believed that therapeutic relationships should be patient-centered. Peplau described the nurse-patient relationship as consisting of two or more people (nurse and patient/patient's family), professional expertise, and patient need. According to Peplau, every interaction with a patient has the potential to be therapeutic, with the goal of the nurse-patient relationship to help patients develop intellectual and interpersonal skills required for improved health and/or wellness through the use of active listening skills and verbal and non-verbal communication strategies.

The seminal work of Peplau is reflected in the College of Registered Nurses of British Columbia's position on therapeutic relationships. The College of Registered Nurses of British Columbia (2013) states that nurse-patient relationships are the foundation of nursing practice and describes these relationships as therapeutic; focused on patients' needs; based on trust, respect and professional intimacy; protective of patients' dignity, autonomy, and privacy; and are distinguished from non-professional relationships by professional boundaries and a focus on therapeutic aspects. This description reflects many of the nursing values and ethical responsibilities contained within the Canadian Nurses Association (CNA)'s *Code of Ethics for Registered Nurses*, which include providing safe, compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision-making;

preserving dignity; maintaining privacy and confidentiality; promoting justice; and being accountable (CNA, 2008).

In contrast to the nursing profession, the medical profession has historically focused more on disease management than relationships with patients (Donabedian, 1966). The traditional biomedical agenda refers to a model for medicine that views people as biologic systems, with disease occurring independent from social behaviour (Johnson, 1993). In this model, relationships between physicians and patients are more restricted to the biomedical agenda and aimed at achieving performance targets (Greenhalgh & Heath, 2010). Conversely, one prominent physician, William Osler (1892), endorsed the importance of the physician-patient relationship. However, evidence-based medicine was also beginning to change medical practice around the same time (Silverman, 2012). It may have been that the demand for evidence-based medicine overshadowed the attention to physician-patient relationships as medical evidence rapidly increased. In keeping with the biomedical agenda, Donabedian (1966) presented a framework for evaluating the effectiveness of medical care at the level of the physician-patient interaction. Donabedian proposed that there are three categories from which to measure quality of medical care: structure, processes, and outcomes. Using Donebedian's framework in primary care, the structure and process of primary care was arranged to attempt to produce performance-related outcomes.

Inadvertently, the focus on performance-related outcomes diminished the importance of the therapeutic relationship in achieving those health outcomes; family physicians may not have focused on knowing patients, their concerns and priorities, their family and work life, or why these things are important to health (Greenhalgh & Heath, 2010). Hence, developing and maintaining therapeutic relationships may have been hindered. Fortunately, the work of Levestein, McCracken, McWhinney, Stewart, and Brown (1986) began to bring more attention

back to the importance of physician-patient relationships in primary care. However, the traditional disease-focused model of medicine persists and this approach continues to be evident in practice today (Miller, Crabtree, Nutting, Stange & Jaén, 2010; Robinson, Tate, & Heritage, 2016; Sheridan et al., 2012). A disease-focused approach may be the result of increasing pressures on the health care system from the current shortage (CIHI, 2016) and/or ineffective use of family physicians (Berry et al., 2017). Nonetheless, the lens of medical care is historically different from nursing. Thus, nurse practitioners, with their education and experience grounded in nursing, may have a different perspective than physicians regarding therapeutic relationships with patients.

Because the practice of nurse practitioners is grounded in nursing values and expanded from the knowledge and theories of professional nursing practice (CNA, 2010), nurse practitioners readily recognize the centrality of therapeutic relationships to their professional practice with patients. Nurse practitioners bring the qualities and skills from their nursing background (as well as their experiences using these skills as registered nurses) to their advanced practice roles. Furthermore, the addition of advanced education at the Masters or Doctoral level, including advanced practice nursing education (such as diagnosing, treating, and managing diseases and illnesses, prescribing medications, ordering and interpreting laboratory and diagnostic tests, and initiating referrals to specialists), means that nurse practitioner practice encompasses medical competencies traditionally delivered by physicians, but from a nursing epistemology (Prodan-Bhalla & Scott, 2016). The competencies for nurse practitioners in British Columbia describe the knowledge, skills, attitudes and judgments required for nurse practitioners (CRNBC, 2010), and provide some indication of the expectations for nurse practitioner-patient interactions. The competencies that seem to be the most relevant to nurse practitioner-patient

interactions include those regarding the incorporation of knowledge into assessment, diagnosis, therapeutic management, and evaluation of outcomes; the provision of information, support, and education to patients; the use of advanced knowledge in communication, negotiation, coalition building, change management, and conflict resolution; the creation of environments conducive to communication, learning, and patient participation; the consideration of personal patient information/attributes/perspectives/values/goals and evidence-informed practice when exploring therapeutic options and negotiating plans of care with patients; and the provision of culturally safe care (CRNBC, 2010, pp. 9-15).

Within the transition from registered nurse to nurse practitioner, there is an accompanying shift in how nurse practitioners develop and maintain their therapeutic relationships with patients, as the additional education and change in practice environment/context allows novice nurse practitioners to interact with patients in ways that they did not as registered nurses. Nurse practitioners have the opportunity to develop and maintain therapeutic relationships with patients in the context of directly managing patients' health conditions through ordering investigations, medications and treatments, and making shared management decisions. Advanced practice nursing education provides nurse practitioners' with a systematic approach to medical problems and new knowledge regarding diagnosing and managing diseases and conditions, whereas entry-level nursing education and experience working with patients as registered nurses guides nurse practitioners in how they approach therapeutic relationships with patients. Thus, novice nurse practitioners must take their knowledge of therapeutic relationships from their registered nursing background and apply this knowledge to their new role as nurse practitioners in the context of primary care and new practice challenges.

Despite the lack of literature that offers advice on developing and maintaining therapeutic relationships between nurse practitioners and patients, there is literature that indirectly addresses therapeutic relationships through evaluations of nurse practitioners' practice, including patients' evaluations of nurse practitioners' care and nurse practitioners' communication practices. Nurse practitioners receive high levels of patient approval. Evaluations of nurse practitioners demonstrate that patients believe nurse practitioners provide comprehensive care, attentiveness to their needs, and a feeling of caring (Sangster-Gormley & Canitz, 2015). Charlton et al. (2008) reviewed nurse practitioner-patient communication in primary care, and found that nurse practitioner communication with patients reflects both the traditional biomedical/provider-centered model and the patient-centered model. Charlton et al. argue that patient-centered communication results in more positive patient outcomes. Given that nursing historically adopted patient-centered communication (Peplau, 1992), the biomedical/provider-centered communication that was identified by Charlton et al. indicates that there may be other factors interfering with how nurse practitioners communicate with patients. Thus, examining nurse practitioner-patient interactions in more depth, and examining factors that may interfere with nurse practitioner-patient communication, may help determine actions that can be taken to develop and maintain therapeutic relationships.

Although therapeutic attitudes, communication, and other factors are identified as important to therapeutic relationships (Greenhalgh & Heath, 2010), it is also important to consider the social context and power relationships within which these therapeutic attitudes, communication, and factors take on particular, contextual meanings. In contrast to physician studies, Grainger (2004) found that nurses use humour to balance power in relationships with patients in geriatric wards and gain a sense of unity, or solidarity, between them. In addition, Defibaugh (2014) discovered that nurse practitioners create solidarity with patients in ways that

have not been seen in previous studies of medical visits involving physicians. The findings from Grainger (2004) and Defibaugh (2014) imply that nurse practitioners negotiate power in a way that is linked to the patient-centered nursing perspective. In contrast, Li, Koehn, Desroches, Yum, and Deagle (2007) found that physicians use power to gain more control over the topics and course of the medical visit. Furthermore, as a display of power, questions can be used to control the direction of conversation and determine when the patient may speak (Ainsworth-Vaughn, 1998; Byrne and Long, 1976; Heritage and Clayman, 2010). Patients may also act passively and display more silent behaviours with providers, perhaps as a way to show reverence to their providers' authority (Ainsworth-Vaughn, 1998; Heath, 1992; Stivers, 2007). Thus, the ways in which providers consciously or unconsciously use power affect how they interact with patients and how the therapeutic relationship is developed and maintained. Exploring how nurse practitioners balance power during interactions with patients may reveal insights into the actions that novice nurse practitioners can take to develop and maintain therapeutic relationships.

Challenges for Novice Nurse Practitioners' and the Effects on Therapeutic Relationships

The transition from registered nurse to nurse practitioner, especially in the first year after graduation, has been described as a stressful and turbulent time, regardless of practice setting (Faraz, 2016). In her integrative review on novice nurse practitioner transition into primary care, Faraz found the most common intrinsic obstacles faced by novice nurse practitioners were perceptions of low competence and poor self-confidence in their new roles. In their study of novice nurse practitioners' transition into primary care, Brown and Olshansky (1997) found that poor self-confidence greatly affects nurse practitioners initial transition into their roles as primary care providers. Defibaugh (2015) affirms that the setting of medical care on its own lends itself to defining general roles for participants (i.e., 'patient' and 'provider'), and more specific roles (e.g., 'good patient' and 'competent provider'). Defibaugh (2015) asserts that these

roles aid in the construction of identities for both patients and nurse practitioners, and that these identities shape interactional patterns between patients and nurse practitioners. Consequently, the ways in which patients and nurse practitioners view themselves affect how they interact together. While nurse practitioners have little control over how patients construct their identities as patients, nurse practitioners may be able to control how they perceive themselves as nurse practitioners and modify (to some extent) how patients perceive them. If some novice nurse practitioners have poor self-identity, there may be repercussions for therapeutic relationships. Exploring how nurse practitioners construct their identity may reveal actions that novice nurse practitioners can take to improve their self-identity, thus improving their interactions with patients, and helping to develop and maintain therapeutic relationships.

There are several other challenges identified from research about the registered nurse to nurse practitioner transition that may affect the way that novice nurse practitioners develop and maintain therapeutic relationships with patients. Although both physicians and nurse practitioners work in primary care settings in British Columbia, there are differences between the practice environment of nurse practitioners and that of physicians. The practice challenges of nurse practitioners include role ambiguity; quality of professional and interpersonal relationships; and extrinsic obstacles, including patient empanelment and lack of privileging/credentialing.

Faraz (2016) found that role ambiguity is the most common issue in the nurse practitioner transition to primary care. In their evaluation of the integration of nurse practitioners into the British Columbia health care system, Sangster-Gormley and Canitz (2015) also identified that managers, physicians, and other staff lack knowledge or understanding about the nurse practitioner role. Prodan-Bhalla and Scott (2016) assert that the current funding models for nurse

practitioners also create barriers to role clarity for patients and professionals alike, and this negatively impacts relationships with nurse practitioners.

The problem of role clarity may be more exaggerated in communities or settings where nurse practitioners are being newly introduced. Lack of role clarity can create several challenges with integrating nurse practitioners into practice teams, including unfair expectations, confusion about nurse practitioners' contributions, and tension in the relationships between nurse practitioners and other professional groups and/or staff (Faraz, 2016; Sangster-Gormley & Canitz, 2015). Lack of understanding about the nurse practitioner role can be a problem in relationships between nurse practitioners and their colleagues (Sangster-Gormley & Canitz, 2015).

Lack of role clarity can also be passed on to patients. When patients are seen in collaborative practice settings where patient rosters are shared, other practitioners may provide patients with inadvertently false information about the role of the nurse practitioner. Thus, the actions that novice nurse practitioners take in regards to improving role clarity may have implications for their therapeutic relationships with patients.

Sullivan-Bentz et al. (2010) found that one third of nurse practitioner graduates from the Ontario Primary Health Care Nurse Practitioner program reported interpersonal conflict or lack of role acceptance in their practice environments. Lack of support from managers, physicians and other colleagues or health care providers impacts nurse practitioners' interprofessional relationships. Lack of support may be demonstrated by a reluctance or refusal to provide professional supports such as formal mentoring for novice nurse practitioners, consultative or collaborative support from colleagues, or exclusion from practice meetings or other meetings. In order to best care for their patients, nurse practitioners (especially novice nurse practitioners) need support from management, colleagues, and other health care providers. Without these

supports, patient care may be impacted, and therapeutic relationships between nurse practitioners and patients may be affected. Thus, the actions that novice nurse practitioners take in regards to obtaining support and fostering interprofessional relationships may have implications for their therapeutic relationships with patients.

The majority of nurse practitioners in British Columbia are employed by health authorities (CIHI, 2015), so many nurse practitioners do not have the freedom to empanel their own patients. Patient empanelment allows patients to register with a provider or family practice team (The College of Family Physicians of Canada, 2012). Nurse practitioners in British Columbia are often recruited by health authorities to improve access to care for certain panels of patients, such as patients with chronic conditions and complexity (Sangster-Gormley & Canitz, 2015). Thus, nurse practitioners are often assigned to a particular patient panel, without any patient or nurse practitioner input. There may be implications for therapeutic relationships when these relationships are created without nurse practitioner and/or patient input.

In addition, the lack of privileging and credentialing for many nurse practitioners means that nurse practitioners cannot follow patients across settings as other primary care providers may choose to (Sangster-Gormley & Canitz, 2015). Hospital admitting privileges continue to be an issue for many nurse practitioners. Despite nurse practitioners' otherwise favorable evaluations from patients, patients reported that they did not like that their nurse practitioners did not have hospital admitting privileges (Sangster-Gormley & Canitz, 2015). Thus, the lack of privileging has implications for therapeutic relationships between nurse practitioners and patients.

Summary

It is clear that therapeutic relationships are important for patients and providers alike. Nurse practitioners retain the values, theories, and knowledge of therapeutic relationships that

were established during their nursing education and experience practicing as registered nurses, and combine this knowledge and these values with their advanced practice education to their new roles as primary care providers. Thus, while novice nurse practitioners are new to their role and new to the setting of primary care, engaging in therapeutic relationships is not new. Yet, because of this new role and care setting, the approach to therapeutic relationships is necessarily different. However, there is a lack of literature that directly examines how nurse practitioners develop and maintain therapeutic relationships with their patients. Adapting to the new role and context of primary care, novice nurse practitioners may require further direction or education about engaging in therapeutic relationships with patients in primary care. Based on differences in education, experience, focus, and practice challenges, the actions that physicians may take to develop and maintain therapeutic relationships when they are new in their role may be different than the actions novice nurse practitioners may take. Moving forward, the next chapter outlines the methods used for the literature review in order to answer the question of what actions novice nurse practitioners can take to develop and maintain therapeutic relationships with adult patients in primary care.

Chapter Three

Method

Using criteria from Whittemore and Knafl (2005), an integrative literature review was conducted, guided by the following question: What actions can novice nurse practitioners take to develop and maintain therapeutic relationships with adult patients in primary care? The literature search process occurred in the following three stages: (1) search strategy and preliminary search, (2) application of inclusion and exclusion criteria, and (3) analysis of final articles. The searches were last rerun on May 5, 2017, in order to determine whether additional articles might be added.

Search Strategy and Preliminary Search

The preliminary literature search used the following databases, which were accessed through the University of Northern British Columbia's library: Cochrane Database of Systematic Reviews (CDSR), CINAHL with Full Text, MEDLINE, PsycINFO, and Social Sciences with Full Text. These databases were selected because they represented sources of a wide selection of original research articles and systematic reviews from the areas of medicine, nursing, and social sciences, which were all relevant to the topic of therapeutic relationships. Medical databases and journals were included to widen the scope of the results, so as not to miss relevant literature on nurse practitioners that may appear in non-nursing journals. Because of the large body of literature available about provider-patient relations, designing the search strategy was a challenge. In order to ensure a thorough search of the literature, search terms were developed by breaking down the key components of the research question. These individual search terms were then combined in various ways in keyword searches, using appropriate truncation, and formulated into MeSH terms when available. MeSH terms were exploded where possible. This search strategy improved the relevance of search results and decreased the time spent sorting

through extraneous results. The search terms and combinations with results can be found in Table 1. The types of journals found in the results included those dedicated to primary care, applied communication, general medicine, and nursing.

The following websites were also searched for relevant guidelines pertaining to therapeutic relationships: Academic Consortium for Integrative Medicine and Health (United States), Agency for Healthcare Research and Quality (United States), Canadian Foundation for Healthcare Improvement, Canadian Institute for Health Information, University of British Columbia Research Circle, National Institute for Health Research (United Kingdom), and National Institutes of Heath (United States). No relevant guidelines were found for inclusion.

Table 1

Search Terms and Combinations with Results

Databases	Search Terms and Results	Combinations and Results
CDSR (Ovid)	1. SH “Nurse practitioners+”= 0 2. (SH "Family Practice") OR (SH "Physicians, Family")= 0 3. (SH "Professional-Patient Relations") OR (SH "Physician-Patient Relations") OR (SH "Nurse-Patient Relations") = 0 4. KW “Therapeutic relationship”= 57 5. KW “Primary care” = 1077	Combinations: 1 + (3 OR 4) = 0 1 + 2 + 3= 0 1 + 2 + 4= 0 1 + 3 + 5= 0
CINAHL with Full Text (EBSCO host)	1. MH “Nurse practitioners+” = 16064 2. (MH "Family Practice") OR (MH "Physicians, Family") = 20288 3. MH "Professional-Patient Relations") OR (MH "Physician-Patient Relations") OR (MH "Nurse-Patient Relations") = 58930 4. KW “Therapeutic relationship”= 958 5. KW “Primary care”= 34501	Combinations: 1 + (3 OR 4) = 587 1 + 2 + 3= 35 1 + 2 + 4= 0 1 + 3 + 5= 99 (Total 572 non-duplicate)
MEDLINE (Ovid)	1. SH “Nurse practitioners+”= 16643 2. (SH "Family Practice") OR (SH "Physicians, Family")= 77022 3. (SH "Professional-Patient Relations") OR (SH "Physician-Patient Relations") OR (SH "Nurse-Patient Relations") = 133970 4. KW “Therapeutic relationship”= 1771 5. KW “Primary care”= 82870	Combinations: 1 + (3 OR 4) = 656 1 + 2 + 3= 57 1 + 2 + 4= 0 1 + 3 + 5= 118 (Total 644 non-duplicate)
PsycINFO (EBSCO host)	1. MH “Nurse practitioners+”= 0 2. (MH "Family Practice") OR (MH "Physicians, Family") = 0 3. MH "Professional-Patient Relations") OR (MH "Physician-Patient Relations") OR (MH "Nurse-Patient Relations") = 0 4. KW “Therapeutic relationship”= 6904 5. KW “Primary care”= 33430	Combinations: 1 + (3 OR 4) = 0 1 + 2 + 3= 0 1 + 2 + 4= 0 1 + 3 + 5= 0
Social Sciences with Full Text (EBSCO host)	1. MH “Nurse practitioners+” = 94 2. (MH "Family Practice") OR (MH "Physicians, Family") = 21 3. MH "Professional-Patient Relations") OR (MH "Physician-Patient Relations") OR (MH "Nurse-Patient Relations") = 4 4. KW “Therapeutic relationship”= 1870 5. KW “Primary care”= 4043	Combinations: 1 + (3 OR 4) = 0 1 + 2 + 3= 0 1 + 2 + 4= 0 1 + 3 + 5= 0

Application of Inclusion and Exclusion Criteria

The preliminary search results were imported into EndNote reference management software. After automatic removal of duplicates, 1101 articles were identified as a result of the combined searches. In order to narrow the results to the most relevant articles, the titles and abstracts were reviewed using specific inclusion and exclusion criteria. The inclusion and exclusion criteria were updated during the last search. These criteria, along with rationale for selecting the criteria, are summarized in Table 2.

Table 2

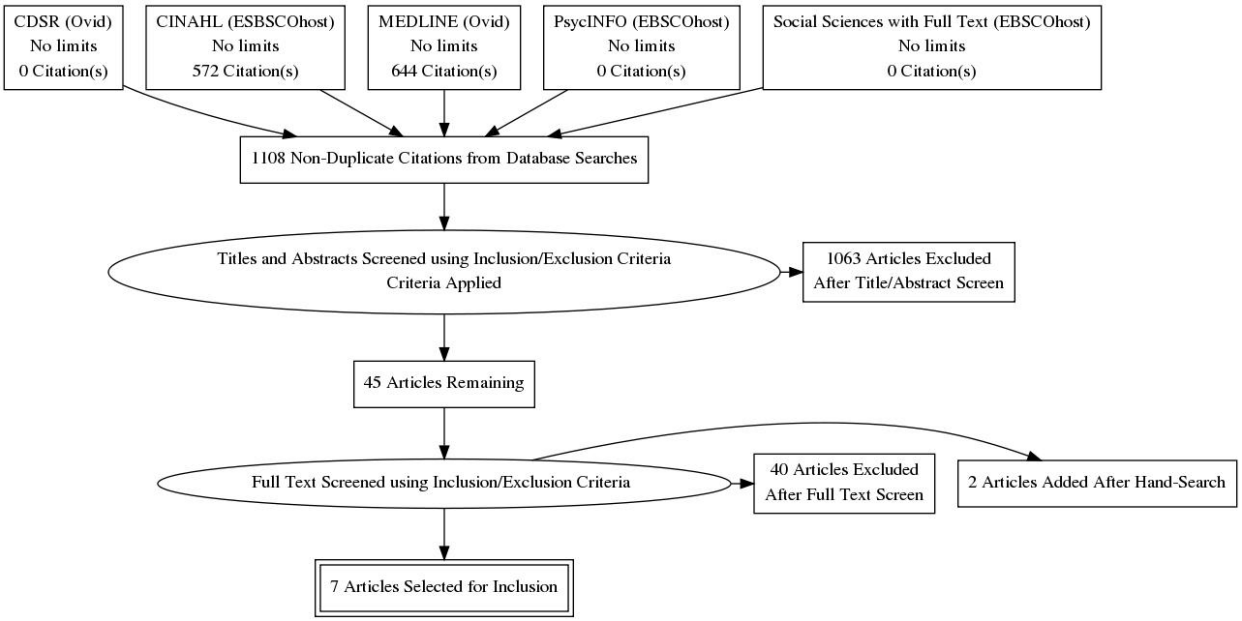
Inclusion and Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**	**Rationale**
English language	Not available in English	Readability
Original research (e.g., controlled studies and systematic reviews) and reviews in peer-reviewed journals.	Book reviews, abstracts, meeting briefs, commentaries, letters to editor, updates.	Integrative literature reviews focus on analyzing literature from original research sources and peer-reviewed journals.
Adult age 19 years and older.	Age under 19/pediatrics.	Review focus is on the relationship with the patient, not the family; a pediatric context introduces more focus on family dynamics.
Focus on clinical context.	Focus on teaching, education, or research.	Review focus is on clinical context.
Focus on primary care settings or types of patients that would be seen in primary care.	Articles were not excluded if the focus was on settings other than primary care.	Even though there are implications for generalizability, there was not enough nurse practitioner-focused literature that focused exclusively on the primary care setting.
Focused on nurse practitioner-patient relationship and/or interactions that may reveal information about the therapeutic relationship.	Focused on specific element of care (e.g., treatment advice, consultation time).	Review focus is on therapeutic relationships, not on specific skills or clinical practices demonstrated by nurse practitioners with no linkage to therapeutic relationships.
Research conducted on nurse practitioners.	Research not conducted on nurse practitioners. Must not be focused on nurses, physicians, or other health care providers. May include other health care providers as comparison, but nurse practitioners need to be a part of the sample.	To enhance the focus on nurse practitioners and avoid difficulties applying physician literature to nurse practitioners.
Individual article with findings that are included in an integrated review, but not represented in the review in a way that highlights its importance to this literature review question.	Article that reiterates the general findings of a review article, with no new considerations or insights into the subject.	Avoid repetition/over-representation of the same findings.
All years.	No date exclusions.	There is not as much literature specifically for nurse practitioners, thus limiting time of publication would limit the search results even further.

After titles and abstracts were reviewed with the inclusion and exclusion criteria, and non-relevant articles were removed, the full text of the remaining 45 articles were reviewed and inclusion and exclusion criteria were reapplied, in order to again improve upon the relevancy of the results to the research question, and produce a more manageable body of literature for focused review. After full text screening, five articles remained. The references from these five articles were then hand-searched, in order to ensure other relevant articles were not missed. The hand-search produced two more articles for inclusion. A summary of the full search process with results is illustrated in Figure 1.

Figure 1.

Literature Search Strategy



Analysis of Final Articles

At the conclusion of the search, a total of seven articles were selected for critical analysis and inclusion in the literature review. The analysis was executed using a literature review matrix. Column headings in the matrix were guided by literature appraisal guidelines and content in the matrix was guided by themes that emerged from the literature. The literature review matrix can be found in Appendix A. Each article was appraised for methodological rigour, validity, and strength of evidence using the Critical Appraisal Skills Programme (CASP, 2013) checklists. The results of the analysis are presented in the next chapter.

Chapter Four

Findings

Seven articles were selected for inclusion in this literature review. These articles were analyzed using a literature review matrix. The literature review matrix is provided in Appendix A. This analysis was guided by the research question: What actions can novice nurse practitioners take to develop and maintain therapeutic relationships with adult patients in primary care? The literature analysis revealed four key themes regarding the actions of nurse practitioners: (a) competence and knowledge, (b) valuing and affirming exchanges, (c) patient engagement and reciprocity, and (d) appreciating context. The articles and findings will be discussed in alphabetical order. A table of themes and subthemes found in each article is provided in Appendix B. This chapter concludes with a summary of the findings.

The Nurse Practitioner-Patient Therapeutic Encounter

Bentley et al. (2016) conducted an integrative review of the key features of nurse practitioner-patient interactions in therapeutic encounters. Ten studies were included in their review, which represented over 900 nurse practitioners and their patients. The studies included in this review focused on the care of older people in the community and facilities, including primary care settings. There are many strengths to Bentley et al.'s review. Bentley et al. used Whittemore and Knafl's methodology that provided the tools for the detailed analysis of the articles. The studies included were all assessed as moderate in quality, using the National Institute for Health and Clinical Excellence's (NICE) quality appraisal checklists, and the analysis of individual articles was very detailed. The studies were all from the United States and United Kingdom, so the Canadian health care context was not represented. The location may have some effect on how nurse practitioners are perceived by patients, and the challenges for and facilitators to the nurse practitioner-patient interaction. Bentley et al. included studies of nurse

practitioners in primary care settings, thus the findings are directly applicable to nurse practitioners working in primary care. The findings of Bentley et al.'s review reveal key factors in the therapeutic encounter that improve patient outcomes, thus help to answer the question of how nurse practitioners can develop and maintain therapeutic relationships with patients.

Bentley et al. (2016) found that there are three key factors in the nurse practitioner-patient interaction: nurse practitioner expertise and influence of context (e.g., the clinic setting and purpose of the visit), affirming exchange, and high levels of patient engagement. Bentley et al. observed that patients trusted the competence of nurse practitioners who were acting as autonomous primary practitioners. Competence was demonstrated by the giving and seeking of information, such as biomedical information about treatments and alternatives, as well as discussing the psychosocial aspects of the patients' lives. Bentley et al. addressed context in terms of the purpose of patients' visits. Bentley et al. described affirming exchanges as the giving of emotional support or encouragement. Affirming exchanges were the result of affirming communication, which was characterized by positive regard, respect, trust, openness, empathy, reciprocity, reassurance and concern or inquisitiveness into the biopsychosocial aspects of the patients' lives and their conditions. Bentley et al. observed that high patient satisfaction with nurse practitioners was related to this kind of communication and the time spent with the patient. Bentley et al. also found that, with this approach, patients were more engaged and more likely to adhere to treatment plans. Several of the studies reviewed by Bentley et al. mentioned patients' satisfaction with the increased time generally provided to them by nurse practitioners. This particular finding will be discussed further by analyzing one of the articles that highlighted the importance of time. Patient engagement was not well-described, but was reported to be increased with the use of affirming exchanges, particularly the inquisitiveness of the nurse practitioner.

Although Bentley et al. (2016) found that the context of the visit impacted the type of therapeutic encounter (e.g., highly sensitive health concerns, simple health concerns, and initial visits for a particular concern versus repeat visits), it was noted that the other key factors of the interaction remained the same. Thus, nurse practitioners consistently used their expertise, affirming communication, and patient engagement across visit contexts. This particular finding of Bentley et al. suggests a consistency of approach that may be important for nurse practitioners in primary care. Furthermore, of all three key factors identified by Bentley et al., the key feature of successful interactions is affirming exchanges, which seem to enhance the interaction significantly even when the visit is more time-limited or for a more simple health concern. The use of affirming exchanges may be the most important finding from Bentley et al., likely contributing to developing and maintaining therapeutic relationships.

Solidarity, Alignment, and Identity Construction in Nurse Practitioner-Patient Interactions

The studies by Defibaugh (2014, 2015) were concerned with the language used by nurse practitioners in order to achieve solidarity and alignment, and create certain practitioner and patient identities. Defibaugh (2014) conducted an ethnographic study on how solidarity is negotiated in interactions between nurse practitioners and patients. The study was conducted with one nurse practitioner working as a diabetes specialist on a hospital internal medicine team, and 20 of her patients. The patients were aged 28-82, with 13 females and seven males. The data was collected over a period of two months and comprised audiorecordings of visits, interviews with the nurse practitioner and her 20 patients, and ethnographic field notes. The rigor of the research was ensured by the analysis of the actual linguistic material collected, however, the study was quite limited since only one nurse practitioner was under consideration and Defibaugh (2014) does not explain how the nurse practitioner was chosen. The strengths of this study lie in

the utilization of a multi-theoretical approach and conversation analysis as the analytical framework. The interactions between the nurse practitioner and the patient were well-described, with several verbatim excerpts presented, and these examples seemed consistent with Defibaugh's (2014) conclusions.

It is noted that the nurse practitioner in Defibaugh's (2014) study was not practicing in a primary care setting, so the impact of the inpatient context must be taken into consideration. The types of interactions described by the Defibaugh (2014), such as discussing a new diagnosis and changing medications, are similar to what is done in primary care, thus there are some similarities in practice despite the differing contexts. The power imbalance between ill patients and their professional caregivers is amplified in the hospital environment. This imbalance was likely beneficial for Defibaugh's (2014) study, as the nurse practitioner's attempts to achieve solidarity and alignment with her patients may have been more pronounced in this setting and thus easier to study. Since the nurse practitioner in Defibaugh's (2014) study works with patients in the hospital context, her relationship with these patients is short-term. The concepts of solidarity and alignment may look different in longitudinal relationships, such as those in primary care. However, there is still an inherent power imbalance between patients and practitioners in primary care.

Defibaugh (2014) found that nurse practitioners decrease the social distance between themselves and their patients in order to allow their patients to share power, and allow patients to identify as themselves outside of their patient identity. Defibaugh (2014) found that decreasing the social distance creates solidarity between nurse practitioners and patients. The nurse practitioner in Defibaugh's (2014) study did this by using small talk, and using first-person plural pronouns (e.g., "we" or "our") when discussing treatment options and decision-making. Defibaugh (2014) asserts that these techniques create a sense of shared ownership, shared role of

experiencer, and shared decision maker. It also encourages patients to speak and share their narratives, showing interest in their non-patient identity. To support this, the nurse practitioner did not interrupt narratives; instead, she enacted supportive moves (such as saying "yes", "okay", and "good"). In return, the patients also used the first person plural pronouns, thus demonstrating reciprocity. Defibaugh (2014) reasons that solidarity may be sought due to the "middle space" position of the nurse practitioner in the traditional medical hierarchy (i.e., where the physician is given the most power), or in the patients' or nurse practitioners' own views. In fact, the nurse practitioner in this study explained that she worked more on the relationship with the patient because she perceived that patients would not tolerate any negative interaction with her, whereas they would tolerate more from the attending physician. The nurse practitioner felt that the patients may ask her to leave and then she could not do her job, whereas she did not think patients would ask the "more powerful" physician to leave. According to Defibaugh (2014), gaining solidarity with the patient then became a way in which to provide the nurse practitioner with more perceived power. Defibaugh (2014) did not identify how long the nurse practitioner had been practicing in her study, so it is unknown if this perspective may be connected to the transition period that novices go through. The nurse practitioner in Defibaugh's (2014) study worked as part of an internal medicine team, so this perspective on power imbalance between nurse practitioners and physicians may not be shared in the same way in primary care settings. However, the significance of this particular finding will be explored more in the discussion chapter.

Defibaugh (2015) expanded on her previous study and conducted an ethnographic study for her dissertation on identity construction in the interactions between nurse practitioners and patients, with the aim to identify the specific linguistic moves and stylistic choices that nurse practitioners use in communication with patients. This study incorporated the analysis of 48

medical visits with five different nurse practitioners involving the investigation of the audiorecordings of visits and interviews with the nurse practitioners and patients. This time, only one hospital-based nurse practitioner was a part of the sample, with four other nurse practitioners from different community clinics, three of which were men's health primary care clinics. Using an ethnographic discourse analytic methodology, Defibaugh (2015) utilized Agha's theory of figures of personhood to study the ways in which nurse practitioners constructed the identity of caring provider. Defibaugh (2015) also studied the ways in which patients construct their own identities, though this section of her dissertation will not be discussed here due to this review's focus on the actions of nurse practitioners. Defibaugh (2015) strengthened her study by using emic and etic viewpoints and the ethnographic analytical discourse approach. Defibaugh (2015) satisfied rigour by using the actual linguistic material upon which Defibaugh (2015) studied the communicational process of the nurse practitioners and patients, and keeping a very detailed and thorough description of her data collection and analysis techniques. Defibaugh (2015) also provided information on whether the visits were first-time visits or follow-up visits, and the length of time of the visits. Many verbatim excerpts of the interactions were presented, including tables identifying specific linguistic choices within verbatim excerpts (such as singular and plural pronouns). Thus, this writer verified Defibaugh's (2015) interpretations, and came to the same or similar conclusions.

As a result of the analysis, Defibaugh (2015) noted that nurse practitioners are able to balance both instrumental and interactional goals to construct the identity of a "caring and competent" provider. Alignment with the caring provider identity was accomplished by using linguistic moves of solidarity. These linguistic moves included small talk, inclusive first person pronouns, hedging and indirect speech. Alignment with the competent provider identity was accomplished by attending to their occupational and professional responsibilities, recognizing a

responsibility to patients, and creating alignments to organizations and institutions. Nurse practitioners created a comfortable communicational atmosphere for the patients by using lay terms to explain medical information to the patient, and following the medical checklist though sometimes allowing the topic to deviate based on patient's responses, directing attention to what the nurse practitioner felt was important while still addressing patient's concerns. Thus, Defibaugh (2015) concluded that in communication with patients, nurse practitioners balance their interpersonal goals (using caring identity) and instrumental goals (using competent identity), which resulted in patient satisfaction and reciprocity. In terms of patient engagement, Defibaugh (2015) reasoned that nurse practitioners demonstrate patient engagement by encouraging patients to share their narratives, getting to know their patients beyond their identity as patients, and involving them in decision-making. Defibaugh (2015) reported that these patients were very satisfied with these nurse practitioners and rated them very highly. Furthermore, Defibaugh (2015) referenced the relevance of her findings to developing long-term relationships with patients, like those seen in primary care. Thus, these engaging behaviours on the part of the nurse practitioner may aid the maintenance of therapeutic relationships.

Defibaugh (2014) provided insights into the concepts of solidarity and alignment in the therapeutic relationship that are hinted at in other articles, but not explicitly described. Defibaugh's (2015) descriptions of techniques used to create solidarity and alignment have some overlapping themes and similarities with Bentley et al.'s (2016) key factors. Defibaugh's (2014, 2015) description of linguistic moves, balance of interpersonal goals with instrumental goals, creation of a caring identity, and moves to create solidarity and alignment seem to have conceptual overlap with Bentley et al.'s description of affirming exchanges. The overlap is most obvious in the descriptions of reciprocity, interest in the biopsychosocial aspects of the patient's lives, and patient engagement. Defibaugh (2014, 2015) and Bentley et al. also both describe

competence as important in the nurse practitioner-patient interaction. These overlapping themes increase the validity of the shared findings.

The Empathetic Partnership Framework

Flemmer, Dekker, and Doutrich (2014) created a framework for nurse practitioners in primary care to create effective and therapeutic partnerships with patients. Flemmer et al.'s Empathetic Partnerships framework was influenced by the work of US sociologist Dr. Brenè Brown and "the tenets of cultural safety" (Flemmer et al., 2014, p. 546). In particular, the framework draws on Brown's Acompañar theory of professional helping, and her work on shame resilience, vulnerability, authenticity, and empathy. These theories, along with a focus on cultural safety, give strength to the framework being used with marginalized patients. The framework was developed by nurse practitioners in primary care. Although Flemmer et al. encourage broad use of the framework, the framework seems to have particular relevance for vulnerable patients, as they use a marginalized patient population (women who have sex with women) as an example. The focus on marginalized and vulnerable patients may be of particular relevance to nurse practitioners, who are often employed through initiatives aimed to provide health care to these underserved patients (Sangster-Gormley & Canitz, 2015). However, this focus may also limit its use in general primary care settings. Another weakness of this framework is that there has been no research to support the framework or test its use in practice. However, a possible strength of this framework is that its key elements reflect the four main themes from the findings of this literature review.

In Flemmer et al.'s (2014) Empathetic Partnership framework, there are six elements: reflection, environment, language, knowledge, partnership, and empathy. The reflection element involves nurse practitioners' continuous reflection on their own biases, cultures, power, and privilege, and questioning of roles, assumptions, filters, and perceptions. The environment

element consists of the physical space in which the interaction between nurse practitioner and patient occurs; attention is paid to displays of art and information, such as posting a nondiscrimination policy. Flemmer et al. recommended posting a nondiscrimination policy, and even including health care advertisements in gay media and other welcoming promotional materials. The exemplar population for Flemmer et al.'s framework was women who have sex with women, so these specific recommendations make sense in this context. The language element emphasizes the use of nondiscriminatory and nonjudgmental language with attention to assumptions. The knowledge element encourages nurse practitioners to sustain a knowledge base for diverse populations and consider the individual patient within given statistical tendencies. The last element is partnership and empathy. This framework uses the term 'partnership' to describe the relationship between nurse practitioner and patient. The partnership element encourages nurse practitioners to shift the power dynamic between themselves and patients. Within a partnership, patients are experts on themselves, and nurse practitioners focus on the needs and desires identified by the patient. To promote partnership, Flemmer et al. encourage nurse practitioners to be nonjudgmental, open, and encouraging of patients. To demonstrate empathy, the nurse practitioner understands the patient's feelings and world view, is nonjudgmental, and communicates that understanding to the patient.

The use of the term 'partnership' in Flemmer et al.'s (2014) framework, instead of the term 'therapeutic relationship' seems to be aimed at emphasizing the importance of patient engagement and reciprocity, which was also found to be one of the main themes of this literature review. The other key elements of Flemmer et al.'s framework also reflect the four main themes of this literature review. The elements of reflection and knowledge can be included in this review's competence and knowledge theme; the key elements of language and empathy can be included in this review's valuing and affirming exchanges theme; the key element of partnership

can be included in this review's patient engagement theme; and the key element of environment can be included in this review's context theme. Flemmer et al. emphasized the importance of addressing the physical environment more than any of the other authors included in this review, though this was also mentioned by Bentley et al. (2016), and Defibaugh (2014, 2015). Each element of Flemmer et al.'s framework fits in well with the themes from the literature, thus this framework may provide a basis on which to discuss how to develop and maintain therapeutic relationships with patients.

Essential Meanings of Nurse Practitioners' Lived Experiences Interacting with Patients

Kleiman (2004) explored the lived experience and meaning of nurse practitioners' interactions with patients. In this phenomenological study, Kleiman conducted interviews with six nurse practitioners working in a variety of settings. The nurse practitioners interviewed included a psychiatric nurse practitioner in community mental health, an adult nurse practitioner in a hospital cardiac unit, a family nurse practitioner in a college student health center, a geriatric nurse practitioner in a long-term care facility, an adult nurse practitioner in a private urology practice, and a pediatric nurse practitioner in partnership with a physician. Kleiman's study had a very small sample size, but this was appropriate for the phenomenological nature of the study. Kleiman used systematic criteria to evaluate the described experiences, which established the rigor of this qualitative work. The verbatim excerpts provided by Kleiman accurately illustrate the essential meanings that she identified. Although the study was not focused exclusively on nurse practitioners in primary care, it did include the perspective of a family nurse practitioner and two nurse practitioners working in population-focused primary care. This study was included in Bentley et al.'s (2016) review, but is included here in order to better represent the nurse practitioner's perspective. Kleiman's study is one of two studies included in this review

that explored nurse practitioners' own reflections on their work, providing this review with a perspective that was not directly observational or patient-focused.

Kleiman (2004) found that nurse practitioners assigned many meanings to their interactions with patients. Kleiman states that these interactions evolved within the context of the relationship between the nurse practitioner and patient. Kleiman found that nurse practitioners focused on their relationships with patients (which sometimes extended to patients' family, but the focus was on the patient), the meanings, and understandings that stem from this relationship that are not necessarily related to outcomes of health-related interventions. In other words, nurse practitioners were relationship-oriented rather than purely disease-oriented. One nurse practitioner in Kleiman's study emphasized, " 'It's the person-to-person exchange that is the most important aspect of patient care. Make them comfortable so you can communicate, find out what their needs are and take care of them'" (2004, p. 265). Kleiman reported that the interactions between nurse practitioners and patients were unhurried, open, and attentive, despite time concerns. Kleiman identified the following meanings from the interactions between nurse practitioners and patients: openness, connection, concern, respect, reciprocity, competence, time, and professional identity. These meanings reflect qualities that define valuing and affirming exchanges, such as attentiveness, availability, welcoming demeanor, authentic presence, values, and evocative interactions.

Some of the essential meanings discovered by Kleiman (2004)– particularly connection, concern, respect, and reciprocity– are reflected in Bentley et al.'s (2016) identification of affirming exchanges and patient engagement as key factors in the nurse practitioner-patient interaction. However, Bentley et al. did not fully capture the underlying finding that nurse practitioners consciously self-manage during patient interactions and engage in self-reflection. Kleiman thought that competence was demonstrated by nurse practitioners through their ability

to understand their own personal and professional capabilities and their ability to identify and act to meet patients' needs. This perspective integrates self-reflection with competence. This finding that self-reflection and self-management are integral to the nurse practitioner-patient interaction also underlies Defibaugh's (2014, 2015) studies and is a key element in Flemmer et al.'s (2014) framework. Kleiman remarks that the "connection [between nurse practitioner and patient] flourishes in an ongoing reciprocal process of collaborative engagement of the patient's health-related concerns" (p. 268), and this connection is sustained over time in an intimate, ongoing relationship. This remark by Kleiman is important because it signifies not a singular exchange, but rather a process that develops over repeated interactions that occur during the relationship. It suggests that reciprocity, or patient engagement, is one of the most important features in establishing longitudinal relationships with the patients, a finding that is shared with Defibaugh (2014, 2015) and Flemmer et al. (2014).

Nurse Practitioner-Patient Interaction as Resource Exchange

Whereas Kleiman (2004) focused on the connections made with patients on an emotional level, Koeniger-Donohue (2007) focused on the resource exchange between nurse practitioners and patients. Her exploratory descriptive study aimed to explore nurse practitioner-patient encounters from the nurse practitioner's perspective using a resource exchange paradigm. Koeniger-Donohue explained that "exchange theorists deal with valued resources that persons expect and receive which contribute to and build the exchange relationship" (p. 1051). The focus of the study was on what resources nurse practitioners anticipated they would provide to their patients before a visit, the resources that were actually provided, and the nurse practitioner's perception of what transpired after the visit. The study by Koeniger-Donohue was conducted with two expert nurse practitioner participants and eight patient participants in a women's health practice. Data consisted of pre- and post-encounter interviews with the nurse practitioners,

audio-recordings of the full encounters, and field notes made by the researcher. All the patients were middle-aged females. Koeniger-Donohue selected the nurse practitioners in her study purposely for their excellent reputations, so the practices of these expert nurse practitioners may not be typical of most nurse practitioners. The study is relevant to primary care as it was conducted in a primary care setting, with a population focused on women's health. Koeniger-Donohue used Foa and Foa's Resource Exchange Theory as a framework for interpreting her data, but she did not limit her interpretation when her findings did not fit within Foa and Foa's classes of resources. By adding an "affirmation" resource category in addition to Foa and Foa's standard categories, Koeniger-Donohue provided a better representation of her findings. Koeniger-Donohue's study was included in Bentley et al.'s (2016) review, but is included here in order to more fully capture the patient engagement theme. While the focus of Koeniger-Donohue's study was not necessarily on the therapeutic relationship between nurse practitioners and patients, her findings have implications for relationship development, particularly regarding factors that reinforce the relationship.

Koeniger-Donohue (2007) observed five out of six of Foa and Foa's Resource Exchange Theory classes of resources between nurse practitioners and their patients: services (activities that affect the body and include labour for another); information (advice, opinions, instruction); goods (tangible products); love (an expression of affectionate regard, warmth, or comfort); and status (an evaluative judgment that conveys prestige, regard, or esteem). Koeniger-Donohue noted that she did not see the resource class of money (currency or a standard unit of exchange) used in any of the nurse practitioner-patient interactions. Based on her observations, Koeniger-Donohue added a resource category called affirmation, which included the provision of reassurance, reinforcement, support and feedback. Koeniger-Donohue also noted that nurse practitioners more easily used the full range of resources in established relationships (compared

to new relationships). Although the focus of her study was on the nurse practitioner's perspective of what was given to the patient, it would be interesting to explore nurse practitioner-patient encounters from the patient's perspective using a resource exchange paradigm, in order to obtain complementary information about what resources patients expect, and how patients perceive the interactions using the same resource-exchange paradigm.

Though the categories of resources described in Koeniger-Donohue (2007)'s study were represented in the findings of Bentley et al.'s (2016) review, Bentley et al. did not emphasize the perspective that the resources used in interactions change depending on the stage of the relationship. This particular context factor was touched on by Defibaugh (2014, 2015). This perspective acknowledges that there are differences in how nurse practitioners may navigate resources during the initial establishment of the relationship versus an established relationship.

Patients' Assessments of Consulting a Nurse Practitioner

Williams and Jones (2006) conducted a qualitative study with the aim to explore patients' views about consulting with a primary care nurse practitioner. Williams and Jones conducted in-depth interviews with ten patients immediately after their consultation with one particular nurse practitioner. The patients were between the ages of 19-76, half were men, and half were women. It is noted that this study was a part of a wider case study conducted in the UK, and Williams and Jones emphasized that their findings reflected the findings of larger studies comparing nurse practitioners to general practitioners in terms of patient satisfaction. This study was conducted in primary care, thus is directly relevant to nurse practitioners in primary care. Williams and Jones' study was included in Bentley et al.'s (2016) review, but is included here to further describe the time factor in patient visits. This study is valuable as it uncovers patients' perspective on nurse practitioners' consultations, unlike Kleiman (2004) and Koeniger-Donohue (2007), whose studies focused on the perspectives of practitioners.

Williams and Jones (2006) found that all but one patient appreciated the extra time given by the nurse practitioner in the consultation in order to discuss all the issues. When the details of this visit were reviewed, it was found that the one patient who did not indicate appreciation for extra time was a 76 year-old male patient who visited for an emergency chest problem, whereas other patients appeared to be visiting for chronic conditions or minor acute infections. This finding may be explained due to the presumed emergent nature of this concern, thus efficiency may have been preferred over extra time. Otherwise, Williams and Jones found that patients appreciated having time to attend to complex emotional needs, discuss factors affected by their problem (such as family, work, and relationships), and appreciated the style of consulting, questioning, and discussing of treatment options other than prescriptions. These findings seem to indicate that it was not the extra time that was appreciated by patients, but that the practitioner went into more depth with the consultation as a result of the time given.

In Williams and Jones' (2006) study, patients with complex or chronic conditions seemed to have more satisfaction with longer visits. However, time is likely not the true reason for satisfaction. The importance of time as context was also mentioned by Bentley et al. (2016), Defibaugh (2014, 2015), Kleiman (2004), and Koeniger-Donohue (2007), though time was not explored in depth. Some of the patients' comments from Williams and Jones' study were not about time at all; instead, they commented on the nurse practitioner's thoroughness, less intimidating manner, lack of forceful directives, good listening, and flexibility with treatment approaches that met the patients' needs and upheld their values. These comments also reflect the competence and knowledge of nurse practitioners that was identified as a key factor by Bentley et al., Kleiman, and Koeniger-Donohue. Several of the patient comments in Williams and Jones' study reflect or demonstrate the other key factors of the nurse practitioner-patient interaction identified by Bentley et al. (2016); the essential components of Flemmer et al.'s (2014)

Empathetic Partnership model; the meanings discovered by Kleiman (2004); and the classes of resources described by Koeniger-Donohue (2007). Overall, Williams' and Jones' study contributes to this review by adding more of the patient's perspective and highlights the time factor in patient consultations.

Summary

In summary, this analysis has provided a critical review of the findings of the seven articles selected for inclusion in this literature review. This literature addressed the features of the nurse practitioner-patient interaction (Bentley et al., 2016); how solidarity is negotiated in nurse practitioner-patient interactions (Defibaugh, 2014); how identity is constructed in nurse practitioner-patient interactions through specific linguistic moves and stylistic choices (Defibaugh, 2015); what meaning nurse practitioners give to their lived experiences of their interactions with patients (Kleiman, 2004); how nurse practitioners view and conduct patient encounters from a resource exchange paradigm (Koeniger-Donohue, 2007); and patient views about consulting with a nurse practitioner in primary care (Williams and Jones, 2006). In addition, the Empathetic Partnership model from Flemmer et al. (2014) was presented for consideration.

In the findings, the authors described factors, elements, concepts, resources, and meanings within nurse practitioner-patient interactions. These factors, elements, concepts, resources, and meanings resulted in actions aimed at developing and maintaining the therapeutic relationship on the part of the nurse practitioners in the studies. For example, Defibaugh (2014) identified solidarity as an important concept in nurse practitioner-patient interactions. Defibaugh (2014) then described specific ways nurse practitioners established solidarity; the use of small talk was one of the actions that nurse practitioners took to establish solidarity. Another example is the identification of affirmation as a resource by Koeniger-Donohue (2007). Koeniger-

Donohue then described ways that nurse practitioners provided affirmation; using reassurance, reinforcement, support, and feedback were actions that nurse practitioners took to provide affirmation. A table of the factors, elements, concepts, resources, or meanings identified from each article is provided in Appendix C. The next chapter of this literature review synthesizes the background evidence with the literature search findings to identify what actions novice nurse practitioners can take to develop and maintain therapeutic relationships with adult patients in primary care.

Chapter Five

Discussion

The wide effects that therapeutic relationships can have on patients' health outcomes underscores the importance for novice nurse practitioners to develop and maintain these relationships in order to maximize patients' health outcomes. Through this literature review, the topic of therapeutic relationships between nurse practitioners and patients was explored, in order to better understand how the context of primary care and changes in professional education and focus might change how novice nurse practitioners develop and maintain therapeutic relationships. In addition, the shifting practice environment of nurse practitioners and its associated challenges may impact how novice nurse practitioners are able to develop and maintain therapeutic relationships with patients in primary care. An integrative literature review was conducted, guided by the following question: What actions can novice nurse practitioners take to develop and maintain therapeutic relationships with adult patients in primary care? A combination of qualitative and quantitative studies concerning nurse practitioner-patient interactions was examined. This chapter answers the research question. The chapter begins with a review of the key findings. This is followed by a discussion of the implications and proposed recommendations for clinical practice and future research. The implications and recommendations focus on the practice environment of nurse practitioners in primary care in British Columbia. Next, the limitations of this literature review are discussed. To complete this chapter, a final summary and conclusion are provided.

Key Findings

The literature analysis revealed four key themes regarding the actions of nurse practitioners: (a) competence and knowledge, (b) valuing and affirming exchanges, (c) patient engagement and reciprocity, and (d) appreciating context. Within these themes, several actions

taken by nurse practitioners are identified that may help novice nurse practitioners to develop and maintain therapeutic relationships. A summary table of the actions identified by theme is provided in Table 3 below. These actions will now be presented and discussed in light of the literature reviewed and the context of the question.

Table 3

Summary of Actions by Theme

THEMES	ACTIONS
Competence and Knowledge	- Uses/provides expertise and knowledge with/for patients [1, 2, 3, 4, 5, 6] - Aligns with the competent provider identity by attending to occupational and professional responsibilities and creating alignments to organizations and institution [3, 5] - Balances instrumental and interactional goals in patient consultations (i.e. follows the medical checklist but allows the topic to deviate based on the patient's responses) [3] - Reflects on own biases, cultures, power, and privilege [4, 6] - Reflects on own personal and professional capabilities and ability to identify and act to meet patient needs [5] - Questions roles, assumptions, and perceptions [4] - Sustains a knowledge base for diverse populations [4] - Considers individual patients within given statistical tendencies [4]
Valuing and Affirming Exchanges	- Provides affirming exchanges by giving emotional support and encouragement (empathy), showing concern, providing reassurance and reinforcement, giving full attention, making self available, being welcoming, and eliciting feedback [1-7] - Aligns with the caring provider identity and creating solidarity by using small talk and first-person pronouns (e.g., 'we' or 'our'), especially when discussing treatment options and engaging patients in decision-making [2, 3] - Demonstrates inquisitiveness/curiosity into patients' lives [1, 2, 3, 5] - Avoids interrupting narrative; instead, uses supportive moves to encourage narratives, such as saying 'yes', 'okay', and 'good' [2, 3] - Creates a comfortable communicational atmosphere by using lay terms that patients can understand [3] - Incorporates culturally safe actions, such as using nondiscriminatory and nonjudgmental language with attention to assumptions, avoiding diminishing or demeaning a person's culture[*4], and avoiding intimidation [4] - Demonstrates positive regard and openness with all patients [1, 4, 5]
Patient Engagement and Reciprocity	- Encourages patients to share their narratives [1, 2, 3, 5, 6] - Gets to know patients beyond their identity as patients [*1, 2, 3] - Discusses other life areas that are affected by the patient's problem (e.g., family, work, relationships) [1, 2, 3, 7] - Promotes partnership by communicating an understanding of the patient's feelings and worldview to the patient in a nonjudgmental way [4] - Involves patients in decision-making and respects patient self-determination [1-7] - Discusses treatment options with patients, especially options other than prescriptions[7]
Appreciating Context	- Consider context and purpose of visit [1] - Creates a culturally safe environment by displaying appropriate art and information in the care setting [4] - Identifies vulnerability [4] - Maintains unhurried consultations despite time concerns [2, 5, 6, 7] - Takes as much time as needed to provide an in-depth, thorough consultation[5, 6, 7]

1. Bentley et al. (2016); 2. Defibaugh (2014); 3. Defibaugh (2015); 4. Flemmer et al. (2014); 5. Kleiman (2004); 6. Koeniger-Donohue (2007); 7. Williams and Jones (2006).

The key findings and identified actions reflect the competencies for nurse practitioners in British Columbia, but specific actions that novice nurse practitioners should take are not clear within the competencies (CRNBC, 2010). Novice nurse practitioners are expected to be competent, but practicing in the new setting of primary care requires novice nurse practitioners to act in ways that may be different from registered nursing practice. The actions listed under the competence and knowledge theme can help novice nurse practitioners meet the competencies related to incorporating knowledge and providing information and education. There are specific actions that novice nurse practitioners can take to meet these competencies, such as sustaining a knowledge base for diverse populations and considering patients as individuals. Novice nurse practitioners might overlook certain actions when trying to meet these competencies, such as the actions around self-reflection and questioning assumptions. In addition, novice nurse practitioners may not feel competent in all visits to enact certain competencies in practice, such as incorporating knowledge from a variety of subjects to perform health assessment, make diagnoses, and provide therapeutic management. This will be discussed further in implications and recommendations.

The actions listed under the valuing and affirming exchanges theme can help novice nurse practitioners meet the competencies related to communication skills, coalition building, and patient education and counseling. The actions that novice nurse practitioners can take to meet the competencies related to communicating with patients about health assessment findings and diagnosis and applying their advanced knowledge and skills in communication and coalition building include giving emotional support and encouragement (empathy), showing concern, providing reassurance and reinforcement, giving full attention, making oneself available, being welcoming, eliciting feedback, using small talk and first-person pronouns, avoiding interrupting, using nondiscriminatory and nonjudgmental language, demonstrating positive regard and

openness, and avoiding intimidation. There are other specific actions that novice nurse practitioners may overlook when trying to meet the communication and patient education competencies, such as demonstrating inquisitiveness or curiosity into patients' lives. This particular action allows a better understanding of patients' perspectives and supports, thus resulting in the patient feeling known and being provided with education that takes their personal lifestyle into account. Novice nurse practitioners may be curious about their patients' lives but not realize that this helps meet competencies for practice. The actions under valuing and affirming exchanges also reflect Peplau's (1992) patient-centered approach to therapeutic relationships, Charlton et al.'s (2008) description of patient-centered communication, and support the assertion that nurse practitioners are attentive and caring (Sangster-Gormley & Canitz, 2015).

The actions listed under the patient engagement and reciprocity theme can help novice nurse practitioners meet the competencies related to exploring therapeutic options with patients, determining care options in negotiation with patients, evaluating and revising care plans with clients, and creating an environment that maximizes patient participation. The actions that novice nurse practitioners can take to determine care options and create an environment that maximizes patient participation include encouraging patients to share their narratives, getting to know patients beyond their patient identity, and discussing other life areas that are affected by the patient's problem. These actions help novice nurse practitioners explore therapeutic options with a patient while considering implications for the individual patient that are based on the patient's perspectives. These actions also help novice nurse practitioners educate using appropriate teaching and learning strategies, and coach and counsel patients while considering their personal responses. The actions that novice nurse practitioners can take to negotiate with patients and encourage active participation when prescribing drug therapy, determining care options, and

therapeutic interventions based on patient goals and preferences include promoting partnership, involving patients in decision-making, discussing treatment options, and respecting patient self-determination. The actions listed under patient engagement and reciprocity also take into account the values of patients in primary care (Laberge et al., 2014).

The actions listed under the appreciating context theme can help novice nurse practitioners meet the competencies related to creating an environment for effective communication and learning, and providing culturally competent care. The actions that novice nurse practitioners can take to meet these competencies include displaying appropriate art in the office, using nondiscriminatory and nonjudgmental language with attention to assumptions, avoiding diminishing or demeaning a person's culture, and avoiding intimidation. Some of these actions are listed under other themes, but also relate to appreciating context. Because novice nurse practitioners are still solidifying many competencies, they might overlook certain actions when trying to meet these competencies, such as maintaining unhurried consultations despite time concerns. The competencies for nurse practitioners do not mention anything specifically about timing of visits, though providing adequate time for visits likely facilitates the competency of teaching and maximizing client participation and control of their own health. In addition, the competencies do not particularly consider how the practice environment affects nurse practitioners' ability to enact the competencies.

There are several important differences in the findings of this review compared to the findings of Bentley et al.'s (2016) review. While the four key themes of this review are essentially the same as Bentley et al.'s three key factors, this review has greater focus on the practical application of the findings, which resulted in greater detail in regards to actions that novice nurse practitioners can take to develop and maintain therapeutic relationships with patients in primary care. For example, the inclusion of Defibaugh's (2014, 2015) articles in this

review allowed for greater description of linguistic choices that aid valuing and affirming exchanges. In addition, this review focuses on novice nurse practitioners and clinical recommendations that consider practice challenges.

Implications and Recommendations for Clinical Practice

A table summarizing the implications and recommendations for clinical practice can be found in Appendix D.

Professional identity. Since nurse practitioners' professional identity can shape interactional patterns between patients and themselves (Defibaugh, 2015), the new and developing identity of a novice nurse practitioner deserves attention. The new role of novice nurse practitioners involves changes to occupational and professional responsibilities, new knowledge and skills, as well as new organizational and institutional alignments. Novice nurse practitioners may already have a clear alignment with the caring provider identity, but in their new role in primary care, they may have a more tenuous alignment to the competent provider identity. Thus, actions like using their new expertise and knowledge with patients in primary care may initially be more difficult. Novice nurse practitioners may also identify concerns about competence upon reflecting on their capabilities, and may question their ability to identify and act to meet patient needs. A novice nurse practitioner who portrays an image of poor self-confidence may pass this perception onto patients as an image of nurse practitioners in general, thus negatively impacting the therapeutic relationship.

Novice nurse practitioners' identity may also be affected by how the context of primary care or responsibilities of providing medical care changes power dynamics in their relationships with patients. In Defibaugh's (2014) study, the power imbalance between nurse practitioners and patients was exaggerated by the hospital setting. For nurse practitioners in primary care, the power imbalance between themselves and patients may be less in the community setting, yet

novice nurse practitioners may feel it more intensely due to the recent transition to their new professional responsibilities. Novice nurse practitioners may feel more uncomfortable with this newfound sense of increased professional power and/or authority and its potential to increase the social distance between themselves and patients. Or, novice nurse practitioners may consciously or unconsciously use their new authority to be more directive of patients, instead of engaging patients and involving them in decision-making.

Recommendations. To address problems with professional identity, novice nurse practitioners can examine and use the list of actions in Table 3 to reflect on their own actions in practice. Self-reflection informs nurse practitioners' future interactions with patients, providing insights that are valuable to developing and maintaining therapeutic relationships over time and promoting self-awareness. Self-reflection should be a daily practice, whereby novice nurse practitioners reflect on patient visits in regards to all four key themes of this literature review as guidance, identify issues, and create actions to address the issues. Novice nurse practitioners could seek support from their nurse practitioner colleagues, mentors, and leaders to practice or discuss these actions. Nurse practitioner mentors or leaders could help novice nurse practitioners incorporate these actions into their formal learning plan, and nurse practitioner colleagues may be willing to act-out patient counseling cases with novice nurse practitioners to practice certain actions. Practice will improve novice nurse practitioners' skill and self-confidence with these actions, thus helping to develop and maintain therapeutic relationships with patients. Networking with other nurses by creating alignments to professional support organizations or groups (e.g., British Columbia Nurse Practitioner Association and/or practice-based small group learning programs or more informal journal/case review groups) could also provide opportunities for novice nurse practitioners to practice these actions and become more comfortable with their new professional identity.

Solidarity. Defibaugh (2014) thought that gaining solidarity with patients was a way in which nurse practitioners were able to demonstrate more perceived power in their new roles. If this is true, gaining solidarity as a way to demonstrate more power may allow nurse practitioners to align more with the competent provider identity, thus contributing to nurse practitioner self-confidence. Yet, the way nurse practitioners were observed to negotiate power with patients seems to be more closely related to valuing and affirming exchanges, as it was done in ways that engaged, reassured, and encouraged patients. However, in gaining solidarity with patients, the question arises as to whether this solidarity is in danger of being achieved at the expense of interprofessional relationships. If patients perceive themselves in solidarity with nurse practitioners, but not with other providers, this may create an us/them dynamic with other providers. Essentially, this risks becoming favoritism, which violates professional boundaries and fails to uphold the nursing standards set by the College of Registered Nurses of British Columbia. This favoritism can also limit patients' ability to create therapeutic relationships with other providers at the expense of one all-encompassing relationship, which is harmful because nurse practitioners and physicians in primary care often need to make referrals to other health-care providers. Furthermore, if other providers notice this us/them dynamic, nurse practitioners' ability to collaborate with other providers may be disrupted, as other providers will begin to view nurse practitioners in opposition to them. Hence, too much solidarity may exacerbate preexisting issues with quality of nurse practitioner-colleague relationships and cause further confusion for colleagues' understanding of nurse practitioners' role.

Recommendations. When aligning with patients for solidarity, the 'we' of solidarity should be extended not just to the nurse practitioner-patient team, but also to the health care team as a whole. Novice nurse practitioners in primary care can still create solidarity between themselves and patients, but need to be mindful to not create distance between themselves and

other providers. When sharing patient care with other nurse practitioners and/or physicians in the same office or on different teams, the novice can make reference to the other providers when using the term "we". For example, the novice nurse practitioner might say, "The physicians, other nurse practitioners, other health care team members, and I here at the primary care clinic are working together with you, your family, and the senior's clinic. Collectively, we will help to achieve your goal of remaining at home."

Role ambiguity. Role ambiguity can cause difficulties in understanding the changes to occupational and professional responsibilities. In addition, this role ambiguity can also contribute to strained relationships with other providers, thus limiting support for novice nurse practitioners. Without support from interprofessional colleagues, managers and other staff, patient care may be impacted, thus therapeutic relationships may be hindered between nurse practitioners and patients. Role ambiguity could be passed on to patients as well. When patients are seen in collaborative practice settings in primary care where patient rosters are shared, other practitioners may provide patients with inadvertently false information about the role of the nurse practitioner. Patients may even perceive that nurse practitioners who work in primary care offices with physicians are not autonomous, resulting in a more negative view of nurse practitioners, thus affecting nurse practitioners' ability to develop and maintain therapeutic relationships with patients. This lack of understanding about the role of nurse practitioners in primary care may also be reinforced by the limitations imposed by the lack of long-term funding model for nurse practitioners in British Columbia and other practice challenges.

Recommendations. Role ambiguity may dissipate as more time passes and nurse practitioners become more integrated in the British Columbia health care system. For now, some of the actions that help develop and maintain therapeutic relationships with patients can also improve nurse practitioner role clarity. Reflecting on their professional capabilities can help

novice nurse practitioners improve role clarity for themselves. Using their expertise and knowledge and creating alignments to organizations and institutions can help novice nurse practitioners improve nurse practitioner role clarity for others. When starting a new position, novice nurse practitioners can use their expertise and knowledge to talk with colleagues about their experiences with nurse practitioners, and/or attend a staff meeting to introduce themselves and explore staff/colleague perceptions and understanding about nurse practitioners. Novice nurse practitioners can align with their nurse practitioner practice leader to discuss education for physician colleagues through partnership with the local division of family practice or medical advisory committee, or the provincial general practice services committee. Nurse practitioner practice leaders may also be able to develop and facilitate education for health authority leadership and specialists, perhaps through the distribution of health-authority wide notices about the addition of nurse practitioners to their teams and how this impacts other practices and referrals for their services.

Novice nurse practitioners can also consider aligning with the British Columbia Nurse Practitioner Association to further the discussion on nurse practitioner role clarity with government, interdisciplinary team members, and patients. By evaluating and/or redefining the purposes, priorities, functions, and tasks of primary care, the identified functions and tasks can then be aligned into roles and positions for nurse practitioners that are matched to their skills and capabilities. Novice nurse practitioners can educate themselves about and advocate for funding models that facilitate better understanding of the contributions and role of nurse practitioners in the health care system. Different models may be better suited for different areas, depending on population and provider size and characteristics, and resources. The British Columbia Nurse Practitioner Association recently published a document titled *Primary Care Transformation in British Columbia: A New Model to Integrate Nurse Practitioners* (Prodan-Bhalla & Scott, 2016),

that nurse practitioners can read to familiarize themselves with some of the models that are proposed, and to advocate for a model that will work in their practice. Novice nurse practitioners in British Columbia can become involved at advocating at whatever level they are comfortable, including discussing practice issues (e.g., rigid performance measures) with colleagues, practice leaders, or management (alone or with practice or colleague support); participating in formal practice surveys; providing feedback to the British Columbia Nurse Practitioners Association; and lobbying government.

Patient empanelment. Some challenges for novice nurse practitioners are employer, position, or location specific, such as whether patients can be empaneled by the nurse practitioner, size of patient panel or volume of patient visits, and characteristics of the patient panel. Nurse practitioners in primary care do not need to be able to empanel their own patients in order to develop and maintain therapeutic relationships, but novice nurse practitioners may have more difficulty with patient engagement and reciprocity if they feel they have been empanelled too many patients. Novice nurse practitioners may not feel that they have enough time for some actions; for example, getting to know their patients beyond their patient identity, discussing other life areas that are affected by the patient's problem, and involving patients in decision-making. The pressure to see more patients may also cause novice nurse practitioners to have some difficulty with valuing and affirming exchanges, specifically using small talk and encouraging patient narratives.

Recommendations. A fair caseload will vary depending on community size, supports, and population needs. In order to advocate to their employers for a well-rationalized and fair caseload, novice nurse practitioners can look to research for evidence regarding fair caseloads for nurse practitioners in primary care. Novice nurse practitioners can then discuss adequate time

for patient visits with site managers, colleagues, or employers. The exact number of patients or visits per day will be variable between nurse practitioners, depending on setting, complexity, patient needs/wants, and experience level. A plan for a fair caseload for a novice nurse practitioner may include more administration time at the outset, a few call-backs for some patients, or longer visits with certain patients for the first few months. Novice nurse practitioners may find it helpful to connect with colleagues through their local community of practice and/or the new British Columbia Nurse Practitioners Association's Member Forum on Facebook. Novice nurse practitioners can then compare practices and reflect on their own personal capabilities.

Complex patients. Novice nurse practitioners in primary care who predominantly care for complex and/or high-needs patients may find that these complex visits necessarily require more time to explore issues in more depth and breadth with patients. In addition to time pressures, novice nurse practitioners may feel more stress and fatigue from the increased intensity and frequency of interactions with complex or high-needs patients. Thus, novice nurse practitioners may require more support from colleagues and may need to be very mindful in taking measures to maintain psychological fitness to practice. Actions for valuing and affirming exchanges and patient engagement and reciprocity take more time with complex patients, but are necessary for developing and maintaining therapeutic relationships and improving health outcomes.

Recommendations. Developing and maintaining therapeutic relationships with complex patients requires novice nurse practitioners to engage in daily self-reflection as part of maintaining psychological fitness to practice. Novice nurse practitioners can practice the actions under knowledge and competence, valuing and affirming exchanges, patient engagement and

reciprocity, and appreciating context consistently across all types of visits. Flemmer et al.'s (2014) model of empathetic partnership for primary care was designed with marginalized or more complex patients in mind, and the six key elements of Flemmer et al.'s model (reflection, environment, language, knowledge, and partnership and empathy) incorporate all the themes for actions that nurse practitioners can take to develop and maintain therapeutic relationships with patients in primary care. Thus, this model is recommended for nurse practitioners working with complex patients in primary care. If Flemmer et al.'s model were used in practice, it would need to be taken up by the practice team as a whole, so as to provide consistency of approach, and equivalent potential for therapeutic relationships between providers and patients. Additionally, a team approach for complex patients may be beneficial for a number of reasons, including better support for novice nurse practitioners. Working in a team may help to prevent psychological distress or burnout over time, and may be more beneficial for nurse practitioners and patients, opposed to independent practice settings.

Care transitions. A potential disruption in the consistency of care between nurse practitioners and patients in primary care occurs when patients become hospitalized or transition to other care settings (such as moving to a long-term care facility or community mental health facility, becoming home-bound, or requiring referral to another provider for something outside of the nurse practitioner's scope of practice). Since patients value continuity in primary care–or at least providers who are knowledgeable about their problems and history–and this continuity is associated with improved provider-patient communication, it is important to consider how to maintain therapeutic relationships during transitions in care. In this situation, the nurse practitioner may not be able to provide the expertise to manage the patient's current condition and there may be a sense of loss of partnership and reciprocity between patients and their primary care providers. Furthermore, a major health crisis, such as one that requires

hospitalization, would likely make patients feel more vulnerable, partly due to a loss of provider continuity. However, there are actions novice nurse practitioners can enact in order to maintain therapeutic relationships with patients who transition to other care settings.

Recommendations. Nurse practitioners need to address transitions in care and prepare their patients in advance. In regards to hospitalization, novice nurse practitioners can advise their patients about this limit on practice, advise patients how providers are notified about hospitalizations and how they are able to remain updated on their condition (e.g., through electronic records), and reassure patients that the nurse practitioner (or perhaps another colleague from the same practice) will still visit them while they are in hospital (if this is possible, depending on the location of hospital within a reasonable distance) or will speak with hospital care providers (as needed) to receive updates as to the patient's progress and expected discharge date. Information should also be given about how (or whether) ongoing care from the nurse practitioner will be provided during other transitions in care (as applicable), such as patient movement to a long-term care facility, community mental health facility, or becoming home-bound. When patients are referred to other care teams (e.g., private counseling, or home care nursing), novice nurse practitioners can discuss with patients how the teams work together to meet patients' goals. In addition, novice nurse practitioners should create a clear care plan to address how care will be provided when it is outside of the nurse practitioner's scope (e.g., collaboration with another physician in a shared practice, or referral outside of primary care). Having this care plan established in advance would help patients to feel that their needs will be met and that they are comprehensively cared for by the nurse practitioner.

Summary. The new role and identity of novice nurse practitioners and new role in primary care comes with changes to occupational and professional responsibilities, and organizational and institutional alignments, thus changing how the proposed actions may be

enacted. In consideration of the challenges for novice nurse practitioners, the findings and proposed actions have many implications for practice. Competence (or perceived competence) may be affected by role identity. Enacting solidarity and problems with role ambiguity can potentially worsen interprofessional relationships, decreasing support for novice nurse practitioners and generally making it more difficult for novice nurse practitioners to develop and apply their newfound knowledge and competence. Assigned patient panels with expectations for high numbers of patient visits may lead to difficulties with patient engagement, reciprocity, and some actions for valuing and affirming exchanges. Complex patients may require more time and energy of novice nurse practitioners. Transitions in care present challenges for developing and maintaining therapeutic relationships. The actions identified for developing and maintaining therapeutic relationships can address some of the challenges identified by the implications for practice. The other recommendations for addressing the implications and challenges can better enable novice nurse practitioners to take action to develop and maintain therapeutic relationships with patients in primary care.

Recommendations for Research

Unfortunately, there was no literature found that directly studied the therapeutic relationships between nurse practitioners and patients in primary care. This may be due in part to the associated difficulty in designing high-quality studies that would not be challenged by too many interfering factors. Considering that therapeutic relationships underlie every interaction with patients, the lack of research may also be due to the difficulty in separating the components of the therapeutic relationship from the other more objective elements of providing primary care. As a result, this literature review has generated implications for research. Due to the lack of consensus on the relational processes, provider competencies, and relational outcomes of therapeutic relationships in primary care, a concept analysis may be helpful. Due to the lack of

nurse practitioner-specific information regarding developing and maintaining therapeutic relationships, it may be beneficial to research and develop models for therapeutic relationships between nurse practitioners and patients in primary care. Due to the implications for nurse practitioners in primary care who work predominantly with complex patients, it may be beneficial to research how relationships between primary care providers and complex patients may be different than relationships with patients who have simpler health care issues, and how therapeutic relationships with complex patients can be best maintained over long periods of time. Due to the number of implications and recommendations related to practice environment, future research should also focus on how practice environment affects nurse practitioners' (and other primary care providers') ability to develop and maintain therapeutic relationships.

Limitations

There are several considerations that limit the strength of the recommendations made in this literature review. The conceptual consistency of components discussed in each of the studies is unknown. For example, Kleiman's (2014) concepts of connection, concern, respect, and reciprocity were thought to be similar concepts to Bentley et al.'s (2016) concepts of affirming exchanges and patient engagement. While a glossary of terms may provide some clarification, I found this to be of little value, as many of these concepts were not defined in the studies themselves. When the authors used terms like "patient-centered" to describe findings, the descriptions of those terms provided in the studies were used instead. This allowed for greater precision in the meaning of the concept in the study, comparing and contrasting concepts between findings, and uncovering conceptual consistency. Still, conceptual consistency from study to study cannot be confirmed with exact certainty.

This literature review did not aim to examine the impact of patient and provider factors on therapeutic relationships, such as age, gender, ethnicity and culture. As stated in the

background, these factors cannot be controlled by nurse practitioners in practice. Although it is difficult to make inferences into the effects that these factors had on the results of the studies presented, the presence and effect of specific cultural beliefs in the participating patients cannot be eliminated. However, factors such as these are not alterable, and controlling for such factors is likely of little value to most general practices that roster a variety of patients from different age groups, genders, ethnicities, and cultures.

The geographic location of the studies may have some affect on how nurse practitioners are perceived by patients and other providers. Based on the political, environmental, and professional climate, challenges and facilitators to nurse practitioner-patient interactions also vary from location to location. Thus, application of this literature review's findings may be limited in areas where nurse practitioners are well established and well integrated into the regional (or national) health care system. While the focus of this literature review was on the context of practice in British Columbia, the findings of this review could still be applied to other locations that are experiencing similar challenges that may be related to the newness of the nurse practitioner role.

Summary and Conclusion

The results of this literature review have answered the question of what actions novice nurse practitioners can take to help develop and maintain therapeutic relationships in primary care. The findings can also be used to describe more specific actions that novice nurse practitioners can take to meet the College of Registered Nurses of British Columbia's entry-level competencies for nurse practitioners (CRNBC, 2010). Based on the identified implications of these actions for novice nurse practitioners in British Columbia, several recommendations for clinical practice have been made. Challenges for novice nurse practitioners include role identity, role clarity, quality of interprofessional relationships, and extrinsic obstacles (e.g., patient

empanelment, credentialing and privileges, and funding models). These challenges can be addressed or reduced by adopting the recommendations for clinical practice. In addition, this literature review provides recommendations for future research to address the gaps in knowledge regarding the concept of therapeutic relationships in primary care, models for therapeutic relationships, therapeutic relationships with complex patients, and the effects of practice challenges on therapeutic relationships.

Perhaps it was Greenhalgh and Heath (2010) who best captured the essential challenge in examining how practitioners can improve their therapeutic relationships: "the therapeutic relationship is a complex, intersubjective and dynamic phenomenon that cannot be fully captured objectively or reduced to a set of competencies or behaviours." (p. 31). The identified actions are not intended to be used as a checklist for practice. Instead, the identified actions must be considered within the individual, organizational, social, environmental and political contexts of practice. Despite this complexity, there is great value in the study of therapeutic relationships. This literature review has identified that practicing as a nurse practitioner in primary care is largely about therapeutic use of the nursing self in the context of providing medical care, while navigating the context and challenges of advanced practice. This literature review is a valuable to contribution to practice because nurse practitioners in primary care, from novice to experienced practitioners, have to make complex, context-bound judgments about how to approach consultations with patients, and all while navigating difficult times throughout the therapeutic relationship. This literature review can prompt self-reflection and awareness, and foster advancement by helping novice nurse practitioners to enact and further develop their practice through consideration of the actions identified in this literature review.

References

Ainsworth-Vaughn, N. (1998). *Claiming power in doctor-patient talk*. Oxford, England: Oxford University Press.

Auditor General of British Columbia. (2017). *Physician funding models*. Retrieved from http://www.bcauditor.com

Bentley, M., Stirling, C., Robinson, A., & Minstrell, M. (2016). The nurse practitioner-client therapeutic encounter: An integrative review of interaction in aged and primary care settings. *Journal of Advanced Nursing, 72*(9), 1991-2002. doi:10.1111/jan.12929

Berry, S., Bloch, J., Goldenthal, H., Higgins, S., Hoath, L., Mattar, P…. Westamacott, G. (Producers). (2017, May 03). *Government has to stop looking for cheap way to address doctor shortage, says GP* [Audio podcast]. Retrieved from http://www.cbc.ca/radio/thecurrent/

Brown, M. A., & Olshansky, E. F. (1997). From limbo to legitimacy: A theoretical model of the transition to the primary care nurse practitioner role. *Nursing Research*, *46*(1), 46-51.

Burge, F., Haggerty, J. L., Pineault, R., Beaulieu, M., Lévesque, J., Beaulieu, C., & Santor, D. A. (2011). Relational continuity from the patient perspective: Comparison of primary healthcare evaluation instruments. *Healthcare Policy, 7*(Special Issue), 124-138.

Byrne, P., & Long, B. (1976*). Doctors talking to patients: A study of verbal behaviors of doctors in the consultation*. London, England: Her Majesty's Stationery Office.

Canadian Institute for Health Information. (2015). *Regulated nurses, 2014: RN/NP data tables*. Retrieved from https://www.cihi.ca/en

Canadian Institute for Health Information. (2016). *Supply, distribution and migration of physicians in Canada, 2015: Data tables*. Retrieved from https://www.cihi.ca/en/physicians

Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa, ON: Author. Retrieved from https://www.cna-aiic.ca

Canadian Nurses Association. (2010). *Canadian nurse practitioner: Core competency framework.* Ottawa, ON: Author. Retrieved from https://www.cna-aiic.ca

Charlton, C. R., Dearing, K. S., Berry, J. A., & Johnson, M. J. (2008). Nurse practitioners' communication styles and their impact on patient outcomes: An integrated literature review. *Journal of the American Academy of Nurse Practitioners, 20*(7), 382-388. doi:10.1111/j.1745-7599.2008.00336.x

College of Family Physicians of Canada. (2012). *Best advice: Patient rostering in family practice.* Retrieved from: http://www.cfpc.ca

College of Family Physicians of Canada. (2016). *Four principles of family medicine.* Retrieved from http://www.cfpc.ca

College of Registered Nurses of British Columbia. (2010). *Competencies required for nurse practitioners in British Columbia* (Pub. No. 416). Vancouver, BC: Author. Retrieved from https://www.crnbc.ca/

College of Registered Nurses of British Columbia. (2013). *Boundaries in the nurse-client relationship* (Pub. No. 432). Retrieved from https://crnbc.ca

College of Registered Nurses of British Columbia. (2017). *Nurse practitioners*. Retrieved from https://www.crnbc.ca/

Critical Appraisal Skills Programme. (2013). *CASP checklists*. Retrieved from http://www.casp-uk.net

Defibaugh, S. (2014). Solidarity and alignment in nurse practitioner-patient interactions. *Discourse & Communication, 8*(3), 260-277. doi:10.1177/1750481314537573

Defibaugh, S. (2015). *Identity construction in nurse practitioner-patient interactions* (Doctoral dissertation). Retrieved from https://www.ideals.illinois.edu

Donabedian, A. (1966). Evaluating the quality of medical care. The Milbank Quarterly, 83(4), 691-729.

Faraz, A. (2016). Novice nurse practitioner workforce transition into primary care: A literature review. Western Journal of Nursing Research, 38(1), 1531-1545. doi: 10.1177/0193945916649587

Flemmer, N., Dekker, L, & Doutrich, D. (2014). Empathetic partnership: An interdisciplinary framework for primary care practice. *The Journal for Nurse Practitioners, 10*(8), 545-551.

Grainger, K. (2004). Verbal play on the hospital ward: Solidarity or power? *Multilingua, 23*(1-2), 39-59.

Greenfield, S., Kaplan, S. H., Ware, J. E., Jr., Yano, E. M., & Frank, H. J. (1988). Patients' participation in medical care: Effects on blood sugar control and quality of life in diabetes. *Journal of General Internal Medicine, 3*(5), 448-457.

Greenhalgh, T., & Heath, I. (2010). *Measuring quality in the therapeutic relationship*. Retrieved from: http://www.kingsfund.org.uk

Griffin, S. J., Kinmonth, A. L., Veltman, M. W., Gillard, S., Grant, J., & Stewart, M. (2004). Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: A systematic review of trials. *Annals of Family Medicine, 2*(6), 595-608.

Heath, C. (1992). The delivery and reception of diagnosis and assessment in the general practice consultation. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings*. Cambridge: Cambridge University Press.

Heritage, J., & Clayman, S. (2010). *Talk in action: Interactions, identities, and institutions.* Oxford, England: Wiley-Blackwell.

Hojat, M., Louis, D. Z., Markham, F. W., Wender, R., Rabinowitz, C. G., & Gonnella, J. S. (2011). Physicians' empathy and clinical outcomes for diabetic patients. *Academic Medicine, 86*(3), 359-364. doi:10.1097/ACM.0b013e3182086fe1.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science, 241*(4865), 540-545.

Johnson, R. (1993). Nurse practitioner-patient discourse: Uncovering the voice of nursing in primary care practice. *Scholarly Inquiry for Nursing Practice: An International Journal, 7*(3), 143-163.

Kaplan, S. H., Greenfield, S., & Ware, J. E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care*, 27(3 Suppl), S110-S127.

Kelley, J. M., Kraft-Todd, G., Schapira, L., Kossowsky, J., & Riess, H. (2014). The influence of the patient-clinician relationship on healthcare outcomes: A systematic review and meta-analysis of randomized controlled trials. *PLoS ONE, 9*(4), e94207. doi: info:doi/10.1371/journal.pone.0101191

Kitson, A., Marshall, A., Bassett, K., & Zeitz, K. (2013). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing 69*(1), 4-15. doi:10.1111/j.1365-2648.2012.06064.x.

Kleiman, S. (2004). What is the nature of nurse practitioners' lived experiences with patients? *Journal of the American Academy of Nurse Practitioners, 16*(6), 263-269.

Koeniger-Donohue, R. (2007). Nurse practitioner-client interaction as resource exchange: The nurse's view (NP-client interaction). *Journal of Clinical Nursing, 16*(6), 1050-1060.

Krumholz, H. M, Butler, J., Miller, J., Vaccarino, V., Williams, C. S., Mendes de Leon, C. F., … Berkman, L. F. (1998). Prognostic importance of emotional support for elderly patients hospitalized with heart failure. *Circulation, 97*(10), 958-964. doi:10.1161/01.CIR.97.10.958

Kuhl, D. (2013). *Relationships and healing: What we know cures; who we are heals*. Workshop presented at the College of Physicians and Surgeons of British Columbia Education Day and Annual General Meeting 2013, Vancouver BC. Retrieved from https://www.cpsbc.ca

Laberge, M., Pang, J., Walker, K., Wong, S., Hogg, W., & Wodchis, W. P. (2014). *QUALICOPC (Quality and costs of primary care) Canada: A focus on the aspects of primary care most highly rated by current patients of primary care practices.* Retrieved from http://www.cfhi-fcass.ca

Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldstein (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 94-129). New York, New York: Basic Books.

Levenstein, J. M., McCracken, E. C., McWhinney, I. R., Stewart, M. A., & Brown, J. B. (1986). The patient-centred clinical method. 1. A model for the doctor–patient interaction in family medicine. *Family Practice, 3*(1), 24–30.

Li, H., Koehn, C., Desroches, N., Yum, Y., & Deagle, G. (2007). Asymmetrical talk between physicians and patients: A quantitative discourse analysis. *Canadian Journal of Communication, 32*(3), 417-433.

Miller, W. L., Crabtree, B. F., Nutting, P. A., Stange, K. C., & Jaén, C. R. (2010). Primary care practice development: A relationship-centered approach. *Annals of Family Medicine, 8*(Suppl 1), s68-s79. doi:10.1370/afm.1089.

Mohammadi, E., Abedi, H. A., Jalali, F., Gofranipour, F., & Kazemnejad, A. (2006). Evaluation of 'partnership care model' in the control of hypertension. *International Journal of Nursing Practice, 12*(3), 153-159.

Mumford, E., Schlesinger, H. J., & Glass, G. V. (1982). The effect of psychological intervention on recovery from surgery and heart attacks: An analysis of the literature. *American Journal of Public Health, 72*(2), 141-151.

Osler, W. (1892). *Principles and Practice of Medicine*. New York, New York: Appleton.

Peden, A., Staal, J., Rittman, M., & Gullett, D. (2015). Nurse-patient relationship theories: Hildegard Peplau, Joyce Travelbee, and Ida Jean Orlando. In M. Smith, & M. Parker (Eds.), *Nursing theories and nursing practice* (4th ed., pp. 67-86). Philadelphia, PA: F. A. Davis Company.

Peplau, H. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly, 5*(1), 13–18.

Peplau, H. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly, 10(*4), 162-167.

Prodan-Bhalla, N., & Scott, L. (2016). *Primary care transformation in British Columbia: A new model to integrate nurse practitioners*. Retrieved from: http://www. http://bcnpa.org

Registered Nurses Association of Ontario. (2012). *Establishing therapeutic relationships*. Retrieved from http://www.rnao.org

Robinson, J. D., Tate, A., & Heritage, J. (2016). Agenda-setting revisited: When and how to primary-care physicians solicity patients' additional concerns? *Patient Education & Counseling, 99*(5), 718-723.

Sangster-Gormley, E., & Canitz, B. (2015). *A survey of nurse practitioner practice patterns in British Columbia. January 2014*. Victoria, BC: University of Victoria.

Sheridan, N. F., Kenealy, T. W., Kidd, J. D., Schmidt-Busby, J. L., Hand, J. E., Raphael, D. L., … Rea, H. H. (2012). Patients' engagement in primary care: Powerlessness and compounding jeopardy. A qualitative study. *Health Expectations, 18*(1), 32-43. doi:10.1111/hex.12006

Silverman, B. D. (2012). Physician behavior and bedside manners: The influence of William Osler and The Johns Hopkins School of Medicine. *Proceedings of Baylor University Medical Center, 25*(1), 58-61.

Squier, R. W. (1990). A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships. *Social Science Medicine, 30*(3), 325-339.

Stivers, T. (2007). *Prescribing under pressure: Parent-physician conversations and antibiotics*. New York: Oxford University Press.

Street, R. L., Jr., & Voigt, B. (1997). Patient participation in deciding breast cancer treatment and subsequent quality of life. *Medical Decision Making, 17*(3), 298-306.

Sullivan-Bentz, M., Humbert, J., Cragg, B., Legault, F., Laflamme, C., Bailey, P. H., & Doucette, S. (2010). Supporting primary health care nurse practitioners' transition to practice. *Canadian Family Physician*, *56*(11), 1176-1182.

Ward, M. M., Sundaramurthy, S., Lotstein, D., Bush, T. M., Neuwelt, C. M., & Street, R. L. (2003) Participatory patient-physician communication and morbidity in patients with systemic lupus erythematosus. *Arthritis Care and Research, 49*(6), 810-818.

Whittemore, R., & Knafl, K. (2005). *The integrative review: Updated methodology. Journal of Advanced Nursing, 52*(5), 546-553.

Wiechula, R., Conroy, T., Kitson, A. L., Marshall, R. J., Whitaker, N., & Rasmussen, P. (2015). Umbrella review of the evidence: What factors influence the caring relationship between a nurse and patient? *Journal of Advanced Nursing, 72*(4), 723-734. doi:10.1111/jan.12862

Williams, A., & Jones, M. (2006). Patients' assessments of consulting a nurse practitioner: The time factor. *Journal of Advanced Nursing, 53*(2), 188-195.

Appendix A

Literature Review Matrix

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Bentley et al. (2016) Integrative review using Whittemore and Knafl's methodology. To review key features of NP-ct interaction in therapeutic encounter to inform the development of NP-led memory clinics. Focus on care of older people in community and facilities. Included primary care settings. Authors are research fellows or professors in health sciences and nursing, all from Australia.	- 10 studies included, representing >900 NPs and their cts. - qualitative, quantitative, mixed methods - search methods and search terms well-described - quality of papers included were assessed using certain criteria; all studies assessed as moderate in quality - data abstraction and synthesis described - studies included in the review were from the US and UK - detailed analysis of individual articles	- 3 key factors of NP-ct interation: NP expertise & influence of context (clinic setting, visit purpose); affirming exchange; high levels of ct engagement. - affirming communication= positive regard, respect, trust, openness, asking for more information about ct's lives/condition - affirming exchange= giving emotional support of encouragement20154 - social and emotional aspects of pt's lives discussed when the context of the encounter required it- e.g. concerns with acceptability/cost of treatments - high pt satisfaction tied to style of communication (biopsychosocial engagement provides affirming exchange) and time spent with ct - with this approach, cts are more engaged, more satisfied, and more likely to adhere to tx plans - to understand each episode of care as a therapeutic encounter	- the therapeutic encounter is where the therapeutic relationship is developed and maintained, thus answers questions about features of these encounters that have positive results with patients, thus may contribute to maintain therapeutic relationships - noted that different contexts created different types of therapeutic encounter- implications for primary care setting where patients present in different contexts over a long period of time- does increased breadth of contexts of visits in primary care contribute to therapeutic relationships? - review included articles that studied the PC setting and studied NPs, thus very applicable

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Defibaugh (2014) Ethnographic research study discussing how solidarity is negotiated in interactions during medical visits between NPs and pts. Sample was one female NP working as diabetes specialist on internal medicine team in hospital, plus 20 of her patients (13F, 7M, age 28-82). Data collected over 2 month period July-Aug 2012. Included pre and post interviews with NP, audio-recordings of medical visits, and written survey for patients. Focus on NP in inpatient setting (not primary care) Author is philosophy major from U of Illinois US	- used multi-theoretical approach: transcribed recordings of medical visits, observational data, and interviews - used conversation analysis as analytical framework - does not explain how the NP was chosen - data based on only one NP's consultations - need to consider other contextual factors to fully understand the influence of solidarity and alignment, and the author does mention tehis	- NP decreases social distance between self and pt, allows pt to share power, and allows pt to identify as self outside of pt identity. This creates solidarity btw NP and pt. - NP does this by using small talk, saying "we" or "our" (1st person plural pronouns)when discussing tx options and decision-making (this creates a sense of shared ownership, shared role of experiencer, and shared decision maker), encouraging pt to speak/share narratives, and being interested in their non-pt identity - pt's also use "we" in similar ways - NP doesn't interrupt, enacts supportive moves (e.g. yes, okay, good, aren't you glad you mentioned it) - reasons for solidarity may be the middle space position of the NP in the medical hierarchy/pt's eyes/NP's eyes - the NP said she worked more on the relationship with the pt because she perceived that pts would not tolerate any negative interaction with her whereas they would tolerate more from the attending physician; feels pts will ask her to leave but wouldn't for the MD - in this way, gaining solidarity with the pt may provide the NP with more perceived power	- discusses new concepts- solidarity and alignment- in the therapeutic relationship that are only hinted at in other articles, but clearly have influence on aspects of the therapeutic relationship described by other authors – although the NP's relationship in hospital context is short-term, solidarity and alignment certainly would have effects in longitudinal context, building relationship over time - not a primary care setting, so there is the impact of the inpt context and the power imbalance within the hospital context (pt taken out of community/ normal environment= more vulnerable) - types of interactions- e.g. discussing new diagnosis, changing medications- are similar to what is done in primary care (e.g., the NP in this setting wasn't performing specialized hospital procedures)

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Defibaugh (2015) Doctoral dissertation based on an ethnographic study exploring identity construction in NP-pt interactions as it occurs through specific linguistic moves and stylistic choices. Sample was 48 medical visits with 5 different NPs. Data from audiorecordings of visits and interviews with providers and pts. Uses Agha's theory of figures of personhood. Patients aged 28-82, 13F 7M Focus is on inpatient and outpatient visits: 1 inpatient diabetes specialist NP (20 visits with pts), 4 outpatient NPs at community clinic (3 at men's health primary care clinic and one from cardiac clinic; total 28 visits with pts). Location Midwest US. Used audiorecordings and post-visit interviews with pts and NPs. 2-phase data collection (the inpt NP was used in Defibaugh's previous work). Author is philosophy major from U of Illinois US	- Ethnographic discourse analytic methodology - uses both emic and etic viewpoints - very detailed, thorough description of data collection and analysis - all female NPs used	- NPs are able to balance both instrumental and interactional goals to construct the ID of "caring and competent" provider, using a pt-centered approach - NPs align with caring provider ID using linguistic moves of solidarity (e.g. using small talk, inclusive 1st person pronouns, hedging and indirect speech) - NPs align with competent provider ID by attending to their occupational and professional responsibilities, recognizing responsibility to pts, and creating alignments to organizations and prof institutions. Also share knowledge and use singular 1st person pronouns, use of "I" and institutional "we", to highlight medical competency - use of "I" as experienced authority figure - use lay terms and translate health information, providing "epistemic access" to medical info for the pt - follow medical checklist but allow topic to deviate based on pt responses; direct attention to what NP feels is important but still address pt concerns - balance of interpersonal (using caring ID) and instrumental goals (using competent ID) - Pts align with different IDs- deferent pt (older, not sanctioned by NPs), good pt, pt-consumer -"small talk can be seen as one way in which providers are able to build long-term relationships with patients through a focus on interpersonal rather than instrumental goals" (p. 62) - dual responsibility with use of"we" in different ways- including pt in NP actions, including self in pt actions (sometimes pts do this too) - use of "we" encourages shared connection and responsibility, sense of devotion	- expands on earlier 2014 article which discussed techniques, but explains in more detail how pts and NPs view the NP as caring and competent and that this balance is what gives pts satisfaction - references the relevance of findings to developing long-term relationships with pts, as those seen in primary care - unlike previous 2014 article, this is based mostly on NPs in primary care role (4/5 NPs in primary care) - findings align with caring themes in other articles

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Defibaugh (2015)		- indirect speech, including use of mitigated and justified advice, for medical directives allows for shared decision-making, decreases imposition on pt, thus creates rapport, improved relationships. - NPs prioritize rapport and relationship building - pt's co-construct competent provider by confirming info told to them by others - pts were very satisfied and rated these NPs highly - pts also construct their own identities: deferent pt, good pt, knowledgeable but non-compliant pt, and non-pt (often shifting, rather than static IDs) - pts may be willing to share more about themselves (non-pt ID) personally due to the "middle spacing" of the NP/ NP not as powerful/distant as MD	
Flemmer et al. (2014) Presentation of framework, to create effective and therapeutic partnerships with patients. Authors are a FNP, educator, and CNS, all from New Zealand. No patient data- exemplar for women who have sex with women/ used theories relevant to vulnerable or marginalized patients	- uses WSWs as an example of a marginalized population; this focus on marginalized patients is relevant to the patient rosters of many NPs in BC - framework can be used for all pts, not just marginalized pts - framework influenced by New Zealand nursing's cultural safety- ? applicability to BC - has not been tested in practice- no original research to support the framework, though the key elements of the framework were developed from other research	- Empathetic Partnership comprises 6 elements: reflection, environment, language, knowledge, partnership, and empathy - reflection: reflect on own biases, cultures, power, privilege; question roles, assumptions, filters, perceptions. ongoing process. - environment: physical- art and information, nondiscrimination policy posted - language- reveals assumptions; nuanced language - knowledge- for diverse populations; individual pt within statistical population - partnership & empathy- shift power to partnership focus. Pt is the expert on themselves. NP is able to understand the pt's feelings and world view, be nonjudgmental, and communicate that understanding.	- the framework is supposed to help practitioners create effective and therapeutic partnerships with patients - the framework seems to have particular relevance to maintaining therapeutic relationships in the context of increased patient vulnerability- that is, vulnerability of the marginalized patient - is intended for and informed by primary care nurse practitioners

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Kleiman (2004) Qualitative study with interviews of 6 NPs. To explore the lived experience and meaning of NPs interactions with patients, and create a structure to articulate. Specialties and work settings for the NPs were: psychiatric NP in community mental health, adult NP at cardiac unit in hospital, FNP in college student health center, geriatric NP in LTC facility, adult NP in urology private practice, and pediatric NP in partnership with a physician. No patients Author is a PhD psychiatric NP in New York, U.S.	- used systematic criteria to evaluate the described experiences - small sample size, but appropriate for a phenomenological study - all female NPs- did not include male NPs- are their experiences different than female NPs?	- meanings: openness, connection, concern (for pt and self), respect, reciprocity, competence, time, and professional identify - focus on relationship between the patient and NP and the meanings/understandings that stem from this relationship that are not necessarily related to outcomes of health-related interventions - relationship-oriented not disease-oriented - "connection flourishes in an ongoing reciprocal process of collaborative engagement of the patient's health-related concerns." - despite time concerns, interactions are unhurried, open and attentive - intimate and ongoing relationship	- emphasizes the importance of establishing and maintaining relationships with patients - considers the NP's perspective, which differs from most of the other articles that focus on patient's perspectives, observational studies, or presenting frameworks - included the perspective of a FNP - some primary care but population-focused primary care.

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Koeniger-Donohue (2006) Qualitative observational study with 2 expert NP participants and 8 client participants. Aim to explore NP client encounters from the nurse's perspective using a resource exchange paradigm. Focus on what resources NPs anticipate they will provide to their clients before a visit, the resources that are actually provided and the NPs perception of what transpired after the visit. Focus on NPs working in women's health. Didn't go into details about pts- but all middle aged females. Author is a PhD APRN and assistant professor in the graduate program in primary health care nursing in Boston, U.S	- NP participants selected purposely for their excellent reputations - studied beginning, evolving, and established relationships between NPs and their pts - examined findings using Foa and Foa's resource exchange theory as a framework, but did not limit their interpretation when findings did not fit within Foa and Foa's classes of resources - only female NPs *Note: "Resource exchange is defined as any situation where two people interact voluntarily (providing each other with activities in a reciprocal arrangement), communicate freely and derive some mutual benefit from the interaction" (p. 1052/Foa & Foa 1974, 1976). Exchange theorists have found that the nature of interpersonal exchange processes can be understood by examining what resources are involved in a reciprocal context (Foa 1971, Foa et al. 1972, Foa & Foa 1974, Turner 1987)	- saw 5/6 of Foa and Foa's Resource Exchange Theory classes of resources: (a)'services' (activities that affect the body and include labour for another); (b) 'information' (advice, opinions, instruction); (c) 'goods' (tangible products; (d) 'love' (an expression of affectionate regard, warmth, or comfort); (e) 'status' (an evaluative judgment that conveys prestige, regard, or esteem). Did not see (f) 'money' (currency or a standard unit of exchange). - added a resource category called affirmation (reassurance, reinforcement, support and feedback) - NPs more easily use the full range of resources in established relationships	- exchange theory= resources expected and received which contribute to and build the exchange relationship - the focus of this article is not necessarily on the therapeutic relationship, but has implications for relationship development- NPs may need to reflect on how initial visits differ from visits later in the relationship, in terms of the amount and type of resources the NP provides to clients over time. - primary care, but population focused on women's health

Article/Study Design/ Overview	Strengths & Limitations	Important Findings	Utility
Williams et al. (2006) Qualitative study using 10 patient interviews based on 1 NP's consultations with these patients. Part of a wider case study. Aim to explore patients' views about consulting with a primary care NP. Focus on primary care. Authors are Based in the UK.	- in-depth patient interviews occurred immediately after the consultation - pts were aged 19-76, half men half women - breadth of exploration sacrificed for depth of analysis - data coded and analyzed by both investigators - only based on 1 NPs consultations, but it did reflect the findings of larger studies comparing NPs to GPs in terms of patient satisfaction - only 1 female NP studied - adds to qualitative data that explains WHY pts are satisfied with NP care	- all but one pt appreciated the extra time given by the NP (note: the one pt came in for emergency chest problem was the oldest at age 76 and male; other pts appeared to be visiting for chronic conditions or minor acute infections) - pts appreciated discussion of factors affected by their problem/symptoms, such as family, work, and relationships. - pts appreciated time to attend to complex emotional needs - pts appreciated style of consulting, questioning, and discussing of treatment options other than prescriptions	- time was also mentioned in other articles, and focusing on that one element of time in this article allows a better explanation for why and how (?if) that element can be effectively used to maintain therapeutic relationships - focused on primary care setting exclusively - focused on NPs exclusively for the study, though participants were asked to compare to GP care (but no specific GPs were formally assessed by the study)

Appendix B

Themes and Subthemes

THEMES Sub-themes	**Bentley et al. (2016)**	**Defibaugh (2014)**	**Defibaugh (2015)**	**Flemmer et al. (2014)**	**Kleiman (2004)**	**Koeniger-Donohue (2006)**	**Williams (2006)**
Competency & Knowledge	Yes	Indirect	Yes	Yes	Yes	Yes	Yes
Reflection & self-management of practitioner	No	Yes	Yes	Yes	Yes	Yes	No
Affirming exchanges	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Empathy/Recognizing emotions	Yes	Yes	Yes	Yes	Indirect	Indirect	Yes
Presence/mindfulness/ attentiveness	Indirect	Yes	Yes	Yes	Yes	Indirect	Indirect
Patient engagement/ Reciprocity	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Patient satisfaction	Yes	Yes	Yes	Indirect	Indirect	Yes	Yes
Consistency/ commitment	Indirect	Yes	Yes	Indirect	Yes	Indirect	Yes
Context	Yes	Yes	Yes	Yes	No	Yes	Yes
Context of encounter/ reason for visit	Yes	Yes	Yes	No	No	Yes	Yes
Health care environment	No	Yes	Yes	Yes	No	No	No
Time spent by practitioner	Yes	Yes	Yes	No	Yes	Yes	Yes

Yes= explicitly mentioned by name/descriptor in the article
Indirectly= implicitly mentioned in the article through the description of patient interviews/data, or present but not mentioned using the same name/descriptor
No= not mentioned explicitly or indirectly

Appendix C

Factors, Elements, Concepts, Resources, and Meanings by Article

Author	Factors, Elements, Concepts, Resources, and Meanings
Bentley et al. (2016)	- show expertise/knowledge - provide affirming exchanges by giving emotional support and encouragement - positive regard, respect, trust, openness, empathy, reciprocity, and concern/inquisitiveness into biopsychosocial aspects of patients' lives/conditions typify an affirming communication style - consider the context/purpose of the visit
Defibaugh (2014)	- decrease social distance between NP and patient by using small talk, and first-person pronouns (e.g. 'we' or 'our') when discussing treatment options and engaging patient in decision-making (solidarity and reciprocity) - do not interrupt narratives; show supportive moves instead such as saying 'yes', 'okay', and 'good' - explore patient's identity outside of their patient identity
Defibaugh (2015)	- balance instrumental and interactional goals in the patient consultation (competence/caring) - align with caring provider identity and create solidarity with patient by using small talk, inclusive first person pronouns, hedging, and indirect speech - align with competent provider identity by attending to occupational and professional responsibilities and create alignments to organizations and institutions - create comfortable communicational atmosphere by using lay terms, following medical checklist but allowing topic to deviate based on patient's responses - engage patients by encouraging them to share their narratives, getting to know them beyond their identity as patients, and involving them in decision-making
Flemmer et al. (2014)	- reflect on own biases, cultures, power and privilege - question roles, assumptions, filters, and perceptions - display appropriate art and information to create cultural safety - use of nondiscriminatory and nonjudgmental language with attention to assumptions - openness - be empathic, encouraging - sustain knowledge base for diverse populations and consider individual patient within given statistical tendencies - promotes partnership by communicating an understanding of the patient's feelings and worldview to the patient in a nonjudgmental way

Author	Actions
Kleiman (2004)	- provide affirming exchanges by being attentive, available, open, welcoming, authentic, and evocative - show openness, concern, respect - engage patients in care decisions, ensure there is patient exchange (not just one-sided) - consultations are unhurried despite time concerns - self-reflection on own personal and professional capabilities and ability to identify and act to meet patient needs
Koeniger-Donohue (2006)	- provide affirming exchanges by using reassurance, reinforcement, support, and feedback - engage patient in care decisions - use services, information, goods, love, and status in interactions (i.e. balance instrumental and interactional goals)
Williams and Jones (2006)	- use as much time as is needed to provide an in-depth, thorough consultation - discuss factors affected by their problem (family, work, relationships) - use questions, listen to patients and discuss treatment options other than prescriptions - engage patient in decision-making - non-intimidating manner with patients

Appendix D

Summary of Implications and Recommendations

Implication	Recommendations
Professional Identity	• Daily self-reflection. • Support from colleagues/mentors/leaders. • Incorporate actions into learning plan. • Network with others via BCNPA/practice-based small group learning programs/journal or case review groups for practice.
Solidarity	• The 'we' of solidarity should be extended not just to the nurse practitioner-patient team, but also to the health care team as a whole (e.g.
Role Ambiguity	• Self-reflection. • Discussion with colleagues. • Alignment to nurse practitioner practice leader for inter-disciplinary education and awareness. • Partnership with BCNPA. • Self-education on funding models, and advocating with colleagues, practice leaders, management, through surveys, and lobbying government.
Patient Empanelment	• Look to research for evidence regarding fair caseloads for nurse practitioners. • Discuss fair caseload with site manager/colleagues/employers. • Connect with colleagues through local community of practice and/or BCNPA Member Forum on Facebook.
Complex Patients	• Daily self-reflection. • Team approach for complex patients. • Team use of Flemmer et al.'s Empathetic Partnership model for Primary Care.
Care Transitions	• Prepare patients in advance of care transitions. • Advise patients, re: how provider remains updated, how teams work together, and prepare patients for times when care may be outside nurse practitioner scope.