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Spiritual Dimensions of Nurse Practitioner Consultations in Family Practice

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Spiritual Dimensions of Nurse Practitioner Consultations in Family Practice.

Original Empirical Research – Qualitative:

Abstract:

Purpose of Study:

To explore the spiritual dimensions of Advanced Nurse Practitioner consultations in Primary Care through the lens of Availability and Vulnerability.

Design of Study and Methods Used:

A Hermeneutic Phenomenological enquiry exploring the spiritual dimensions of Primary Care consultations consisting of two interviews per participant over an eighteen-month period was conducted with Advanced Nurse Practitioners in the United Kingdom.

A purposive sample of 8 Advanced Nurse Practitioners were recruited and interviewed. Interviews were fully transcribed and analysed thematically.

Findings:

Participants identified that spirituality can be difficult to conceptualise and operationalise in practice. Participants articulated the meaning of spirituality and gave examples of when they had witnessed a spiritual dimension in practice. Key themes included how ANPs conceptualise spirituality, the context for spirituality to be integrated into care and the importance of spirituality as an aspect of holistic care. The concepts of Availability and Vulnerability were used intentionally as a lens in the study to explore whether these concepts and approaches to practice could enhance integration of spirituality into practice.

Conclusion:

Knowledge and understanding regarding spirituality in Advanced Nurse

Practitioners consultations in Primary Care has been uncovered. A framework for operationalising spirituality has been developed.

Introduction:

Over recent decades, research on spirituality in nursing and healthcare has increased globally (Pesut et al., 2009, Milligan, 2011, Clarke 2013, Beres, 2017, Martins, Romeiro & Caldeira 2017, Penman, 2018; Ross et al., 2018,). The International Council of Nurses (ICN) (2012), American Association of Nursing (2015) and the Nursing and Midwifery Council (NMC) (2009 & 2014) in the UK have recognised the importance of spirituality to good nursing practice. Challenges of conceptualising spirituality often obscure the issue of how to integrate spirituality in practice (Cook, 2011, Reinert & Koenig, 2013, Rogers & Wattis 20015; Wattis, Curran & Rogers., 2017).

The word spirituality was introduced into the English language in the 17th century (from the French *spiritus*) to denote direct knowledge of the divine or supernatural (McGrath 1999). In its original meaning it was close to the modern English 'mystical' and was religious in connotation. However, over the years a concept of spirituality has developed that also embraces the secular. In line with Cook's (2004) definition, our understanding of spirituality embraces issues of meaning, purpose, hope and connectedness whether or not they expressed through religion (Wattis, Curran & Rogers, 2017). Spirituality is an innate part of being human and attention to spirituality is a fundamental aspect of holistic care (Rogers, 2017).

Defining spirituality for research purposes is complex and for this reason, some authors have used religious observance as a surrogate for spirituality, especially in

quantitative research (Koenig King and Carlson 2012). Robust studies have

demonstrated the importance of spirituality (sometimes expressed through religion)

in helping patients regain hope, meaning and purpose in the midst of illness

(Burkhardt, 2007, D'Souza, 2007, Koenig, King and Carlson 2012; Penman 2018).

Growing evidence suggests that addressing spirituality improves comfort levels

(emotionally and physically) and has a positive effect on patients' responses to

illness and treatments (Koenig, King and Carlson 2012).

Holistic care has been defined as "all nursing practice that has healing the whole

person as its goal" (American Holistic Nursing Association 2018, p.1). It should

consider the mind-body-spirit- emotion-environment approach to nursing practice

(Klebanoff 2013). Clarke (2013) argued that spirituality epitomises holistic care and

is at the heart of nursing. One helpful (but not very specific suggestion) is that

spiritual care in practice "begins with encouraging human contact in compassionate

relationships and moves in whatever direction need requires" (National Health

Service Scotland, 2009, p.6). All nursing care should be based on compassion and

human connection but spiritual care goes further, including helping patients find or

re-establish meaning, hope and purpose in lives disrupted by illness and suffering

(Cook, 2004, Pesut, et al 2009; Pfeiffer, Gober & Johnson-Taylor 2014).

 Nurse Practitioners (NP) are in an ideal place to put holistic care, including spiritual

care, into practice because of the nature of their daily work, including long-term

involvement with many patients (Shuler & Davis, 1993; Rogers 2016). Familiarity

with ongoing aspects of the patient's life enables NPs to address many areas of

concern. However, there has been very little research into how they do this. The

first step is to establish how NPs experience and deal with spiritual issues in their

consultations. The researcher explored how a concept of Availability and

Vulnerability that she had found helpful in developing her own work as an NP could

be applied in the experience of others.

Methodology:

In 2016, the author completed this phenomenological study as part of her doctoral

studies. A two-stage study was conducted which comprised of two interviews over

an 18 month period. The first stage interview examined the issue of how NPs

experienced and understood spirituality in clinical practice, their lived experience.

Perceptions of the words availability and vulnerability were explored during this

stage to ascertain participants' thoughts about these words. The second stage

interview 18 months later explored the utility of the concept of Availability and

Vulnerability, derived from the traditional wisdom of a Christian community, in

developing a framework to enhance understanding. This specific concept of

Availability and Vulnerability was only introduced after the first stage interview. The

concept of Availability and Vulnerability was seen by the Celtic Christian community

as key to authentic living and building relationship. This concept included

welcoming and accepting others as they are, being authentic in relationship and

being willing to connect with others (Miller, 2014). Details of the community's

understanding of the concept was given to participants prior to the second stage

interview. In the second stage interview, in addition to clarifying issues from the first

interview, the utility of the concept of Availability and Vulnerability in understanding

NP experiences of addressing spiritual issues was explored in depth.

Aim and objectives:

The study aimed to establish a phenomenological understanding of the spiritual dimensions of Nurse Practitioner consultations in family practice and to examine the utility of the concept of Availability and Vulnerability as a framework for this understanding. The research aimed to address:

➢ How the NPs interviewed experienced and conceptualised spirituality in practice.

➢ Whether or not spirituality was experienced as an important aspect of their consultations.

➢ How spirituality was operationalized in consultations by these NPs.

➢ Whether these NPs identified spiritual dimensions of practice.

➢ Whether they experienced any barriers to integrating spirituality into practice.

➢ Whether a framework of Availability and Vulnerability was useful in understanding and operationalizing spirituality within NP consultations.

Design:

A hermeneutic phenomenological enquiry (Gadamer, 2006) using face-to-face interviews was designed to allow the unique lived experiences of the NPs to be explored and understood (Paley, 1997). Prolonged engagement allowed dialogue to occur between the researcher and participants facilitating a thick description of the phenomenon of spirituality (Gadamer, 2006). In the second stage, the concept of Availability and Vulnerability was applied to the developing dialogue to examine their utility as a framework for further exploration of spirituality in this context.

Participants:

A purposive sample of 8 experienced NPs (Table 1) was recruited in 2012 via a local NP forum. This small sample size was appropriate for a phenomenological study as the aim of the study was not generalizability (Munhall, 2012). Participants were interviewed twice over an 18-month period. The data collected during both interviews enabled extended interactions with participants to refine and clarify meaning and integrate personal interpretation of the data. Prolonged engagement is recommended to support in depth analysis and increase credibility of the findings (Houser, 2015).

The inclusion criteria were: experienced Nurse Practitioners (5 years post qualification); members or affiliates of a regional Nurse Practitioner Forum; and active Nurse Practitioners working in family practice.

Ethical approval was given by the relevant University and National Health Service ethics boards. All participants gave written consent prior to being interviewed and agreed to prolonged engagement for up to 2 years. All were aware they could withdraw from the study.

Data collection:

Data were collected during two interviews per participant over an 18-month period from November 2013 to June 2015. Interviews (Moule & Goodman, 2006; Munhall, 2012) allowed for dialogue between the researcher and participant to explore their thoughts, feelings and experiences with the aim of gaining understanding and clarity about the phenomenon (Laverty, 2003). To explore the lived experiences of spirituality enough time was allowed for each interview to develop in whatever

direction the participant wanted it to. A topic guide was used as a prompt and to

ensure all participants covered the same areas for comparison (Table 2).

Data Analysis:

Data were analyzed using Fleming et al.'s (2003) method. Interviews were

transcribed and anonymized. Transcripts were read repeatedly to ensure deep

understanding of and familiarity with the data (Moule & Goodman, 2006).

Manual systematic coding of the data was carried out (Fleming et al, 2003). Codes

were abstracted into broad overarching themes then scrutinised for any duplication.

After each interview individual participant summaries were made after transcript

analysis of key findings. Each summary was then sent to the participant and later

discussed via email or phone after the participants had chance to reflect on the

findings. Participants deemed all summaries to be accurate analyses of meaning

and understanding. Ongoing dialogue with the participants was used to orientate

participants to the study and initial findings, allowing them the opportunity to

challenge interpretations and understandings that might have been misconstrued by

the researcher.

After transcription, interpretive understanding of themes and patterns were sought

via thematic analysis. The major themes emerged from this textual analysis and

recognition of repeated patterns. This process followed Gadamer's (2006)

hermeneutic rule of movement looking at the whole of the data, then the part and

returning to the whole. Each interview was analysed before proceeding with further

interviews. This was then related back to the whole research completing a

continuous hermeneutic circle. A fusion of horizons, marrying the participants and researchers views, enabled a thick description of the phenomenon of spiritual dimensions in NP consultations to be developed (Gadamer, 2006; Vessey 2009). Synthesis of the data and returning a second time to the participants enabled the researcher to discover whether this thick description was accurate and gave the participants time to reflect on the interviews and material presented to them.

Rigor and Credibility:

Rigor was attained through the completeness of the data collection and analysis in addition to the interpretation (Yardley, 2000). Hermeneutic phenomenology does not fit stringently into the validity and reliability methods terminology (Moule & Goodman, 2006). Bradbury-Jones (2007, p.291) has suggested that credibility is a term most qualitative researchers use rather than validity or reliability as it "refers to the fit between the experiences of the respondents and the researchers' representation of them". Prolonged engagement and ongoing reflexivity supported in depth analysis, which as Houser (2015) suggested increases credibility of the findings and enhances rigor. Exploration of the authors' subjectivity through the use of a research journal supported ongoing reflexivity. This was important in demonstrating rigor and enhancing credibility as it identified the interplay between myself and participants in addition to my own reflections (Bradbury-Jones 2007). Credibility is important in hermeneutic phenomenology. It was enhanced during this study by allowing each participant to review the key findings of their interview and offer continued dialogue with participants to develop of shared understanding through the fusion of horizons and completing the hermeneutic circle. Despite this

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study having a small sample the findings may have transferability to other

populations and settings (Slevin & Sines, 2000)

The freedom of the methodology is liberating in allowing for flexibility in the structure

of analysis but, in order to ensure rigor, maintaining the focus on the phenomenon

under investigation is paramount (Crotty 1996). Others have suggested the lack of

structured "rules" for the methodology leads to questions of rigor and validity

(Sharkey 2001). He argued that method in itself does not lead to good interpretation.

It was the researchers' ability to explore and understand the nuances of the

phenomenon with the participants and engage in dialogue to confirm the

understanding with the participants which appeared to increase rigor and validity

(Gadamer 2006). However, in the hermeneutic phenomenological context of this

study rigor was achieved and demonstrated through acknowledgement of bias,

prolonged engagement with the participants and reflexivity throughout the study. Set

criteria for rigor are "problematic" and not consistent philosophically with hermeneutic

approaches (Witt & Ploeg 2006) Subjectivity with hermeneutic phenomenological is

well recognised (Bradbury-Jones 2007) and integral to the process. However to

enhance rigor prolonged engagement with the participants over 18 months at and

between interviews in addition to presenting the summaries back to each of them

allowed for the findings to be as authentic as possible Strengths:

The methods followed during this study followed the hermeneutic process fully.

Prolonged engagement with the participants and ongoing dialogue enhanced

credibility and rigor of the study.

Findings:

Description of Participants:

Out of 8 participants were interviews, seven were Caucasian and one was Afro-Caribbean. The mean age was 48 years. Only 1 participant had not attained a master's degree in advanced practice. Three participants reported to having a Christian faith, three had been brought up as Christians but were now agnostic and two participants did not mention any religious belief or background.

Drawing on both interviews, broad findings are articulated in this paper under the inclusive subheadings of *defining spirituality*; *integrating spirituality into the consultation* and *Availability and Vulnerability*.

Defining Spirituality:

During the first interview some participants had not thought about a personal definition of spirituality and were confused about spirituality. Their ideas developed and were revisited in the second interview.

Some participants recognized that spirituality was difficult to define. One suggested:

"You can't quite put your finger on it"

Others had a much clearer understanding of spirituality. One described spirituality as being unique like a fingerprint:

"Spirituality for me is about the essence of a person… it's about your make-up, some of the things you are born with, some things you develop because of your environment and how you are brought up. I think it's probably like a fingerprint really, it's different for everybody...You have to know it's about being who you are".

For some religion was linked to spirituality (one asked: *"Is there a difference? I don't suppose there is really…..they must be interlinked to a certain extent"*)

Two participants had considered definitions of spirituality and articulated

differences between spirituality and religion. They differentiated religions as being

about "*guidance*" and a *"belief in God"*. One suggested that religion was:

"…a set of guidance and principles which you can adopt and adhere to and there's

a church and maybe there's a doctrine and a ritual"

For another, time to develop her ideas between interviews took her from initially

confusing spiritualism with spirituality to a clearer definition:

"….[Spirituality].involves experiences of deep seated sense of meaning and

purpose in life, a sense of belonging, a sense of connection of the deeply personal

with the universal, acceptance, integration and a sense of wholeness."

During the second interview meaning, hope and purpose were all reflected in

definitions of spirituality, as was human-to-human connection and a willingness to

recognise human need and suffering during consultations and respond to these.

Spirituality was seen as pervasive:

"…spirituality is how you live…"

Integrating Spirituality within the Consultation:

The first interview explored whether there were consultations when spirituality was

particularly relevant. For many participants this led to examples of complex, long-

standing cases and for one spiritual issues most often arose in consultations about

"...life and death…"

Spirituality could also be a part of minor presentations or a one-off consultation.:

*"In a consultation I think it [*spirituality*] is something that sometimes happens. I*

don't think it's always a conscious effort. I think it comes back to whether you are

having time to sit and let the person talk and tell you what's important to them"

During the second interview participants recognized that spirituality included

connecting with patients, presencing, empathy, compassion and care. Having a

depth of connection with patients was seen as rewarding but could also impact on

the NP emotionally:

"being able to connect with them [patients] *on that level* [depth] *I think is sort of*

spirituality in nursing….and I have always accepted there is a sort of spiritual

element…it's about a deeper connection that you sometimes experience in a

consultation … and then you feel that something has happened there that isn't run

of the mill, that isn't your normal consultation, I think it's really rewarding, when it

does happen".

Participants discussed whether the term spirituality might cause misunderstanding

for patients as it had initially for them. One observed:

"….*sometimes words create huge barriers"*.

For participants, spiritual dimensions of practice included openness and willingness

to be present and fully hear the patient. This led to reflections on the emotional

impact of the consultations and an awareness of professional and personal

boundaries. One participant recalled revealing her humanity when she had to: "

..blink back tears .." . Another was aware that she sometimes risked sharing her

own similar experiences and that she:

"tried to share empathy with them [patients] … saying … I understand it's difficult

and perhaps I can understand a bit more because I am going through the same

thing. Now whether that's a good thing or a bad thing would be debatable"

Availability and Vulnerability:

Participants' recognition of spiritual elements to practice and the related emotional

and professional impact facilitated growing discussion of the concept of Availability

and Vulnerability. All recognized availability within their NP role and related it to

being "*there when you're needed", "being open and ready to respond to someone's*

needs", and "being ready to listen".

They recognized availability could be physical, which could be closely controlled, or

emotional which involved more choice. Vulnerability was closely connected as it

could be a consequence of availability:

"On occasions you do show your vulnerability and it's not a bad thing to do because

it shows you are a human being at the end of the day not automatons"

After participants had read and reflected on the origins of the concept of Availability

and Vulnerability, in the second interviews their thoughts and views about this

concept included more "*spiritually focused"* concepts with availability being seen as

involving *"human connection", "love", "hospitality"* and "*opening oneself up more*

with others".

Vulnerability was viewed as more complex and multi-faceted than availability. The

NPs were insightful in recognising the varied facets of vulnerability. One

summarised this:

"I am vulnerable because I am a human being…I am vulnerable because I have to

manage risk and make decisions minute by minute…I am vulnerable because I

have to make the right diagnosis, because I need to choose the right treatment, to

prescribe the right drug, I am vulnerable because if I screw up I can be sued and I

am vulnerable because I am a nurse in a traditionally medical domain. I am

vulnerable because I stood on the parapet to be a spokesperson for my

professional discipline…I am vulnerable because I am trying to say that what I do is

as good as medicine so I am vulnerable on so many levels. My main vulnerability,

the one that makes me anxious, is that I am doing the right thing for the right patient

at the right time".

The final point, was for her was a deeply spiritual connection with patients,

indicative of the "*transformative*" nature of vulnerability.

Multiple narratives of consultations where participants had given of themselves

emotionally revealed the depth of care and compassion the NPs had for their

patients and were powerful examples of how vulnerability had impacted them,

including the recognition of the risk of burn out.

During the second interview participants linked availability and vulnerability to

spirituality. One felt that:

" *they* [availability and vulnerability] *are important for me….they fit with my spiritual*

beliefs because of what spirituality means for me"

Another returned to the issues of professional and personal balance:

"*It's [*spirituality*] how I think it is* [Availability and Vulnerability], *it's probably how a*

lot of people think really….I think it's what we do …. I think I agree with the fact that

you need to be available and vulnerable but I do think it needs balancing with rules

[boundaries]. *I think it's about trying to ensure that you are clear as a professional*

that the things you put into your work time and your life have balance….that

whatever vulnerability you experience at work you can balance with the rest of your

life….."

Discussion:

In this unique study, understanding aspects of the spiritual dimensions of NP

consultations in family practice has been developed. Spiritual dimensions of

practice are multi-faceted and at times difficult to verbalize. The specific concept of

Availability and Vulnerability has not been studied before however, the authors'

personal experience of integrating this concept personally and professionally had

revealed their possible application to NP practice in general. The concept derives

from the Northumbria Community, a dispersed Celtic Christian monastic

community, based in Northumberland, England (Miller, 2014). Availability and

Vulnerability are seen as ways of relating to others and God in order to build

relationship. Although the heritage of this concept is Christian, the author hoped to

explore whether the concept of Availability and Vulnerability could be applied to a

secular setting. The study findings appear to show that Availability and Vulnerability

enable spirituality to be more easily operationalized by the participants. Author bias

of introducing the concept was explored and acknowledged throughout the study.

The finding that spirituality is difficult to conceptualize is unsurprising and reflects

findings from other studies (Miner-Williams, 2005, McSherry, 2007; Reinert &

Koenig, 2013). Struggling to define spirituality is a common experience of nurses

(McSherry & Jamieson, 2013). Burkhardt (2007) suggested that spirituality is like

the wind, it can be sensed and felt but cannot be tied down. However, recognizing

that spirituality is connected to hope, meaning and purpose and is innate may make

understanding spirituality easier (McSherry, 2006, Burkardt, 2007; Pesut et al,

2008).

There appeared to be some confusion about the difference between religion and

spirituality. This reflected other research (Treloar, 2000, Stranahan, 2001, Hubbell

et al, 2006, Helming et al, 2009; Carron et al., 2011). For this reason Sessana et al,

(2007) and Pesut et al., (2008) suggested separating spirituality completely from

religion. However, it seems logical to view them as distinct but overlapping concepts (Wattis, Curran & Rogers, 2017). One approach to the problems of defining spirituality is to look instead at the concept of spiritually competent practice (Wattis, Curran & Rogers, 2017). Spiritually competent practice engages with each person as a unique individual supporting a sense of meaning, hope, purpose and connection. It involves the clinician recognising and addressing suffering and helping patients to develop coping strategies to improve their quality of life. Fundamentally, it requires compassionate, holistic approaches to care to be offered whilst accepting a patient's beliefs and values and practicing with spiritual competency (Rogers & Wattis, 2015, Wattis, Curran & Rogers, 2017). This approach may reduce some of the confusion and complexities associated with defining spirituality.

To provide space for spiritually competent practice to be part of the consultation NPs need to build relationships based on trust where the patient can feel safe, listened to and valued. Milligan (2011) suggested this leads to a positive and healing experience for the patient by creating a sense of shared humanity. O'Brien (2008) asserted that shared humanity needs to be authentic with a possibility for mutuality including the sharing of self. Participants in this study acknowledged that at times sharing common experiences of life could enhance spiritual care. However, discernment was needed about what experiences would be shared with the aim of being helpful to the patient and not making the consultation about the NP. Spirituality is entwined with love and relationship (Young & Koopson, 2011). Helming (2009) suggested that many NPs entered nursing with a sense of love and care for others. They may have felt called to compassion in alleviating human

suffering which she termed *"spiritual work"*. The NPs all recognized that a

motivation for their work was a desire to care, to support and help their patients

altruistically. One participant also talked of *"love"* in terms of her patients and her

vocation but suggested that the word love like spirituality was often misunderstood.

What she meant connects to *agape* (Ancient Greek ἀγάπη): love which includes

compassion, connection, care of patients and presencing (Lindström, Nyström &

Zetterlund, 2014). Martinsen (2006) suggested that love necessitates emotional

involvement which is an aspect of vulnerability.

Stevens Barnum (2011) suggested that physically being with patients and trying to

understand what was happening for them and how it was affecting them was crucial

to building relationship and integrating spirituality into care. Sherwood (2000)

suggested that *presencing (being fully available)* was an integral aspect of

operationalizing spirituality. Simply being with patients can help them to explore the

many unanswerable questions about their illness and life. Sherwood described this

as one of the highest forms of human interaction. These NPs recognized that by

choosing to be present, open, ready and focused on the person in front of them

they were able to offer a level of availability that helped their patients, this

connected to spirituality for some though others felt this was just "good nursing

care".

White (2006) recognized that spirituality has an emotional cost and if offering truly

holistic care the practitioner must be prepared to realise this could be positive or

negative. There was a sense from the findings that giving of oneself in the

relationship with the patient increased connection, trust and safety. Young and

Koopson (2011) viewed a deeply spiritual dimension when the practitioner was willing to share something of their own life experience.

After participants reviewed the origins of Availability and Vulnerability and reflected on their practice they viewed them as a useful concept for understanding spirituality. This concept have been developed into a framework for learning about and operationalizing spirituality in practice (Figure 1). Availability and Vulnerability are aspects of spiritualty that help practitioners connect with their patients as fellow humans. They enable them to offer hope, meaning and purpose through care, compassion, emotional connection, respect and understanding. They allow the practitioner to be vulnerable and honest in their interactions leading to greater authenticity. Like spiritually competent practice, the framework for Availability and Vulnerability is one way of addressing the confusion about how spirituality can be operationalized in practice.

The framework suggests that availability includes the NP being firstly connected and available to themselves, taking time to understand their own spirituality. Participants recognized the need to be aware of their own spirituality to integrate spiritual care into their own practice. They viewed welcoming patients as unique human beings with the same needs as themselves and being willing during a consultation to be fully present, to listen attentively and understand and accept their patients as they were, as important aspects of spiritual care. Additionally, they viewed availability as being part of how care and concern were shown for their patients, providing a safe place for them to share their concerns.

Participants identified with vulnerability and the need to be open and connect with

their patients authentically and as fellow humans. This necessitated a need to be

self-reflective and willing to engage in supervision and respond to constructive

criticism to maintain appropriate boundaries. They connected vulnerability with

recognizing that practitioners do not have and never will have all the answers and

knowledge. Sharing this with patients created honesty in the relationship. They also

accepted, that vulnerability included being willing to share aspects of oneself, within

professional boundaries, to bring authenticity and connection as a fellow human

being. Vulnerability included being an advocate for patients, challenging authority

and being honest and truthful in interactions

<u>Limitations</u>:

The sample size was consistent with hermeneutic phenomenological studies. The

richness of the data, prolonged engagement throughout the study between

researcher and participants and faithful adherence to the methodology ensured a

robust and valid study but further work is needed to explore the transferability of the

findings. Purposive sampling was a limitation as those who volunteered might have

had a special interest in spirituality, again suggesting the need to explore the

findings in a wider group.

This study was influenced by the researcher's personal and professional

experience. This was addressed by the two-stage design, specifically introducing

the concept of Availability and Vulnerability only at the end of the first interview.

This, combined with analysis and summarization of the first interviews and

agreement of the summaries before the second interview when the concept was

explored in more detail made the process transparent. The issue of bias was also

addressed by analyzing the findings from the practitioners' experiences before re-

examining them in the light of Availability and Vulnerability . The processes of

Gadamerian phenomenology (including fusion of horizons) then enabled a dialogue

which resulted in the suggested Availability and Vulnerability framework for further

exploration. Unconscious bias was minimised by careful reflection to minimise the

risks of selecting data for analysis that fit the researchers' preconceptions. The

supervision team was also used to challenge preconceptions and to ensure

integrity.

Conclusion:

There is no definitive answer to what spirituality is or how to operationalize it in

practice. Our understandings change and respond to the experiences we have and

are dynamic. However, this study has explored the richness of potential meanings

of spirituality in NP consultations. This study gives a glimpse into the lived

experience of experienced NPs who all view holistic care as the central tenet to

their practice. From this study it is clear that Availability and Vulnerability have

helped NPs to operationalize spirituality. A framework of Availability and

Vulnerability has been developed to help NPs utilize this concept in clinical practice.

It is hoped that this concept allows spirituality to be operationalized to improve

holistic patient care. It is also hoped that this framework supports NPs in their own

self-development and practice. The transferability of this concept into wider NP

clinical practice needs further evaluation.

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Table 1: Basic Demographics

Age: 40-50

Gender: All female

Specialist Interest in addition to generic role: Mental Health, Eating Disorders,

Homelessness, chronic disease, acute care, women's health, education

Years working as an NP: 7-10 years

MSc Qualification Nurse Practitioner: 7 participants full MSc

    1 participant In-house training plus some post registration modules.

Table 2: Interview Guide

Interview 1 Guide:

Initial background- discussion of current role, years qualified and any areas of

specialist practice will be ascertained.

What made you decide to become an NP? What influenced your decision?

Discuss your views about the differences in NP consultations with patients who

may present with serious medical problems, complex presentations and mental

health problems as opposed to minor illness. How do you view the relationship

you develop with these patients? Is it different to those consultations with minor

presentations? What happens over a period of time when you see these patients

regularly?

What do you see as the most important aspects of the NP consultation? Does this

differ from the role of other nurses in primary care?

What do feel is important in a holistic assessment of your patient?

Does spirituality have any importance in your approach to your patients? Does

your consultation include acknowledgement of the patient's spirituality?

Is there a difference in your mind between spirituality and religion?

Do you make an emotional connection with your patients or do you keep a

"professional distance"? How much of yourself do you share with patients who you

may be seeing regularly?

What do the words availability and vulnerability mean to you? Is this something

important in a consultation?

)Have you ever felt that you have become more involved in a patient's life than you

should have done as a professional? Can you tell me a little about that

experience?

Interview 2 Guide:

Summary of previous interview and initial findings. Feedback of current

progression of research.

Opening conversation with discussion about the concept of Availability and

Vulnerability as expressed by the Northumbria Community.

You have now read the information I sent you from the Northumbria Community

about Availability and Vulnerability, how does this correlate to your understanding

of these terms?

Do you feel this concept has any relationship to what we have discussed about

"spiritual dimensions" within NP consultation?

Are there any areas which would make you feel uncomfortable about consciously

observing for, and participating in "spiritual dimensions" of care?

Do you see Availability and Vulnerability as a useful lens to address "spiritual dimensions"?
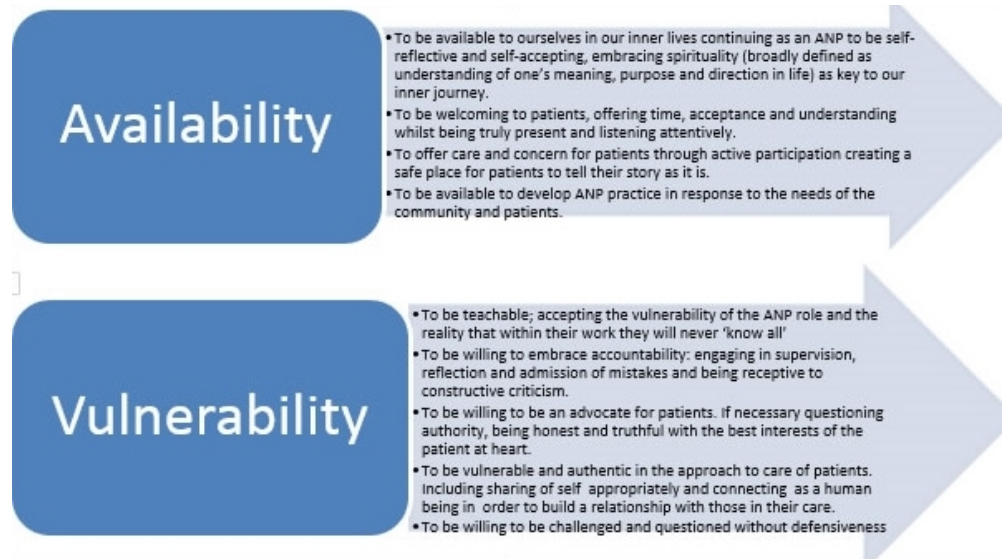
Does integrating Availability and Vulnerability include an acceptance of the role spirituality may have in a consultation

Have you thought further since reading this information about the role of spirituality in your life and work?

What do you feel the safeguards should be when a "spiritual dimension" is apparent in a consultation?

Availability
- To be available to ourselves in our inner lives continuing as an ANP to be self-reflective and self-accepting, embracing spirituality (broadly defined as understanding of one's meaning, purpose and direction in life) as key to our inner journey.
- To be welcoming to patients, offering time, acceptance and understanding whilst being truly present and listening attentively.
- To offer care and concern for patients through active participation creating a safe place for patients to tell their story as it is.
- To be available to develop ANP practice in response to the needs of the community and patients.

Vulnerability
- To be teachable; accepting the vulnerability of the ANP role and the reality that within their work they will never 'know all'
- To be willing to embrace accountability: engaging in supervision, reflection and admission of mistakes and being receptive to constructive criticism.
- To be willing to be an advocate for patients. If necessary questioning authority, being honest and truthful with the best interests of the patient at heart.
- To be vulnerable and authentic in the approach to care of patients. Including sharing of self appropriately and connecting as a human being in order to build a relationship with those in their care.
- To be willing to be challenged and questioned without defensiveness

Availability and Vulnerability