The Advanced Practice Nurse

Issues for the New Millennium

Joellen W. Hawkins & Janice A. Thibodeau

Fifth Edition

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The Tiresias Press, Inc., New York

DEDICATION

In memory of

Sheila A. Packard (1949-1995)

and

Patricia A. Geary (1946-1998)

Advanced practitioners, scholars, and friends

International Standard
Book Number: 0-913292-52-4

Printed in U.S.A.

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Preface

THIS BOOK is intended to be both a text for students enrolled in programs preparing them to be advanced practice nurses (APNs) and as a reference for nurses who are already APNs. It translates broad, theoretical concepts into the practical, everyday concerns of nurses in advanced practice roles, and, by analyzing selected issues affecting role implementation, it directs students and nurses already active as advanced practice nurses to assume, examine, and reality test the various aspects of these roles.

The issues addressed here are those concerned with aspects of being an advanced practice nurse beyond the care of patients: negotiating for a job; credentialing for advanced practice; economics of health care delivery, including managed care; legal and regulatory aspects of practice; scope of practice; use of a nursing model for practice; use of change theory; concepts of power, authority, leadership, and sex-role stereotyping; research in advanced practice roles; quality improvement for practice; communication and assertiveness; mentoring; and community assessment for improved or expanded delivery of care by advanced practice nurses.

Acknowledgments

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We are especially grateful to Catherine Collins and Amy Hochler for allowing us to use the evaluation tools they developed for their practice, and to Lynda Clancy and Ellen Robinson for a sample resume and curriculum vitae, respectively.

Most of all, we owe our deepest gratitude to our friends and families for their support of us and tolerance of our seemingly endless projects.

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Joellen W. Hawkins is a professor at Boston College and a certified obstetrical/gynecological women's health nurse practitioner. Her many books include *Nursing and the American Health Care Delivery System,* The *Dictionary of American Nursing Biography, Protocols for Nurse Practitioners in Gynecologic Settings,* and *Nurse-Social Worker Collaboration in Managed Care: A Model of Community Case Management.*

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Advanced Practice Roles in Nursing

Introduction

The advanced practice role for nurses is not new. The first nurses practicing what is now considered advanced practice nursing were nursing sisters administering anesthesia in 1877 at St. Vincent's Hospital in Erie, Pennsylvania (1, 2). Less than a decade later, nurses in the community were pioneering advanced nursing in public health. The term "public health nurse" was first used by Lillian Wald in 1893 to describe the kind of work her Henry Street Settlement House nurses did when they visited the poor and sick in their homes. Practicing much more independently than hospital nurses, public health nurses at Henry Street and across the United States taught health promotion and disease prevention to school children, workers, citizens in many different community settings, mothers and children through prenatal and well baby clinics, and tenement dwellers served by settlement houses (3). "American nurses saw health visiting as an opportunity for professional independence, status, and economic security. . ." (3, p. 1781). Nurse-midwives were the next group of advanced practice nurses in the U.S.

Thus, advanced practice nursing was not unique to the latter half of the twentieth century when educational preparation moved from service agencies to the academy, although in the years since 1877 it has acquired titles and more formal definitions.

Historical Evolution of Preparation for Advanced Practice and Specialization

Public health nurses led the way in preparing for advanced practice by creating postgraduate courses. In 1906, Charlotte Macleod planned and organized the Training School for Nurses of the Boston

Instructive District Nursing Association (IDNA), the first such course in the country (105). Although the term "advanced practice" would not be used for many years, graduates of postgraduate courses such as those organized by the IDNA prepared nurses for specialist practice and for roles similar to those of today's advanced practice nurses.

By 1931, 137 hospitals were offering postgraduate courses in a wide variety of specialties. Between 1909 and 1912, the first formal postgraduate courses for nurse anesthetists were begun. Nurse-midwives such as Mary Breckinridge were trained in England and other European countries until the Maternity Center Association opened the first U.S. school for them with its affiliate, the Lobenstein Clinic, in New York City (106).

Beginning with postgraduate courses, nurse anesthetists and nurse-midwives went on to develop formal certificate programs for registered nurses based in health care agencies, and in colleges and universities both certificate and degree granting programs were formed. In 1995 there were 95 programs for nurse anesthetists, two-thirds of these in colleges or schools of nursing. Most certificate programs were phased out to meet a 1998 goal that all their accredited programs confer a master's degree. Forty basic and two precertification programs exist for the preparation of nurse-midwives; some are degree granting and others are certificate programs (1, 2, 106).

Nurse Practitioner Education

The first nurse practitioner demonstration project, in 1965, was planned to "determine the safety, efficacy, and quality of a new mode of nursing practice designed to improve health care to children and families and to develop a new nursing role—that of the pediatric nurse practitioner" (4). Loretta Ford was codirector of the project, which took place at the University of Colorado, and she is credited with first using the term nurse practitioner.

By 1998, there were 312 master's programs offering one or more

advanced practice options and fewer than a dozen certificate programs (18, 19). A 1998 core curricula survey showed that of the master's programs, 122 offered preparation in one or more nurse practitioner specialty areas (20). Some of these were combined nurse practitioner/clinical nurse specialist programs.

Advanced practice roles in nursing were given a boost by the Nurse Training Act of 1964 (PL 88-581), Title II of the 1968 Health Manpower Act (PL 92-158), and the Nurse Training Act of 1975 (PL 94-63). All of these provided monies for advanced nurse training and the establishment of practitioner programs (9).

In 1971, the Committee of the Secretary of the U.S. Department of Health, Education, and Welfare presented its findings from a study of extended roles for nurses. The report concluded that nurses could assume responsibility for extended roles in primary, acute, and in long-term care; in some cases with additional preparation.

Also in 1971, the University of Washington began a program to prepare family nurse practitioners. Following that example, which became known as PRIMEX, programs were initiated at Cornell-New York Hospital and the University of North Carolina at Chapel Hill (10). Other early programs included the family nurse practitioner program at the University of California, Davis; Boston College's programs in ambulatory care for women and children which were piloted in 1967 and funded by the Josiah Macy Jr. Foundation in 1968; and a program at Wayne State for health nurse clinicians (11).

Recognizing the need for a statement from the professional nursing organization on nursing's expanded role, in 1974 the American Nurses Association (ANA) Congress of Nursing Practice published definitions of the advanced practice roles. These definitions not only addressed matters of the scope of practice but, in addition, stated that skills were to be acquired in continuing education programs following ANA guidelines or in baccalaureate nursing programs (12).

In 1979, the National League for Nursing published a position paper on the education of nurse practitioners, stating that "the nurse practitioner should hold a master's degree in nursing in order to

ensure competence and quality care." The statement then emphasized the need for nurses to be educated as practitioners within the formal structure of graduate nursing programs (21) (yet more than two decades later, nurse practitioners do not need to hold a baccalaureate degree to practice in many states) (22). As of 1993, preparation at the graduate level is required to sit for certification examinations offered by the American Nurses Credentialing Center as an adult, family, pediatric, school, or gerontologic nurse practitioner, and by 1998 all generalist certification examinations required a minimum of a baccalaureate degree (23).

Nurse Clinician and Clinical Nurse Specialist Education

In a 1943 speech, Frances Reiter first used the term "nurse clinician," and in 1944, Adelaide A. Mayo defined "clinical nursing specialist" in an article in the *American Journal of Nursing* (5). Dorothy Johnson offered clinical nurse specialists as a solution to the problem of the well-prepared nurse moving away from direct patient care (6). An early master's program to prepare advanced practitioners was developed by Hildegard Peplau at Rutgers University in 1954. It focused on psychiatric nursing (7). Two years later, participants at an interdisciplinary conference agreed that clinical specialists in psychiatric nursing should be prepared at the master's level (8).

Educational preparation for clinical nurse specialists/nurse clinicians evolved in a somewhat different model from that for nurse practitioners. Unlike the deluge of programs to prepare nurse practitioners, no comparable explosion of certificate programs occurred to prepare clinical nurse specialists. Instead, beginning in 1954, master's programs were developed whose focus was advanced clinical practice (7). Most, if not all, of the programs were at the master's level. By 1993, there were 250 master's programs offering preparation in one or more specialty areas for clinical nurse specialists and/or other advanced practice roles.

Among the 312 university and college graduate programs in nursing in 1999, the number offering options to prepare clinical

nurse specialists changes almost daily as programs struggle to prepare advanced practice nurses for the twenty-first century (18)

National Credentialing for Advanced Practice

In the late 1960s, certification for advanced practice and certification examinations were developed by the ANA Divisions of Practice. Among the first nurses certified who held advanced practice degrees were those in psychiatric mental health practice (13). Then, in 1976, an ANA program was implemented to provide for certification of nurses as nurse practitioners (14).

Certification for other advanced practice roles followed similar paths. The American Association of Nurse Anesthetists, founded in 1931, began its national certification program around 1941, and the American College of Nurse-Midwives, founded as the American Association of Nurse-Midwives in 1929, established its national certification program in 1971 (1, 2, 106). Thus, in a little over two decades from the first formal nurse practitioner and clinical nurse specialist programs, the concept of role expansion for nurses took hold and gave birth to new definitions of practice and the process of national credentialing for advanced practice.

Preparation for Advanced Practice: Confusion in the Public's Eye

Advanced practice nurses are of four types: nurse anesthetists, nurse-midwives, nurse practitioners, and clinical nurse specialists. There are different educational programs for each of these, with the exception of the blended CNS/NP programs. There is one professional body certifying nurse anesthetists, one for nurse midwives, and several for nurse practitioners and clinical nurse specialists.

Adding to the confusion is the lack of unity in requirements for entry into nurse practitioner programs. Many of the certificate programs require only that one be a registered nurse with a current license to practice. Admission requirements range from physician recommendation and a promise to serve as preceptor to meeting criteria for admission to the graduate school of a university. Upon

completion, the individual may receive nothing, a certificate, a baccalaureate degree, or a master's degree. Settings for programs have ranged from physician's offices to hospitals, other health care institutions, schools of nursing, universities and colleges, and schools of public health and medicine.

The debate continues concerning the setting for and length of advanced practice programs. Federal guidelines mandate that programs be one year in length in order to qualify for funding. Guidelines for programs have been prepared by the American Nurses Association, the Association of Women's Health, Obstetric, and Neonatal Nurses, the American College of Nurse-Midwives, the American Association of Nurse Anesthetists, and the National Association of Pediatric Nurse Associates and Practitioners. In addition, about two dozen specialty organizations offer certification for specialty and/or advanced practice roles and have promulgated educational standards. Graduates of programs adhering to the guidelines are eligible for certification examinations sponsored by these organizations or their certifying bodies. (See Appendix B.)

Advanced Practice Roles: Blending and Merging

By the mid-1980s, the differences between nurse practitioners and clinical nurse specialists were blurring. Certificate practitioner programs were declining and the number of master's programs was rising.

The results of the clinical nurse specialist and nurse practitioner core curricula survey of 1990 demonstrated that, at the master's level, preparation for both roles is quite similar. Differences exist in clinical content (pharmacology, primary care, history taking and physical assessment, nutrition, and health promotion in nurse practitioner programs) and in clinical settings (with more secondary and tertiary for clinical specialists) (24).

In a working document for the Council of Clinical Nurse Specialists and the Council of Primary Care Nurse Practitioners of the American Nurses Association, Sparacino and Durand laid out the

similarities and differences in the two advanced practice roles (27). In 1990, the two councils merged, reflecting a transition to designation as nurses in advanced practice (28). Of course, such a merger did not occur without dissent, and since that time several new nurse practitioner organizations have been formed, as has the National Association of Clinical Nurse Specialists (17).

Some have argued that clinical specialists should move toward the nurse practitioner name and role, in part because of the power base and public recognition associated with the title nurse practitioner (30). In several studies, merging of roles is evident. Elder and Bullough (31) surveyed graduates of nurse practitioner and clinical nurse specialist programs and found fewer differences than the literature might suggest and a general consensus that the roles should merge. The core curriculum study of 1990 supported congruence in master's preparation between the two roles, as noted earlier (24). Diers argued that we no longer have "generalized practice," and that advanced nurse practitioners should be prepared for specialty practice at the master's level (32). The greatest differentiation between clinical nurse specialists and nurse practitioners occurred earlier when education programs developed on divergent paths: certificate and master's. With convergence of those paths, merging of the roles becomes clearer.

Several other changes have propelled us toward merging these two advanced practice roles. Unlike the roles of nurse-midwives and nurse anesthetists, nurse practitioner and clinical nurse specialist roles are far less delineated. The differences between these roles blur as settings for practice become less important as providers move across boundaries, managed care systems grow, lengths of stay in acute care settings shorten, and more care moves back into the community. "The way we define specialties and roles may be becoming obsolete" (25). A merged role could maximize the expertise brought to the advanced practice role and make the role more viable (26, 33).

Tilting for Advanced Practice

In professional nursing literature, as in that of other professions, the

lay press, and in legislation, consensus grew in the 1990s that nurses in advanced practice—nurse practitioners, clinical nurse specialists, certified nurse-midwives, and certified registered nurse anesthetists—should be collectively referred to as advanced practice nurses (15, 22, 85, 102). "Advanced practice nurse (APN)" is "an umbrella term given to a registered nurse who has met advanced educational and practice requirements, usually at the master's level, beyond the basic nursing education and licensing required of all RNs" (109). The American Nurses Association and the American Association of Critical Care Nurses have adopted the term advanced practice nurse (111). The American Association of Colleges of Nursing in 1994 endorsed advanced practice nurse as "an umbrella term appropriate for a licensed registered nurse prepared at the graduate degree level as either a clinical specialist, nurse anesthetist, nurse-midwife, or nurse practitioner" (108, p. 1). The National League for Nursing has recommended merging two advanced practice roles—clinical nurse specialist and nurse practitioner—under a single title, and the Division of Nursing of the U.S. Public Health Service, Department of Health and Human Services, has agreed that by 2010 the roles will be merged (103). Many states are using the term advanced practice nurse in new or proposed legislation authorizing advanced practice under nurse practice acts and in propagating regulations for prescription writing and third-party reimbursement (22, 29).

Debates over titles are considered by some to be counterproductive (107). Others predict that in the new millennium only "the most flexible will be here to practice nursing" (110). Starck pointed out that nurses seem obsessed with titles: "What other profession redefines what it calls itself as often as we do?" (104)

Practice Settings

When Lucille Kinlein became an independent practitioner around three decades ago, she was declaring to the public that she, as a nurse, had something unique and special to offer to patients (34). Numerous other nurses have followed her example and have met