Lucille A. Joel

ADVANCED PRACTICE NURSING

Essentials for Role Development

FOURTH EDITION

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Preface

The content of this text was identified only after a careful review of the documents that shape both the advanced practice nursing role and the educational programs that prepare these individuals for practice. That review allowed some decisions about topics that were essential to all advanced practice nurses (APNs)*, whereas others were excluded because they are traditionally introduced during baccalaureate studies. This text is written for the graduate-level student in advanced practice and is intended to address the nonclinical aspects of the role.

Unit 1 explores *The Evolution of Advanced Practice* from the historical perspective of each of the specialties: the clinical nurse-midwife (CNM), nurse anesthetist (NA), clinical nurse specialist (CNS), and nurse practitioner (NP). This historical background moves to a contemporary focus with the introduction of the many and varied hybrids of these roles that have appeared over time. These dramatic changes in practice have been a response to societal need. Adjustment to these changes is possible only from the kaleidoscopic view that theory allows. Skill acquisition, socialization, and adjustment to stress and strain are theoretical constructs and processes that will challenge the occupants of these roles many times over the course of a career, but coping can be taught and learned. Our accommodation to change is further challenged as we realize that advanced practice is neither unique to North America nor new on the global stage. Advanced practice roles, although accompanied by varied educational requirements and practice opportunities, are well embedded and highly respected in international culture. In the United States, education for advanced practice had become well stabilized at the master's degree level. This is no longer true. The story of our recent transition to doctoral preparation is laid before us with the subsequent issues this creates.

The Practice Environment, the topic of Unit 2, dramatically affects the care we give. With the addition of medical diagnosis and prescribing to the advanced practice repertoire, we became competitive with other disciplines, deserving the rights of reimbursement, prescriptive authority, clinical privileges, and participation as members on health plan panels. There is the further responsibility to understand budgeting and material resource management, as well as the nature of different collaborative, responding, and reporting relationships. The APN often provides care within a mediated role, working through other professionals, including nurses, to improve the human condition.

Competency in Advanced Practice, the topic of Unit 3, demands an incisive mind capable of the highest order of critical thinking. This cognitive skill becomes refined as the subroles for practice emerge. The APN is ultimately a direct caregiver, client advocate, teacher, consultant, researcher, and case manager. The APN's forte is to coach individuals and populations so that they may take control of their own health in their own way, ideally even seeing chronic disease as a new trajectory of wellness. The APN's clients are as diverse as the many ethnicities of the U.S. public, and the challenge is often to learn from them, taking care to do no harm. The APN's therapeutic modalities go beyond traditional Western medicine, reaching into the realm of complementary therapies and integrative health-care practices that have become expected by many consumers. Any or all of these role competencies are potential areas for conflict, needing to be understood, managed, and resolved in the best interests of the client. Some of the most pressing issues confronting APNs today are how to mobilize informational technology in the service of the client, securing visibility for their work, and thinking

*Please note that the terms advanced practice nurse (APN) and advanced practice registered nurse (APRN) are used interchangeably in this text according to the author's choice.

through publication. The chapters in this section aim to introduce these competencies, not to provide closure on any one topic; the art of direct care in specialty practice is not broached.

When you have completed your course of studies, you will have many choices to make. There are opportunities to pursue your practice as an employee, an employer, or an independent contractor. Each holds different rights and responsibilities. Each demands *Ethical, Legal, and Business Acumen,* which is covered in Unit 4. Each requires you to prove the value you hold for your clients and for the systems in which you work. Cost efficiency and therapeutic effectiveness cannot be dismissed lightly today. The nuts and bolts of establishing a practice are detailed, and although these particulars apply directly to independent practice, they can be easily extrapolated to employee status. Finally, experts in the field discuss the legal and ethical dimensions of practice and how they uniquely apply to the role of the APN to ensure protection for ourselves and our clients.

This text has been carefully crafted based on over 40 years of experience in practice and teaching APNs. It substantially includes the nonclinical knowledge necessary to perform successfully in the APN role and raises the issues that still have to be resolved to leave this practice area better than we found it.

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Acknowledgments

This book belongs to its authors. I am proud to be one among them. Beyond that, I have been the instrument to make these written contributions accessible to today's students and faculty. I thank each author for the products of his or her intellect, experience, and commitment to advanced practice.

Contents

UNIT

1

The Evolution of Advanced Practice

1

Advanced Practice Nursing

Doing What Has to Be Done

Lynne M. Dunphy

Learning Outcomes

Learning outcomes expected as a result of this chapter:

- Recognize the historical role of women as healers.
- Identify the roots of professional nursing in the United States including the public health movement and turn-of-the-century settlement houses.
- Describe early innovative care models created by nurses in the first half of the 20th century such as the Frontier Nursing Service (FNS).
- Trace the trajectory of the role of the *nurse midwife* across the 20th century as well as the present status of this role.
- Recognize the emergence of *nurse anesthetists* as highly autonomous practitioners and their contributions to the advancement of surgical techniques and developments in anesthesia.
- Describe the development of the *clinical nurse specialist* (*CNS*) role in the context of 20th-century nursing education and professional development with particular attention to the current challenges of this role.
- Describe the historical and social forces that led to emergence of the nurse practitioner (NP) role and understand key events in the evolution of this role.
- Describe the development of the doctor of nursing practice (DNP) and distinguish this role from the others described in this chapter.
- Describe the current challenges to *all* advanced roles and formulate ways to meet these challenges going forward.

Advanced practice is a contemporary term that has evolved to label an old phenomenon: nurses or women providing care to those in need in their surrounding communities. As Barbara Ehrenreich and Deidre English (1973) note, "Women have always been healers. They were the unlicensed doctors and anatomists of western history . . . they were pharmacists, cultivating herbs and exchanging the secrets of their uses. They were midwives, travelling from home to home and village to village" (p. 3). Today, with health care dominated by a male-oriented medical profession, advanced practice nurses (APNs) (especially those cheeky enough to call themselves "doctor" even while clarifying their nursing role and background) are viewed as nurses "pushing the envelope"—the envelope of regulated, standardized nursing practice. The reality is that the boundaries of professional nursing practice have always been fluid, with changes in the practice setting speeding ahead of the educational and regulatory environments. It has always been those nurses caring for persons and families who see a need and respond—at times in concert with the medical profession and at times at odds—who are the true trailblazers of contemporary advanced practice nursing.

This chapter makes the case that, far from being a new creation, APNs actually predate the founding of modern professional nursing. A look back into our past reveals legendary figures always responding to the challenges of human need, changing the landscape of health care, and improving the health of the populace. The titles may change—such as a doctor of nursing practice (DNP)—but the essence remains the same.

PRECURSORS AND ANTECEDENTS

There is a long and rich history of female lay healing with roots in both European and African cultures. Well into the 19th century, the female lay healer was the primary health-care provider for most of the population. The sharing of skills and knowledge was seen as one's obligation as a member of a community. These skills were broad based and might have included midwifery, the use of herbal remedies, and even bone setting (Ehrenreich, 2000, p. xxxiii). Laurel Ulrich, in *A Midwife's Tale* (1990), notes that when the diary of the midwife Martha Ballard opens in 1785, ". . . she knew how to manufacture salves, syrups, pills, teas, ointments, how to prepare an oil emulsion, how to poultice wounds, dress burns, treat dysentery, sore throat, frost bite, measles, colic, 'whooping cough,' 'chin cough,' . . . and 'the itch,' how to cut an infant's tongue, administer a 'clister' (enema), lance an abscessed breast . . . induce vomiting, assuage bleeding, reduce swelling and relieve a toothache, as well as deliver babies" (p. 11).

Ulrich notes the tiny headstones marking the graves of midwife Ballard's deceased babies and children as further evidence of her ability to provide compassionate, knowledgeable care; she was able to understand the pain and suffering of others. The emergence of a male medical establishment in the 19th century marked the beginning of the end of the era of female lay healers, including midwives. The lay healers saw their role as intertwined with one's obligations to the community, whereas the emerging medical class saw healing as a commodity to be bought and sold (Ehrenreich & English, 1978). Has this really changed? Are not our current struggles still bound up with issues of gender, class, social position, and money? Have we not entered a phase of more radical than ever splits between the haves and have-nots, with grave consequences to our social fabric?

Nursing histories (O'Brien, 1987) have documented the emergence of professional nursing in the 19th century from women's domestic duties and roles, extensions of the things that women and servants had always done for their families. Modern nursing is usually pinpointed as beginning in 1873, the year of the opening of the first three U.S. training schools for nurses, "as an effort on the part of women reformers to help clean up the mess the male doctors were making" (Ehrenreich, 2000, p. xxxiv). The incoming nurses, for example, are credited with introducing the first bar of soap into Bellevue Hospital in the dark days when the medical profession was still resisting the germ theory of disease and aseptic techniques.

The emergence of a strong public health movement in the 19th century, coupled with the Settlement House Movement, created a new vista for independent and autonomous nursing practice. The Henry Street Settlement, a brainchild of a recently graduated trained nurse named Lillian Wald, was a unique community-based nursing practice on the lower east side of New York City. Wald described these nurses who flocked to work with her at Henry Street Settlement as women of above average "intellectual equipment," of "exceptional character, mentality and scholarship" (Daniels, 1989, p. 24). These nurses, as

has been well documented, enjoyed an exceptional degree of independence and autonomy in their nursing practice caring for the poor, often recent immigrants.

In 1893, Wald described a typical day. First, she visited the Goldberg baby and then Hattie Isaacs, a patient with consumption to whom she brought flowers. Wald spent 2 hours bathing her ("the poor girl had been without this attention for so long that it took me nearly two hours to get her skin clean"). Next, she inspected some houses on Hester Street where she found water closets that needed "chloride of lime" and notified the appropriate authorities. In the next house, she found a child with "running ears," which she "syringed," showing the mother how to do it at the same time. In another room, there was a child with a "summer complaint"; Wald gave the child bismuth and tickets for a seaside excursion. After lunch she saw the O'Briens and took the "little one, with whooping cough" to play in the back of the Settlement House yard. On the next floor of that tenement, she found the Costria baby who had a sore mouth. Wald "gave the mother honey and borax and little cloths to keep it clean" (Coss, 1989, pp. 43–44). This was all before 2 p.m.! Far from being some new invention, midwives, nurse anesthetists, clinical nurse specialists (CNSs), and nurse practitioners (NPs) are merely new permutations of these long-standing nursing commitments and roles.

NURSE-MIDWIVES

Throughout the 20th century, nurse-midwifery remained an anomaly in the U.S. health-care system. Nurse-midwives attend only a small percentage of all U.S. births. Since the early decades of the 20th century, physicians laid claim to being the sole legitimate birth attendants in the United States (Dye, 1984). This is in contrast to Great Britain and many other European countries where trained midwives attend a significant percentage of births. In Europe, homes remain an accepted place to give birth, whereas hospital births reign supreme in the United States. In contrast to Europe, the United States has little in the way of a tradition of professional midwifery.

As late as 1910, 50% of all births in the United States were reportedly attended by midwives, and the percentage in large cities was often higher. However, the health status of the U.S. population, particularly in regard to perinatal health indicators, was poor (Bigbee & Amidi-Nouri, 2000). Midwives—unregulated and by most accounts unprofessional—were easy scapegoats on which to blame the problem of poor maternal and infant outcomes. New York City's Department of Health commissioned a study that claimed that the New York midwife was essentially "medieval." According to this report, fully 90% were "hopelessly dirty, ignorant, and incompetent" (Edgar, 1911, p. 882). There was a concerted movement away from home births. This was all part of a mass assault on midwifery by an increasingly powerful medical elite of obstetricians determined to control the birthing process.

These revelations resulted in the tightening of existing laws and the creation of new legislation for the licensing and supervision of midwives (Kobrin, 1984). Several states passed laws granting legal recognition and regulation of midwives, resulting in the establishment of schools of midwifery. One example, the Bellevue School for Midwives in New York City, lasted until 1935, when the diminishing need for midwives made it difficult to justify its existence (Komnenich, 1998). Obstetrical care continued the move into hospitals in urban areas that did not provide midwifery. For the most part, the advance of nurse-midwifery has been a slow and arduous struggle often at odds with mainstream nursing. For example, Lavinia Dock (1901) wrote that all births must be attended by physicians. Public health nurses, committed to the professionalizing of nursing and adherence to scientific standards, chose to distance themselves from lay midwives. The heritage of the unprofessional image of the lay midwife would linger for many years.

A more successful example of midwifery was the founding of the Frontier Nursing Service (FNS) in 1925 by Myra Breckinridge in Kentucky. Breckinridge, having been educated as a public health nurse and traveling to Great Britain to become a certified nurse-midwife (CNM), pursued a vision of autonomous nurse-midwifery practice. She aimed to implement the British system in the United States (always a daunting enterprise on any front). In rural settings, where doctors were scarce and hospitals virtually nonexistent, midwifery found more fertile soil. However, even in these settings, professional nurse-midwifery had to struggle to bloom.

Breckinridge founded the FNS at a time when the national maternal death rate stood at 6.7 per 1,000 live births, one of the highest rates in the Western world. More

than 250,000 infants, nearly 1 in 10, died before they reached their first birthday (U.S. Department of Labor, 1920). The Sheppard-Towner Maternity and Infancy Act, enacted to provide public funds for maternal and child health programs, was the first federal legislation passed for specifically this purpose. Part of the intention of this act was to provide money to the states to train public health nurses in midwifery; however, this proved short-lived. By 1929, the bill lapsed; this was attributed by some to major opposition by the American Medical Association (AMA), which advocated the establishment of a "single standard" of obstetrical care, care that is provided by doctors in hospital settings (Kobrin, 1984).

Breckinridge saw nurse-midwives working as independent practitioners and continued to advocate home births. And even more radically, the FNS saw nurse-midwives as offering complete care to women with normal pregnancies and deliveries. However, even Breckinridge and her supporters did not advocate the FNS model for cities where doctors were plentiful and middle-class women could afford medical care. She stressed that the FNS was designed for impoverished "remotely rural areas" without physicians (Dye, 1984).

The American Association of Nurse-Midwives (AANM) was founded in 1928, originally as the Kentucky State Association of Midwives, which was an outgrowth of the FNS. First organized as a section of the National Organization of Public Health Nurses (NOPHN), the American College of Nurse-Midwives (ACNM) was incorporated as an independent specialty nursing organization in 1955 when the NOPHN was subsumed within the National League for Nursing (NLN). In 1956, the AANM merged with the college, forming the ACNM as it continues today. The ACNM sponsored the *Journal of Nurse-Midwifery,* implemented an accreditation process of programs in 1962, and established a certification examination and process in 1971. This body also currently certifies non-nurses as midwives and maintains alliances with professional midwives who are not nurses. As noted by Bigbee and Amidi-Nouri (2000), CNMs are distinct from other APNs in that "they conceptualize their role as the combination of two disciplines, nursing and midwifery" (p. 12).

At their core, midwives as a group remain focused on their primary commitment: care of mothers and babies regardless of setting and ability to pay. Rooted in holistic care and the most natural approaches possible, in 2015 there were 11,194 CNMs and 97 certified midwives. In 2014, CNMs or CMs attended 332,107 births, accounting for 12.1% of all vaginal births and 8.3% of total U.S. births (National Center for Health Statistics, 2014).

CNMs are licensed, independent health-care providers with prescriptive authority in all 50 states, the District of Columbia, American Samoa, Guam, and Puerto Rico. CNMs are defined as primary care providers under federal law. CMs are also licensed, independent health-care providers who have completed the same midwifery education as CNMs. CMs are authorized to practice in Delaware, Missouri, New Jersey, New York, and Rhode Island and have prescriptive authority in New York and Rhode Island. The first accredited CM education program began in 1996. The CM credential is not yet recognized in all states.

Although midwives are well-known for attending births, 53.3% of CNMs and CMs identify reproductive care and 33.1% identify primary care as main responsibilities in their full-time positions. Examples include annual examinations, writing prescriptions, basic nutrition counseling, parenting education, patient education, and reproductive health visits.

NURSE ANESTHETISTS

Nursing made medicine look good. —*Baer, 1982*

Surgical anesthesia was born in the United States in the mid 19th century. Immediately there were rival claimants to its "discovery" (Bankert, 1989). In 1846 at Massachusetts General Hospital, William T. G. Morton first successfully demonstrated surgical anesthesia. Nitrous oxide was the first agent used and adopted by U.S. dentists. Ether and chloroform followed shortly as agents for use in anesthetizing a patient. One barrier to surgery had been removed. However, it would take infection control and consistent, careful techniques in the administration of the various anesthetic agents for surgery to enter its "Golden Age." It was only then that "surgery was transformed from an act of desperation to a scientific method of dealing with illness" (Rothstein, 1958, p. 258).

For surgeons to advance their specialty, they needed someone to administer anesthesia with care. However, anesthesiology lacked medical status; the surgeon collected the fee. No incentive existed for anyone with a medical

degree to take up the work. Who would administer the anesthesia? And who would do so reliably and carefully? There was only one answer: nurses.

In her landmark book *Watchful Care: A History of America's Nurse Anesthetists* (1989), Marianne Bankert explains how economics changed anesthesia practice. Physician-anesthetists "needed to establish their 'claim' to a field of practice they had earlier rejected" (p. 16), and to do this it became necessary to deny, ignore, or denigrate the achievements of their nurse colleagues. The most intriguing part of her study, she says, was "the process by which a rival—and less moneyed—group (in this case, nurses) is rendered historically 'invisible'" (p. 16).

St. Mary's Hospital, later to become known as the Mayo Clinic, played an important role in the development of anesthesia. It was here that Alice Magaw, sometimes referred to as the "Mother of Anesthesia," practiced from 1860 to 1928. In 1899, she published a paper titled "Observations in Anesthesia" in *Northwestern Lancet* in which she reported giving anesthesia in more than 3,000 cases (Magaw, 1899). In 1906, she published another review of more than 14,000 successful anesthesia cases (Magaw, 1906). Bigbee and Amidi-Nouri (2000) note, "She stressed individual attention for all patients and identified the experience of anesthetists as critical elements in quickly responding to the patient" (p. 21). She also paid special attention to her patients' psyches: She believed that "suggestion" was a great help "in producing a comfortable narcosis" (Bankert, 1989, p. 32). She noted that the anesthetist "must be able to inspire confidence in the patient" and that much of this depends on the approach (Bankert, 1989, p. 32). She stressed preparing the patient for each phase of the experience and of the need to "'talk him to sleep' with the addition of as little ether as possible" (p. 33). Magaw contended that hospital-based anesthesia services, as a specialized field, should remain separate from nursing service administrative structures (Bigbee & Amidi-Nouri, 2000). This presaged the estrangement that has historically existed between nurse anesthetists and "regular" nursing; we see a nursing specialty with expanded clinical responsibilities developing outside of mainstream nursing.

The medical specialty of anesthesiology began to gain a foothold around the turn of the 20th century, led largely by women physicians. However, these physicians were unsympathetic to the role of the nurse anesthetists; they wanted to replace them to establish their own controls. Different variants of this old power struggle echo today in legislative battles over the need for on-site oversight by an anesthesiologist.

The American Association of Nurse Anesthetists (AANA) was founded in 1931 by Hodgins and originally named the National Association for Nurse Anesthetists. This group voted to affiliate with the American Nurses Association (ANA), only to be turned away. As early as 1909, Florence Henderson, a successor of Magaw's, was invited to present a paper at the ANA convention, with no subsequent extension of an invitation to become a member of the organization (Komnenich, 1998). Thatcher (1953) speculates that organized nursing was fearful that nurse anesthetists could be charged with practicing medicine, a theme we will see repeated when we examine the history of the development of the NP role. This rejection led the AANA to affiliate with the American Hospital Association (AHA).

The relationship between nurse anesthetists and anesthesiologists has always been, and continues to be, contentious. Consistent with health-care workforce data in general, there is a maldistribution of MDs, including anesthesiologists, who frequently choose to practice in areas where patients can afford to pay or in desirable areas to live. Rural areas continue to be underserved as well as indigent areas in general. CRNAs pick up the slack, "doing what has to be done" to meet the needs of underserved patients. Complicating this picture is that there is an uneven supply of CRNAs in different geographic areas. As CRNAs retire later, unwilling to give up lucrative positions, some regions experience intergenerational hostility as well.

Despite a brief period of relative harmony from 1972 to 1976, when the AANA and the American Society of Anesthesiologists (ASA) issued the "Joint Statement on Anesthesia Practice," their partnership ended when the board of directors of the ASA withdrew its support of this statement, returning to a model that maintained physician control (Bankert, 1989, pp. 140–150).

The Certified Registered Nurse Anesthetist (CRNA) credential came into existence in 1956. At present, there are approximately more than 50,000 CRNAs (AANA, 2016),* 41% of whom are males (compared with the approximately 13% male population in nursing overall, a figure that has held steady for some time). CRNAs safely

*In some states, the title CRNA has been changed to APN-Anesthesia.

administer *approximately 43 million anesthetics* to patients each year in the United States according to the AANA 2016 Practice Profile Survey.

Interestingly, the inclusion of large numbers of males in its ranks has not eased the advance of this venerable nursing specialty; turf wars between practicing anesthesiologists and nurse anesthetists remain intense as of this writing, further aggravated by the incursion of "doctor-nurses" or "nurse-doctors." Nonetheless, nurse anesthetists continue to thrive and have situated themselves in the mainstream of graduate-level nursing education, including a large portion of programs adapting curriculums leading to the DNP. Their inclusion in the spectrum of advanced practice nursing continues to be invigorating for us.

THE CLINICAL NURSE SPECIALIST

The role of the CNS is the one strand of advanced practice nursing that arose and was nurtured by mainstream nursing education and nursing organizations. Indeed, one could say it arose from the very bosom of traditional nursing practice. As early as 1900, in the *American Journal of Nursing,* Katherine DeWitt wrote that the development of nursing specialties, in her view, responded to a "need for perfection within a limited domain" (Sparacino, 1986, p. 1). According to DeWitt, nursing specialties were a response to "present civilization and modern science [that] demand a perfection along each line of work formerly unknown" (Sparacino, 1986, p. 1). She argued that "the new nurse is more useful, at least to the patient himself, and ultimately to the family and community. Her sphere is more limited, but her patient receives better care" (Sparacino, 1986, p. 1).

Historically, nurses were trained and worked in hospitals that were structured for the convenience of the doctors around specific populations of patients. Early on, nurses initiated guidelines for the care of unique populations and often garnered a hands-on kind of intimacy, an expertise in the care of certain patients that was not to be denied. Caring day in and day out for patients suffering from similar conditions enabled nurses to develop specialized and advanced skills not practiced by other nurses. Think of the nurses who cared exclusively for patients with tuberculosis, syphilis, and polio. Because these conditions are no longer common, any nursing expertise that might have been developed has been lost.

In a 1943 speech, Frances Reiter first used the term *nurse-clinician.* She believed that "practice is the absolute primary function of our profession" and "that means the direct care of patients" (Reiter, 1966). The nurse-clinician, as Reiter conceived the role, consisted of three spheres. The first sphere, clinical competence, included three additional dimensions of function, which she termed *care, cure,* and *counseling.* The nurse-clinician was labeled "the Mother Role," in which the nurse protects, teaches, comforts, and encourages the patient. The second sphere, as envisioned by Reiter, involved clinical expertise in the coordination and continuity of the patient's care. In the final sphere, she believed in what she called "professional maturity," wherein the physician and nurse "share a mutual responsibility for the welfare of patients" (Reiter, 1966, p. 277). It was only through such working together that the patient could best be served and nursing achieve "its greatest potential" (Reiter, 1966). Although Reiter believed that the nurse-clinician should have advanced clinical competence, she did not specify that the nurse-clinician should be prepared at the master's level.

In 1943, the National League for Nursing Education advocated a plan to develop these *nurse-clinicians,* enlisting universities to educate them (Menard, 1987). Traditionally, advanced education in nursing had focused on "functional" areas, that is, nursing education and nursing administration. Esther Lucile Brown, in her 1948 report *Nursing for the Future,* promoted developing clinical specialties in nursing as a way of strengthening and advancing the profession. The GI Bill was also available. Nurses in the Armed Services were eligible to receive funds for their education.

It took the entrance of another strong nurse leader, Hildegard Peplau, to move these ideas forward to fruition. In 1953, she had both a vision and a plan: She wanted to prepare psychiatric nurse clinicians at the graduate level who could offer direct care to psychiatric patients, thus helping to close the gap between psychiatric theory and nursing practice (Callaway, 2002). In addition, as always there was a great need for health-care providers of all stripes in psychiatric settings. In her first 2 years at Rutgers University in New Jersey, Peplau developed a 19-month master's program that prepared only CNSs in psychiatric nursing. In contrast, existing programs, such as that at Teachers College in New York City, attempted to prepare nurses for teaching and supervision in a 10-month program.

The field of psychiatric nursing was in the process of inventing itself. Before the passage of the National Mental Health Act in 1946, there was no such field as psychiatric nursing. It was the availability of National Institute of Mental Health funds to "seed" such programs as Peplau's that allowed psychiatric nursing to begin and eventually to flourish.

In retrospect, Peplau would note that no encouragement was received from the two major nursing organizations of the day, the NLN and the ANA. She stated, "We were highly stigmatized. Any nurse who worked in [the field of mental health] was considered almost certifiable. . . . We were thoroughly unpopular, we were considered queer enough to be avoided" (Callaway, 2002, p. 229).

It should be emphasized that at this point in nursing history it was inconceivable that any nurse, under any circumstances, could become a specialist. The "received wisdom" of the day was the axiom, followed by the vast majority of nurses, that "a nurse is a nurse is a nurse," opposing any differentiation between who was doing what among them. Peplau's rigorous curriculum and clinical and academic program requirements expected that faculty would continue their own clinical practice, do clinical research, and publish the results (Callaway, 2002). This was a radical model for nursing faculty, few of whom were doctorally prepared in the 1950s. In 1956, only 2 years following the initiation of the first clinically focused graduate program, a national working conference on graduate education in psychiatric nursing formally developed the role of the psychiatric clinical specialist.

Most hospital training schools remained embedded in a functional method of nursing well into the 1960s. As originally conceptualized by Isabel Stewart in the 1930s, "nurses were trained and much of nursing practice was rule-based and activity-oriented" (Fairman, 1999, p. 42), relying heavily on repetition of skills and procedures. There was little, if any, scientific understanding of the principles underlying care. There was little, if any, intellectual content to be found in the nursing curriculum.

With the advent of antibiotics in the 1940s and the resulting decline of infectious diseases, nurses' practice shifted to caring for patients with acute, often rapidly changing exacerbations of chronic conditions. Leaders such as Peplau, along with others such as Virginia Henderson, Frances Reiter, and later Dorothy Smith, began developing a theoretical orientation for practice. Students were being taught to assess patient responses to their illnesses and to make analytical decisions. Smith experimented with the idea of a nurse-clinician who had 24-hour responsibility for a patient area and who was on call. Laura Simms at Cornell University–New York Hospital School of Nursing developed a CNS role to provide consultation to more generalist nurses. As opposed to the nurse who might have been expert in procedures, these new clinicians were experts in clinical care for a certain population of patients. This development occurred across specialties and was seen in oncology, nephrology, psychiatry, and intensive care units (Sills, 1983).

Role expansion of the CNS grew rapidly during the 1960s because of several factors. Advances in medical technology and medical specialization increased the need for nurses who were competent to care for patients with complex health needs. Nurses returning from the battlefields of Vietnam sought to increase their knowledge and skills and continued to practice in advanced roles and nontraditional areas (such as trauma or anesthesia). Role definitions for women loosened and expanded. There was a shortage of physicians. The Nurse Training Act of 1964 allocated necessary federal funds for additional graduate nursing education programs in several different clinical specialties (Mirr & Snyder, 1995).

The terms *nurse-clinician, CNS,* and *nurse specialist,* among others, were used extensively by nurses with experience or advanced knowledge who had developed an expertise within a given area of patient care. There were no standards regarding educational requirements or experience. In 1965, the ANA developed a position statement declaring that only those nurses with a master's degree or higher in nursing should claim the role of CNS (ANA, 1965). These trends continued into the 1970s. The number of academic programs providing master's preparation in a variety of practice areas increased. Federal grants, including those from the Department of Health, Education, and Welfare, continued to provide funding for nursing education at the master's and doctoral levels.

In 1976, during the ANA's Congress on Nursing Practice, a position statement on the role of the CNS was issued. The ANA position statement read as follows (ANA Congress for Nursing Practice, 1976):

> The clinical nurse specialist (CNS) is a practitioner holding a master's degree with a concentration in specific areas of clinical nursing. The role of the CNS is defined by the needs of a select client population, the expectation of the larger society and the clinical expertise of the nurse.

The statement went on to elaborate that "by exercising leadership ability and judgment," the CNS is able to affect

client care on the individual, direct-care provider level as well as affect change within the broader health-care system (ANA Congress for Nursing Practice, 1976).

The 1970s were a time of growth in academic CNS programs; the 1980s were years in which refinements occurred. In 1980, the ANA revised its earlier policy statement of 1976 to define the CNS as "a registered nurse who, through study and supervised clinical practice at the graduate level (master's or doctorate) has become an expert in a defined area of knowledge and practice in a selected clinical area of nursing" (ANA, 1980, p. 23). This statement was significant because it was the first time that education at the master's level had been dictated as a mandatory criterion for entry into expert practice.

The CNS role more than any other advanced nursing role was situated in the mainstream of graduate nursing education, with the first master's degree in psychiatric and mental health nursing conferred by Rutgers University in 1955. The inclusion of clinical content in master's degree education was an essential step forward for nursing's advancement. But the implementation and use of the CNS avoided easy categorization and their efficacy was elusive.

In February 1983, the ANA Council of Clinical Nurse Specialists met for the first time (Sparacino, 1990). The Council grew rapidly throughout the subsequent years, supporting and providing educational conferences for the increasing numbers of CNSs. In 1986, the Council published the CNS's role statement. This statement identified the roles of the CNS as specialist in clinical practice and as educator, consultant, researcher, and administrator. This role statement by the Council depicted the changing role of the CNS, notably delegating and overseeing practice as its primary focus (Fulton, 2002). The year 1986 was also notable for the publication of the journal *Clinical Nurse Specialist: The Journal for Advanced Nursing.*

In 1986, the ANA's Council of Clinical Nurse Specialists and the Council of Primary Health Care Providers published an editorial outlining the similarities of the CNS and NP roles. Discussion surrounding the commonalities of both specialties occurred throughout the decade. In 1989, during the annual meeting of the National Organization of Nurse Practitioner Faculty (NONPF), the 10-year-old debate regarding the merger of the two roles reached a crescendo without resolution (Lincoln, 2000). It remains an issue of contention to the present day. Despite this, the two ANA councils did merge in 1990, becoming the Council of Nurses in Advanced Practice (Busen & Engleman, 1996; Lincoln, 2000). Following the merger of the councils, several studies were published comparing CNS and NP roles, finding the education for practice generally comparable (Joel, 2011).

The 1990s was an era of health-care "reform." Health-care costs were skyrocketing; hospital stays were shorter, with acutely ill patients being discharged quicker and sicker. Because of fiscal mandates, hospitals were decreasing the number of beds and personnel and the focus of health care shifted from hospital to ambulatory care within the community and home. The historically hospital-based CNS was considered too expensive and unproven. Thus, CNSs all over were losing positions.

In 1993, the American Association of Colleges of Nursing (AACN) met to discuss educational needs and requirements for the 21st century. At the AACN's annual conference in December 1994, members voted to support the merging of the CNS and NP roles in the curricula of graduate education in nursing. Although the structure of the curricula suggested in the "Essentials of Graduate Education" (AACN, 1995) has been widely adopted, the lived reality of role adaptation and its implementation in the marketplace has been less uniform and more divisive. Sparacino (1990) defined the scope of the CNS as "client-centered practice, utilizing an in-depth assessment, practiced within the domain of secondary and tertiary care settings" (p. 8). The NP role is defined by Sparacino (1986) as being responsible for providing a full range of primary health-care services, using the appropriate knowledge base and practicing in multiple settings outside of secondary and tertiary settings. To some degree this has been the nature of these roles, though many exceptions can be observed today.

Scope of practice barriers continue in this area of advanced practice nursing. The latest setback occurred when the Standard Occupational Classification Policy Committee (SOCPC) announced its recommendations to the Office of Management and Budget for the 2018 Standard Occupational Classification on July 22, 2016. The SOCPC declined to include the CNS in a separate broad occupation and detailed occupation category, stating:

> Multiple dockets requested a new detailed occupation for Clinical Nurse Specialists. The SOCPC did not accept this recommendation based on Classification Principle 2 which states that occupations are classified based on work performed and on Classification Principle 9 on collectability.

In July 2014, the National Association of Clinical Nurse Specialists (NACNS) submitted an extensive filing on why the CNS should be included in the Standard Occupational Classification (SOC) as a "broad category." This is the second time that the SOCPC did not accept the request to make the CNS a new detailed occupation in the SOC. Retaining CNSs in the RNs 2010 classifications is inconsistent with federal agencies, with nursing practice in the states, and with the larger nursing community, all of which distinguish CNSs as APRNs. Congress has accepted CNSs as APRNs for nearly two decades. The *Balanced Budget Act of 1997* allowed CNSs to directly bill their services through the Centers for Medicare and Medicaid Services under Part B participation in Medicare. CNSs were recognized as eligible for Medicare's Primary Care Incentive Program in the *Patient Protection and Affordable Care Act* (PPACA, 2010).

CNSs prescribe medications, durable medical equipment, and medical supplies as well as order, perform, and interpret diagnostic tests including laboratory work and x-rays. Two unequivocal differences exist between CNSs and RNs: diagnosing patients and prescribing pharmaceuticals. CNSs can perform both; RNs are not authorized to perform either. The SOCPC's recommendation to not recognize the CNS as a broad occupation and detailed occupation, similar to how other APRNs are categorized, skews the quality and utility of federal health-care policy data. Linking the CNS workforce data with the RN workforce does not allow CNS contributions to be differentiated from or compared with any other APRN data. Simply put, a database set up by any federal, state, regional, local, research, or private entity using the 2010 SOC categories has no data on the more than 72,000 CNSs in the United States (NACNS, 2016).

The "other side" of this story of advanced practice nursing—NP evolution—is addressed in the next section of this chapter. The futures of these various roles remain on some level intertwined and are further complicated by the emergence of a new model of educational preparation: the DNP.

THE EVOLUTION OF THE NURSE PRACTITIONER ROLE: "A DISRUPTIVE INNOVATION"

The history of the NP "movement" has been well documented (Brush & Capezuti, 1996; Fairman, 1999, 2008; Jacox, 2002). A lesser known story involves Dr. Eugene A. Stead, Jr., of Duke University, who in 1957 conceived of an advanced role for nurses somewhere between the role of the nurse and the doctor. Thelma Ingles, a nursing faculty member on a sabbatical, worked with Stead, accompanying the interns and residents on rounds, seeing patients, and managing increasingly ill patients with acumen and sensitivity. Ingles shared Stead's ideas and returned to the Duke Nursing School to create a master of science in nursing program modeled on her experience with Stead. Stead was gratified and anxious to impart this expanded role to other nursing faculty, envisioning a new role for nurses, with, in his view, expanded autonomy. He was shocked at the "lukewarm" response of the dean of nursing at Duke and the unsupportive stance of several prominent nurses at the university. On top of that, the NLN, the school's accrediting body, did not approve of Ingles's new program for nurse clinical specialization and withheld the program's accreditation. They found the program "unstructured" and criticized the use of physicians as instructors to teach courses for nurses in a nursing program. They disavowed the study of the esteemed discipline of medicine that Stead was so anxious to impart (Holt, 1998). Instead, they wanted the students to study "nursing." Stead could not understand this. What was there in nursing to study? Rejected and disheartened, Stead eventually turned to military corpsmen to actualize this new role, which he named *physician assistant.* He insisted that they be male. In his view, nurse leaders were very antagonistic to innovation and change (Christman, 1998). In the view of some, this was a missed opportunity for organized nursing but one governed by historical circumstances when viewed on the broader stage of history. Fairman (2008), in an extensive study of Stead's papers, offers the appraisement that "Stead's difficulties went beyond his experiences with organized and academic nursing. They reflected his perceptions of the kind of help his physician colleagues needed" (Fairman, 2008, p. 98).

Stead's original proposal was quite prescient. Gender roles were loosening as were hierarchical structures in general; nurses were better educated and well able to assume the role responsibilities that Stead envisioned. Yet it came at a time when nursing was merely a fledgling discipline, new to the university, new to development as an academic discipline, and new to doctoral education. Academic nursing was fixated on defining its own knowledge base and developing its own unique science. Along

with expanded opportunities for women came ideas of an autonomous nursing role separate and distinct from medicine. Stead's deeply rooted gender-role stereotyping no doubt further inflamed nursing resistance to "his" new role. Other settings—such as the University of Colorado, where Henry Silver, a pediatrician, and Loretta Ford, a master's-prepared public health nurse, founded a partnership rooted in collaboration—provided more fruitful results. All these factors were in play when the first NPs emerged in the 1960s.

However, the NP was not really a new role for nurses. Examining our history, it is apparent that nurses functioned independently and autonomously before the rise of organized medicine. If medicine was ambivalent about the emergence of this new role, nursing itself was no less conflicted.

In 1978, the following statement appeared in the *American Journal of Nursing* (Roy & Obloy, 1978, p. 1698):

> The nurse practitioner movement has become an issue in nursing, a topic on which there is no consensus. One question about the movement is whether the development of the nurse practitioner role adds to, or detracts from, the development of nursing as a distinct scientific discipline.

This statement was issued more than 13 years after the initiation of the first NP program at the University of Colorado. If, as Sparacino (1990) spells out, the domain of the CNS is situated in the secondary and tertiary setting, the domain of the NP originally arose as a role situated in primary care.

Loretta Ford and Dr. Henry Silver designed a graduate curriculum for pediatric nurses to provide ambulatory care to poor rural Colorado children. The goal of this program was to bridge the gap between the health-care needs of children and the family's ability to access and afford primary health care (Ford & Silver, 1967; Silver, Ford, & Stearly, 1967). This program was situated in graduate education and included courses such as pathophysiology, health promotion, and growth and development, with the intent of the student understanding the principles of healthy child care and patient education. Nurses would then be able to provide preventive nursing services outside of the hospital setting in collaboration with physicians. Students had to have a baccalaureate degree and public health nursing experience to be admitted to the program.

Ford states the following in an interview: "We looked at the nurse practitioner preparation not as a separate program but as integrated into a role that had already been designed at the graduate level" (Jacox, 2002, p. 155). Ford notes that the lack of organizational leadership in the profession coupled with a lack of responsiveness in academic settings caused a "bastardization of the model" (Jacox, 2002, p. 157). She had envisioned that our professional organization, as in other professions, would identify, credential, and make public advanced NPs. However, Ford was to discover that the "ANA in those early years was reluctant to stick its neck out and give some leadership to the NP groups that were growing rapidly" and that the lack of leadership in nursing education created "a patchwork quilt" of differently prepared NPs (Jacox, 2002, p. 157). Although clinically based programs were growing, there remained resistance to the NP model. Ford (Jacox, 2002, p. 155) says,

> I understood that faculty members were supposed to be doing just that—push the borders of knowledge and publish their work. In my naiveté of faculty politics, I expected that since the NP model grew out of professional nursing and public health nursing—including primary, secondary, and tertiary prevention and community-based services—it was a perfectly legitimate investigation. Instead, it became a battleground, and even recently was labeled in the Harvard Business Review as a "Disruptive Innovation." What a compliment!

The collaboration between NP and physician has been analyzed and debated since the advent of the NP role, including the relationship between Ford and Silver (Fairman, 2002, 2008). The sticking point of collaboration is that it has included the heavy implication of supervision and thus control. In truth, in the early 1970s both NPs and physicians had to give up their traditional roles, tasks, and knowledge to establish this new provider role, often in the face of organizational and societal opposition. Jan Towers describes the growth of her own NP practice as follows: "The area that I perhaps most feared turned out to be the least troublesome, after some initial adjustments between the physician with whom I was working and me were made" (Towers, 1995, p. 269). What would often be impossible on an organizational level was more easily resolvable among professionals with a shared interest and commitment: the good of the patient.

Prescriptive authority was a major issue, and it was either delegated from the medical practice act and carried out under physicians' standing orders or protocols or it

came directly from the nursing practice acts. Nurse historian Arlene Keeling has argued that far from being a new realm of nursing practice, the "prescribing"—or use—of a variety of techniques and substances for therapeutic effect has always been a dimension of nursing practice (Keeling, 2007). The states of Oregon and Washington allowed nurses the freedom to prescribe independently in 1983 (Kalisch & Kalisch, 1986). Some of the fiercest turf battles have heated up over prescriptive privileges. By 1984, nurses were accused of practicing medicine, although they were practicing well within the scope of their expanded role. Physicians remained ambivalent. They pushed NPs to function broadly but did not usually support legislation that authorized an increased scope of practice, especially in the area of prescriptive privileges. Joan Lynaugh, nurse historian, describes NPs as looking for an "exam room of their own"—essentially a clinical space in which to provide nursing care (Fairman, 2008, p. 7). This space is indeed a crowded one (Fairman, 2008, p. 200, note 9). Prescriptive authority is discussed in greater detail in Chapter 6.

The Great Society entitlement programs significantly influenced the need for NPs to care for people who were covered under Medicare and Medicaid. Predominant social movements—women's rights, civil rights, antiwar protest, consumerism—had a profound impact on the need for groups to assert their place in the society of the 1960s and early 1970s. Nurses were not immune to the forces unleashed in these years and took advantage of the opportunities to work with physicians "in relationships that were entrepreneurial and groundbreaking, and to engage in a kind of dialogue that supported new models of care" (Fairman, 2002, p. 165). These nurses were pioneers, rebels, and renegades treading on uncertain ground.

The National Advisory Commission on Health Manpower supported the NP movement (Moxley, 1968). The Committee to Study Extended Roles for Nurses in the early 1970s recommended that the expanded role for nurses was necessary to provide the consumer with access to health care and proposed the inclusion of highly developed health assessment skills (Kalisch & Kalisch, 1986; Leininger, Little, & Carnevali, 1972; Marchione & Garland, 1997). Although the Committee did stop short of providing a definitive scope of practice statement, it recommended support for licensure and certification for advanced practice, recognition in the nursing practice act, further cost-benefit research, and surveys on role impact. Government and private groups rapidly developed funding support for educational programs (Hamric, Spross, & Hanson, 2013). According to Marchione and Garland (1997), "The traditional role of humanistic caring, comforting, nurturing and supporting was to be maintained and improved by the addition" of new primary care functions that the Department of Health, Education, and Welfare approved: total patient assessment, monitoring, health promotion, and a focus that encompassed not only disease prevention but health promotion and maintenance, treatment, and continuity of care.

The Division of Nursing of the Department of Health, Education, and Welfare tracked the development of the NP role from 1974 to 1977. During that time, the number of NP programs rose from 86 to 178 across the country, with significant governmental support through the Nurse Training Act to advanced practice nursing education programs of all types. Although nurse educators by this time wanted NP education standardized, in 1977 most NP programs awarded a certificate with some still using continuing education models and accepting less than a baccalaureate degree for entry. However, the number of NP graduates of master's programs did increase from 20% in 1975 to 26% in 1977, again largely encouraged by the availability of federal funds for support. The education of NPs was the rallying cry for the formation of the NONPF in 1980, dedicated to defining curriculum and evaluation standards as well as pioneering research and development related to NP practice and teaching-learning methodologies. The political voice for NPs was enhanced with the formation of the American Academy of Nurse Practitioners (AANP) in 1985 and the American College of Nurse Practitioners (ACNP) in 2003.

The Nurse Training Acts of 1971 and 1975 were critical in providing federal funding to support NP programs. By 1979, more than 133 programs and tracks existed, and approximately 15,000 NPs were in practice. By 1983 and 1984, NP graduates numbered approximately 20,000 to 24,000; they were primarily employed in sites that served those in greatest need: public health departments, community health centers, outpatient and rural clinics, health maintenance organizations, school-based clinics, and occupational health clinics (Hamric et al, 2013; Kalisch & Kalisch, 1986; Pulcini & Wagner, 2001). NPs were typically providing care for health promotion, disease prevention, minor acute problems, chronic stabilized illness, and the

full range of teaching and coaching that nurses have always provided for patients and families.

A hindrance to practice in rural areas was finding appropriate physician backup. By 1987, the federal government had spent $100 million to promote NP education, primarily through the U.S. Public Health Service Division of Nursing (Pulcini & Wagner, 2001). By the 1980s, the master's degree was viewed broadly as the educational standard for advanced practice (Geolot, 1987; Sultz et al, 1983), and by 1989, 90% of programs were master's and post-master's level (Pulcini & Wagner, 2001). NONPF thrived in the 1980s, developing curriculum guidelines and competencies, surveying faculties, and studying role components.

An interorganizational task force to identify criteria for quality NP educational programs occurred as an outgrowth of the work to unify certification. This work, begun in 1995 by NONPF and the NLN, was the beginning of the development of a model curriculum for NP education that would be used nationally and provide the basis for certification eligibility (Hamric et al, 2013). At that time, the NLN was the only accrediting body for nursing graduate programs, and program standards, curriculum guides, and domains and competencies for NP education from NONPF were often used by the NLN in the accreditation process. In 1998, the Commission on Collegiate Nursing Education, an accreditation arm of the AACN, was formed to provide an alternative to the NLN as a source of accreditation to schools offering baccalaureate and higher degrees in nursing. The thrust of the 2001 meeting of the NP task force when it reconvened was for accrediting bodies to move toward the approval of NONPF guidelines and standards as the reigning accepted standards for accreditation of programs preparing NPs (Edwards et al, 2003). In addition, the APRN Consensus Model (see later section) spells out specific criteria for preapproval and accreditation of APRN education.

There is a cautionary note to this perception of progress. Despite clear statutes in some states, credentialing by insurers for NPs may still lag, providing additional barriers to care. Scope of practice, a primary focus of the 2011 Institute of Medicine (IOM) *Future of Nursing* recommendations, remains a contested battleground for control of professional practice and reimbursement.

In 2008, the adoption of the Consensus Model for Advanced Practice Registered Nurse (APRN) Regulation by the National Council of State Boards of Nursing (NCSBN) gave direction for gains in legal authority, prescriptive privilege, and reimbursement mechanisms across the 50 states and the District of Columbia. Current NPs have achieved a higher degree of autonomy in practice and associated prestige (Phillips, 2011) with the mandate for continued advancement contained in the IOM report, *The Future of Nursing* (2011). More victories than failures provide evidence of success, but, as in the late 1970s, today's NP is still battling for autonomy and consumer recognition in practice, especially in states with many physicians. Veterans' Health Affairs (VHA) Advanced Practice Registered Nurses Proposed Rule (81 Fed.Reg.33155, May 25, 2016) to the Federal Register is under siege. Opponents, as noted earlier, are still trying to block implementation of this policy and are reaching out to members of Congress to delay the proposal through legislation that extends expiring benefits for our nation's veterans. New legislation was introduced late in 2016, the *Veterans Affairs Expiring Authorities Act* (HR 5985).

As early as 1985, Hayes stated, "No role in nursing, or for that matter, in any field has been so debated in the literature, and possibly no other nursing function has ever been so obsessed about by those performing it as has been the NP role" (Hayes, 1985, p. 145). Yet, as Hayes asserts, there has been an avalanche of support from satisfied consumers of NP services.

THE CONSENSUS MODEL

In an effort to bring some clarity to and standardization of advanced practice nursing roles, in 2008 the APRN Consensus Model, also referred to as a regulatory model, was published by the APRN Consensus Work Group and the NCSBN APRN Advisory Committee with extensive input from a larger APRN stakeholder community. The nomenclature *APRN* was adopted, and four APRN roles were defined in the document: CNMs, CRNAs, CNSs, and certified nurse practitioners (CNPs). An APRN is further defined as an RN who has completed a graduate degree or postgraduate program that has prepared him or her to practice in one of these four roles. The acronym LACE—standing for "licensure, accreditation, certification, and education"—demonstrates alliances across these spheres for implementation of the APRN Consensus

Model, thus promoting uniformity and standardization of the APRN role for the safety of the consumer of health care. The target date for model implementation was 2015, with an alignment of current certifying examinations with educational program offerings and subsequent licensure. By December 2016, according to the NCSBN, 15 states were in full compliance with the LACE model and most others were in some stage of change. This is amazing given the continued strength of states' rights and the opposition of organized medicine.

YET ANOTHER "DISRUPTIVE INNOVATION": THE DOCTOR OF NURSING PRACTICE

The future contains clouds on the horizon as well as sunshine. Fairman (1999) cautions that although local negotiations between individual physicians and nurses may have been, in some cases, easily traversed in the interest of the good of the patient, on the professional level hierarchical relationships and power are at stake. As noted at the start of this chapter, within this hotly competitive health-care environment, with the still controversial implementation of the PPACA (2010), the entire health-care sector continues to face hurdles, challenges, and assaults.

In October 2004, the members of the AACN endorsed the *Position Statement on the Practice Doctorate in Nursing,* which called for the movement of educational preparation for advanced practice nursing roles from the master's degree to the doctoral level by 2015. Though this target date has not been achieved, there has been much movement in this direction. This "new" doctorate is a "practice" doctorate in contrast to the doctor of philosophy (PhD)—the traditional research degree—and is not intended to "replace" the PhD. There are many reasons for this development. Some master's programs for APNs had become very lengthy, without any change in the credential awarded at the completion of studies. The number of credits, in many cases, approaches what is required for a doctoral degree. And many educators believe this is necessary to ensure clinical competency. Furthermore, other practice disciplines such as pharmacy, physiotherapy, and occupational therapy have moved on to doctoral-level preparation. The debate continues.

The case can also be made that APNs across the country have been expanding their skills, both formally and informally. One example is the role of "intensivist" in the hospital, which is being assumed by many NPs and CNSs (Mundinger, 2005). This is consistent with nursing's lengthy history of moving where the need in health care surfaces—always "doing what had to be done." The aging of the population, the increased acuity of patients with multiple comorbidities, the complexity of care, the continuation of a dwindling number of primary care physicians, and the decreased hours for residents in the hospital because of legislative and accreditation criteria have fostered the need for these nurses to move well beyond the primary care arena. For example, when Columbia University School of Nursing was asked by Presbyterian Hospital to establish two new ambulatory care clinics to meet the growing demand for primary care among the underserved immigrant populations, the faculty accepted. They also proposed conducting a randomized trial comparing independent NPs and primary care physicians. To reduce the variability among roles and strengthen the study, the faculty requested that the hospital's medical board grant the faculty NPs admitting privileges. Mundinger (2005) describes this evolution at Columbia: "Several physician(s) . . . provided additional training for our faculty nurse practitioners in dermatology, radiology, and cardiology and helped mentor them through the process of admitting, and co-managing patients and conducting emergency room evaluation" (p. 175).

The results of the randomized trials, with excellent patient care outcomes achieved by NPs on a par with primary care physicians, were published in the *Journal of the American Medical Association* (Mundinger et al, 2000). This contributed to a change in hospital bylaws and granted faculty NPs hospital admitting privileges. Mundinger sees the level of service delivered by these faculty NPs as beyond that achieved by colleagues with the traditional master's degree preparation for practice. Based on these observations comes the call for a formal and standardized curriculum leading to a doctoral degree consistent with the practice needs for advanced competencies and increased knowledge. Mundinger (2005) states, "We know that thousands of nurses aspire to this level of education and schools are responding by developing the new degree. We know that the research degree is asynchronous with these goals, and we know from every other profession that

when you reach the competency associated with doctoral achievement, one should receive a doctorate not another MS degree" (p. 175).

As part of the APRN Consensus Model, 2015 was targeted as the year anyone seeking to sit for certification as an APRN would need a DNP. Although the DNP degree has spread and prospered since 2008, there have always been vocal detractors. Recently, opposition to this mandate was voiced by a significant cohort of national nursing leaders in a paper titled "The Doctor of Nursing Practice: A National Workforce Perspective" (Cronenwett et al, 2011), making the case that the need for care providers should take precedence over a professionalizing agenda. Significant retrenchment of the 2015 mandate has occurred, with moves to preserve existing master's programs producing APRNs. See Chapter 4 for more discussion on this issue.

THE INSTITUTE OF MEDICINE ISSUES ITS 2010 REPORT: *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH*

This dramatic, evidence-based report presents the results of 2 years of study by the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the IOM. This committee was chaired by Donna Shalala, PhD, FAAN, long-time nurse advocate, former head of the U.S. Department of Health and Human Services (1992–2000), and now University of Miami president, in concert with Nursing Vice Chair Linda Burnes Bolton, RN, DrPH, FAAN. This report was presented in November 2010. The far-reaching impact of the report's recommendations are just now beginning to be fully absorbed. Key recommendations begin with the assumption that "nursing can fill . . . new and expanded roles in a redesigned healthcare system" (IOM, 2011, p. xi). We will need our renegades, rebels, and trailblazers more than ever.

CONCLUSION

The boundaries of practice are always malleable. They are always subject to myriad external forces—political, economic, social, and cultural—and are interpreted in different ways by different practitioners. APNs are a mixed breed; each trajectory under the umbrella of advanced nursing practice has evolved differently and under variable circumstances. This leads to vigor, strength, and diversity. The struggles documented within this chapter have aimed to strengthen each variant of the nursing advanced practice role. The struggles are not over; in many ways, they are just beginning. It is our hope that nursing will continue to produce rebels, renegades, and trailblazers motivated by concern for patients, concern for community, and concern for humanity. We have no doubt that we will continue to take on new and challenging roles using creative and diverse strategies. Nursing continues to lurch forward; progress is sometimes slow, sometimes variable, sometimes unsteady—but, as always, continuing to find opportunity in chaos, motivated, as ever, by commitment to patients, families, and communities, to human need and suffering.

2

Emerging Roles of the Advanced Practice Nurse

Deborah Becker and Caroline Doherty

Learning Outcomes

Learning outcomes expected as a result of this chapter:

- Describe the advanced practice registered nurses (APRN) Scope of Practice and the Consensus Model.
- Describe the clinical nurse specialist (CNS) role and discuss how their contributions contribute to cost savings and implementation of evidence-based practice.
- Identify role highlights of the nurse practitioner (NP) in primary care with adult and pediatric populations, in various community settings, in psychiatric and mental health care, in women's health/gender-related care and transitional care, and in acute care with neonatal, pediatric adult, and elderly populations.
- Discuss nurse-midwifery with an emphasis on primary care and first-assistant services.
- Summarize the new certification requirements for nurse anesthetists.
- Distinguish palliative care as an emerging practice area for all APRNs.
- Propose diverse practice opportunities for APRNs.

INTRODUCTION

Advanced practice nursing continues to evolve to meet the changing and increasing needs of patients, communities, and society as a whole. Advanced practice registered nurses (APRNs)* have successfully adapted their roles to meet these ever-changing needs and the expectations that go along with them. The growth occurring now can be attributed to several elements, such as health-care reform and fuller implementation of the Affordable Care Act (ACA), a national emphasis on the provision of safe and high-quality care, pay-for-performance initiatives, and the call by the Institute of Medicine (IOM)'s *Future of Nursing* (2011) report for APRNs to work to the fullest extent of their scopes of practice without restrictions or barriers. These initiatives foster new opportunities for the development of advanced practice nursing roles.

Several factors have influenced the emergence and acceptability of advanced practice roles. These factors include the growing numbers of elderly patients as baby boomers reach retirement age, increased complexity and severity of illness in hospitalized patients, further reductions in medical residents' clinical work hours, a call for greater access to care for all citizens, and a varying degree of nursing and primary care physician shortages, depending on geographical region. These and other factors will continue to influence the emergence of the APRN role in the coming decades.

The four major groups of APRNs currently in the United States are certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs), and nurse practitioners (NPs). The range of current advanced practice roles and the numbers of nurses in these roles demonstrate the continued success and acceptance of APRNs. See **Table 2.1.** Studies evaluating clinical outcomes of care delivered by APRNs are overwhelmingly positive as are surveys of patient satisfaction with the delivery of care by APRNs.

*APRN is the title preferred by the American Nurses Association (ANA) and used in most state practice acts. Throughout this chapter, various acronyms will be presented to distinguish between specialty preparations, but the generic title for all these practice roles is APRN. Please note that not all of the four specialty preparations are recognized in their state as APRNs.

TABLE 2.1

Numbers of Advanced Practice Nurses

Clinical nurse specialists	8,395
Certified registered nurse anesthetists	49,113
Certified nurse-midwives	8,332
Nurse practitioners	186,656

Source: Adapted from Phillips, S. J. (2016). 28th annual legislative update. *Nurse Practitioner, 41*(1), 21–52.

A systematic review of outcomes studies conducted between 1990 and 2008 was performed to compare patient outcomes between physician- and APRN-directed teams (Newhouse et al, 2011). The review found that patient outcomes of care provided by NPs and CNMs (in collaboration with physicians as required by state regulations) were similar to—and in some ways better than—care provided by physicians alone for the populations and in the settings included (Newhouse et al, 2011). The review found that CNSs working in acute care settings can reduce length of stay and cost of care for hospitalized patients. Although no specific conclusions regarding CRNA patient outcomes were provided by this review, a few studies show CRNA patient outcomes to be comparable with those of anesthesiologists (Newhouse et al, 2011). A recent Cochrane Review of studies comparing outcomes of anesthesiologists and CRNAs found that, although the quality of studies available to review was poor, there is no available study demonstrating any difference between the quality of care provided by CRNAs or anesthesiologists (Lewis, Nicholson, Smith, & Alderson, 2014).

By accepting the responsibilities of the advanced practice role, APRNs have understood the need to expand legislative recognition of their professional status, including prescriptive authority and reimbursement for care delivered. Recognition of APRNs in the United States varies, with most states providing some level of legal recognition and prescriptive authority.

SCOPE OF PRACTICE

Professional nursing organizations and state boards of nursing understand the need to describe and interpret the responsibilities of advanced practitioners in their areas of specialization. Underlying the recognition of this need is the obligation to ensure public safety, to identify the essential characteristics of advanced practice, and to interpret for the practitioner the components of competent care (American Association of Critical Care Nurses and American Nurses Association, 1995). The scope of practice may be described by the functions performed by the APRN and the minimal competencies needed to perform those functions. These descriptions and guidelines direct APRNs in the implementation and conceptualization of their roles and responsibilities.

In addition, each state has a legislative and regulatory stance on issues affecting advanced practice within its jurisdiction (Phillips, 2016). The legal scope of practice, including prerogatives for diagnosing, prescriptive authority, and reimbursement, is described within these regulations. Scope and standards of practice are defined by the professional organization and enacted into law at the state level. The actual role is further delineated through credentialing of practice responsibilities and activities at the institutional or employment level. Hospitals and other health-care organizations typically define role responsibilities and prerogatives through a review by other practitioners, and this is generally expressed through a contract identifying responsibilities, prerogatives, and limitations of the role. This review results in the granting of institutional- or organizational-based practice privileges for the APRN.

Although scope of practice guidelines are important philosophically and may even have the weight of law, they do not imply that the roles of APRNs are unchanging. When knowledge evolves and different care delivery models emerge, roles also evolve. More commonly, roles change as different practice settings become available and opportunities for improved patient access to care appear. The nature of advanced practice is broader than individual roles or functions.

Regulation of the Advanced Practice Registered Nurse

Regulation of APRNs occurs at the state level, but there are both educational and certification prerequisites. Graduate-level educational preparation of APRNs is guided by educators and members of professional organizations who identify essential curricular goals, content, and competencies expected of APRN graduates. In 2004, the American Association of Colleges of Nursing (AACN) called for doctoral-level preparation as entry level for APRNs, with a proposed implementation date of 2015. However, several barriers to moving entry-level practice preparation to the doctoral level have been identified. These barriers include financial costs, limited faculty resources, the need to obtain permissions from numerous levels of leadership, boards and regulatory bodies, finding clinical sites, and more (Rand Corporation, 2010). Many schools of nursing moved their APRN education to the doctoral level, with most offering the doctorate of nursing practice (DNP) degree; however, only the American Association of Nurse Anesthetists (AANA) has mandated that as of 2022, all graduates of educational programs must be prepared at the doctoral level for entry into practice (AANA, 2010). The remaining APRN groups have not embraced mandating doctoral education for entry into practice.

Content and competencies core to all APRNs and those specific to a particular role must be provided in all APRN educational programs. **Table 2.2** lists major APRN organizations that develop the educational and certification prerequisites and the APRN essential content and competency documents that direct the preparation of APRNs for entry into practice. On completion of an accredited master's or doctoral-level program, graduates generally must pass a national certification examination in the area of intended practice before applying for licensure at the state level.

APRNs may be recognized and licensed at the state level in one of the four aforementioned roles. However, many issues have been identified with the current regulatory process, particularly eligibility for reciprocity of licensure between states. In response to this need to develop more consistent standards for APRN recognition across states, the APRN Consensus Work Group and the National Council of State Boards of Nursing have developed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (Consensus Model, 2008). This document has been accepted by numerous nursing organizations and stakeholder groups. The regulatory model acknowledges the four APRN roles and recommends that advanced practice registered nursing must be

TABLE 2.2

Professional Organizations and Essential Educational Content

Organization	Landmark Publications
American Association of Colleges of Nursing	*The essentials of master's education in nursing.* Washington, DC: Author, 2011. *The essentials of doctoral education for advanced nursing practice.* Washington, DC: Author, 2006.
American College of Nurse-Midwives	*Core competencies for basic midwifery practice.* Silver Spring, MD: Author, 2012. *Competencies for master's level midwifery education.* Silver Spring, MD: Author, 2014. *The practice doctorate in midwifery.* Silver Spring, MD: Author, 2011.
American Association of Women's Health, Obstetric and Neonatal Nurses, and National Association of Nurse Practitioners Women's Health	*The women's health nurse practitioner: Guidelines for practice and education* (7th ed.). Washington, DC: Author, 2014.
Council on Accreditation of Nurse Anesthesia Educational Programs	*Standards for accreditation of nurse anesthesia educational programs.* Chicago, IL: Author, 2016.
National Association of Clinical Nurse Specialists	*Criteria for the evaluation of clinical nurse specialist master's, practice doctorate, and post-graduate certificate educational programs.* Philadelphia, PA: Author, 2012. *Organizing framework and CNS core competencies.* Philadelphia, PA: Author, 2008.
National Organization of Nurse Practitioner Faculties	*NP core competencies with curriculum content.* Washington, DC: Author, 2014. *Adult-gerontological acute care nurse practitioner competencies.* Washington, DC: Author, 2012. *Adult-gerontological primary care nurse practitioner competencies.* Washington, DC: Author, 2010. *Population-focused nurse practitioner competencies: Family/Across the lifespan, neonatal, pediatric acute care, pediatric primary care, psychiatric-mental health, women's health/gender-related.* Washington, DC: Author, 2013.

regulated in one of the four roles and in at least one of six population foci: psychiatric or mental health, women's health/gender-related, adult-gerontology, pediatrics, neonatal, and individual families across the life span. The adult-gerontology and pediatrics populations are further distinguished by either an acute care or a primary care focus. Of note, the CNS practice is described to occur across primary and acute care settings and as such must be reflected in their education.

Requirements for consistent educational preparation across all APRN roles have provided greater uniformity. Content for all APRNs must include graduate-level courses in advanced pathophysiology, advanced physical assessment, and advanced pharmacology, called the *APRN core* (Consensus Model, 2008). In addition, content related to the population served, role development, and clinical experience in the specific role is required. The recommendations of the Consensus Model have and will continue to influence the licensure, accreditation, certification, and educational preparation of all future APRNs, and can be found in **Table 2.3.**

Clinical Nurse Specialist

CNSs are nurses with masters- or doctorate-level education in a defined area of knowledge and practice. They typically work in unit- or population-based settings; in hospitals, offices, or outpatient clinic settings; and in community practice. In an analysis of acute care advanced practice nurses performed by the American Association of Critical

TABLE 2.3

Essential Characteristics of the Advanced Practice Registered Nurse*

Completion of an accredited graduate-level program in one of four areas: nurse-midwifery, nurse anesthesia, NP, or CNS
Successful completion of a national certification examination measuring APRN role and population of focus competencies and maintains competence through recertification
Possession of advanced clinical knowledge and skills needed for direct patient care, and a significant component of education and practice focuses on direct care of individuals
Practice builds on RN competencies and demonstrates depth and breadth of knowledge, data synthesis, complex skills, intervention, and role autonomy
Educational preparation for health promotion and maintenance, assessment, diagnosis, and management of patient problems including use and prescription of pharmacological and nonpharmacological interventions
Possesses depth and breadth of clinical experience reflecting intended area of practice
Possesses license to practice as an RN, and then further as a CRNA, CNM, CNS, or CNP

APRN, advanced practice registered nurse; *CNM,* certified nurse-midwife; *CNP,* certified nurse practitioner; *CNS,* clinical nurse specialist; *CRNA,* certified registered nurse anesthetist; *RN,* registered nurse.

*Adapted from Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education. (2008). Completed through the work of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee.

Care Nurses (Becker et al, 2006), CNSs were asked to rate activities they perform that are most critical to their practices. Activities selected included the following:

- Synthesizing, interpreting, making decisions and recommendations, and evaluating responses on the basis of complex, sometimes conflicting, sources of data
- Identifying and prioritizing clinical problems on the basis of education, research, and experiential knowledge
- Facilitating development of clinical judgment in health-care team members (e.g., nursing staff, medical staff, other health-care providers) through serving as a role model, teaching, coaching, and/or mentoring
- Promoting a caring and supportive environment
- Promoting the value of lifelong learning and evidence-based practice while continually acquiring knowledge and skills needed to address questions arising in practice to improve patients' care
- Evaluating current and innovative practices in patients' care on the basis of evidence-based practice, research, and experiential knowledge
- Incorporating evidence-based practice guidelines, research, and experiential knowledge to formulate, evaluate, and/or revise policies, procedures, and protocols.

These results demonstrated the performance of activities that at one time were performed solely by physicians and currently also overlap with those performed by acute care nurse practitioners (ACNPs).

The CNS shifts functions depending on the needs of the situation and participates in a mix of direct and indirect patient care activities. Still, the traditional roles of CNS practice remain, including those of expert practitioner, educator, consultant, manager, and researcher. See **Boxes 2.1** and **2.2.**

The Clinical Nurse Specialist and Cost Savings

Multiple studies have demonstrated the positive contributions of CNSs to patient care outcomes and patient satisfaction, but fewer studies have evaluated their economic impact and their ability to generate income and save costs. A recent study by Richardson and Tjoelker (2012) demonstrated a CNS-led initiative to decrease central line associated bloodstream infections (CLABSI), saving the organization $214,712 in terms of cost avoidance and 1.4 lives saved out of 8 patients with CLABSI. Similarly, Maze and Riggins (2011) demonstrated a CNS-led initiative resulting in the CLABSI rate to be consistently below the National Healthcare Safety Network (NHSN) benchmark. These savings are real, but they may not be returned to the CNS's home (usually nursing) department. Because of this, the immediate supervisors of CNSs may not appreciate the benefits of expert CNS practice. This reality is compounded by the inability of CNSs to bill directly for services if they are hospital-based, salaried employees. Skilled advanced practice nursing care is not directly reimbursed and remains bundled in the hospital's

Box 2.1

The Unit-Based Clinical Nurse Specialist Profile

Margo is an adult critical care CNS who is master's prepared and has been working in a large academic health system for more than 6 years. Margo works on a neurosurgery step-down unit where her clientele ranges from patients with seizure disorders, those recovering from major strokes or traumatic brain injuries, and a host of neurosurgical conditions. She is a key member of the health-care team, especially because of her wealth of knowledge and experience with neurologically impaired patients. Margo leads interdisciplinary rounds that include attending physicians, fellows and residents in training, nurses, APRNs, pharmacists, dietitians, and physiatrists. She empowers her nursing staff to actively participate in rounds and provides them the resources and encouragement they need to have their voices heard. Margo is instrumental in assuring that the patients on her unit are receiving high-quality and safe care. Recently her unit was recognized for having met or exceeded quality metrics for 6 months in a row. Margo currently leads the CNS Leadership Group in her hospital. This group meets monthly to network with the 30+ CNSs that work throughout the system. This group sets internal standards for clinical and professional activities, reviews initiatives, and provides support to CNSs who often work in silos caring for their specific patient populations.

Box 2.2

Corporate Clinical Nurse Specialist Profile

Sue is a nurse who has doctoral-level training and has been a CNS for the past 20 years. She began her CNS career in a major teaching hospital during which she worked on the writing group to help the organization to achieve Magnet status. She also developed a postcardiothoracic surgery glycemic protocol, an orientation for BSN-prepared nurses and CNSs, along with many other significant initiatives. Subsequently, she was hired by a corporation as a consultant for all their ICUs. In this role, she helped to establish standards of care, has served as chair of numerous committees, developed protocols for safe handoffs, and worked with the interdisciplinary team to address quality and core measures. The significant travel requirement is a challenge, but she is pleased to know that her expertise has had such a significant impact across many organizations, resulting in a positive impact on the interdisciplinary team and the patients that they serve.

room, food, laundry, and supplies bill. More creative and appropriate financial models that could remedy the situation are needed. This limitation on role functioning is usually not faced by self-employed or practice-based CNSs, who likely are not institutional employees and generally work in outpatient or community settings.

One recent randomized controlled trial identified that cost savings were achieved, without loss of quality, by substituting physicians with diabetes nurse specialists in caring for patients with diabetes (Arts, Landewe-Cleuren, Schaper, & Vrijhoef, 2012). Few studies comparing CNS care to physicians exist primarily because of most CNSs working in hospitals. However, the CNS can play a key role in providing care to underserved populations and should be considered instrumental in achieving the goals of the ACA.

The Clinical Nurse Specialist and Evidence-Based Practice (EBP)

CNSs have long been considered change agents; recently, the implementation of EBP is where many CNSs spend their time. However, several barriers to implementing

change exist in clinical settings such as reluctance to change approaches when the "old way still works." A recent study by Campbell and Profetto-McGrath (2013) identified five challenges to implementing EBP by CNSs: time constraints for the CNS, time constraints for the bedside nurses, multiple roles of the CNS reducing dedicated time to focus on EBP implementation, heavy workload and lack of resources, and both individual and organization support (Campbell & Profetto-McGrath, 2013).

However, when CNSs are provided the time and resources to perform their role, positive outcomes occur. Recently, CNS involvement in quality initiatives and their contributions to improved patient outcomes has been recognized as agencies apply for Magnet Recognition. The Magnet Recognition Program® offered by the American Nurses Credentialing Center (ANCC) recognizes health-care organizations for quality patient care, nursing excellence, and innovations in professional nursing practice (ANCC, 2011). The CNS role is essential to implementing innovation and sustaining improved patient outcomes, which are integral components of the Magnet Recognition Program (Muller, Hujcs, Dubendorf, & Harrington, 2010). The CNS role broadly and specifically supports the process by which care is delineated, changes are made, and improvements are noted. CNS participation in the attainment of these goals and the movement of organizations toward achieving Magnet status likely will provide new and expanded opportunities for the CNS.

Ambiguity and the Clinical Nurse Specialist Role

The observation that CNS practice reflects role ambiguity undoubtedly grows out of the ability of the CNS to adapt to changing patient, family, and nursing staff needs, supported by a broad clinical repertoire of skills and knowledge. This adaptability provides role confusion not only for those implementing the role, but also for those observing it. There have been several responses to the problem of role ambiguity with in-hospital CNS roles. One has been the development of AACN's Scope and Standards for Acute and Critical Care Clinical Nurse Specialist Practice (Bell & McNamara, 2010). This document provides guidelines for competent and professional care for acutely and critically ill patients. It also reflects the three spheres of CNS influence: patient and family, nursing personnel and other health-care providers, and the organizational system for care delivery in different settings (Bell & McNamara, 2010). Within this framework, the CNS is expected to provide continuous and comprehensive care to improve outcomes for acutely and critically ill patients. This is done in a collaborative model that includes patients, families, significant others, nurses, and other providers and administrators (Bell & McNamara, 2010).

A contribution of this document is that it sets goals and standards for CNS practice and contributes to further role clarification for hospital-based CNSs. The values identified in this document for continuous and comprehensive care for acutely and critically ill patients suggest that the scope of the critical care CNS's responsibilities are not limited to acute or special care units. Seriously ill patients are found in most hospital units, and their continuing specialized care needs are now frequently required in nonhospital or outpatient settings. It is likely that postdischarge role functions will become more common for the acute or critical care CNS.

The publishing of CNS Core Competencies by the National CNS Competency Task Force (Clinical Nurse Specialist Core Competencies, 2010) also attempts to reduce role ambiguity for the CNS. This task force identified the various roles and activities of CNSs in numerous practice settings and validated them by surveying more than 2,000 CNSs. The range of agreement was 90% to 98%. These competencies will aid educators, employers, and new CNSs in understanding their role and responsibilities as well as their contributions to patient care outcomes.

However, CNSs have not obtained the clarity they are seeking. Recently, the Office of Management and Budget's Standard Occupational Classification (SOC) Policy Committee inaccurately designated CNSs as general registered nurses instead of APRNs. This miscategorization will result in the inability of researchers to capture accurate data and statistics as they relate to the CNS workforce, further reducing the importance of the CNS role to the health care of U.S. citizens (NACNS news release, 2016).

Nurse Practitioner

NPs are frontline health-care providers essential to developing and maintaining successful communication and collaboration among providers across health-care settings. In both primary and urgent care settings, NPs can ensure continuity of care, decrease health-care costs, and optimize health outcomes for patients (Villasenor & Krouse, 2016).

The educational preparation of NPs has moved from continuing education programs offering certification on completion to university-based graduate programs granting a master's or doctorate degree in nursing. Today, NPs are the largest group of APRNs and have prescriptive authority in all 50 states and the District of Columbia (Phillips, 2016). APRNs assess and manage both medical and nursing problems and serve as both primary and acute care providers.

Changing Roles for the Primary Care Nurse Practitioner

Initially, patient populations cared for by NPs were often uninsured immigrants or low-income individuals who were Medicaid recipients. However, NPs since have sought to meet the needs of larger groups of patients and have expanded their practices to include clients from suburban and urban outpatient settings and clinics. This shift to highly populated, high-income areas where physicians are also readily available shows the increased acceptance of NPs.

Retail and Urgent Care Clinics

The development of walk-in, retail, and urgent care clinics has changed the landscape for accessing primary care services. These clinics are major employers of NPs and thus provide an opportunity to showcase to the public some of the care that NPs can provide. According to the National Conference of State Legislatures (NCSL) website, as of 2015, 2,000 retail clinics operate in 41 states and Washington, DC (NCSL, 2015). Recognizing the potential impact of these clinics on the APRNs, the American Academy of Nurse Practitioners (AANP) published *Standards for Nurse Practitioner Practice in Retail-Based Clinics* (AANP, 2007).

Nurse Practitioners in the Community

Primary care NPs have established unique community-centered practice models. In an effort to develop an independent NP service model and to study the ways health care is delivered to various populations in the United States, many schools of nursing opened Academic Community Nursing Centers (Naylor & Kurtzman, 2010; Oros, Johantgen, Antol, Heller, & Ravella, 2001). These centers are used as settings in which to study how health care is provided to vulnerable populations with limited access to care, who face inefficiencies and a lack of coordination in health-care delivery; to determine the specific needs of the community in which the center is located; and to provide a means of improving the quality of the care delivered (Zachariah & Lundeen, 1997).

Building on the concept of nurse-run clinics, the National Committee for Quality Assurance (NCQA), a prominent health-care quality organization, reports that it will recognize "nurse-led" primary care practices as patient-centered medical homes under the Physician Practice Connections®–Patient-Centered Medical Home recognition program (Schram, 2010). In this program, practices are encouraged to add names of eligible NPs to their practice information. The "medical home" concept was developed to reward providers for the coordination and management of patient-centered care of individuals with complex and multiple chronic illnesses, activities that NPs can easily perform. What is uncertain is whether NPs were actually included in the staffing of Medical Homes. In a study conducted in New York (NY) State, Park (2015) compared the number of NPs and physician assistants (PAs) to primary care physicians in both designated and undesignated PCMHs. She found a significant increase in the number of NPs and PAs relative to Primary Care Physicians in designated PCMHs. This is a promising result, but only reflects the current condition in NY State.

Pediatric Nurse Practitioners

Societal changes also affect the care of children. Child abuse continues to be one of the nation's most serious concerns. During 2012, 3.4 million referrals for child abuse were made in the United States, involving 6.3 million children and resulting in 1,640 deaths (CDC, 2014c). Childhood immunization is also a top health priority in the United States. More than 600 cases of measles were reported in 2014, a disease thought to have been eradicated in the United States in 2000 (CDC, 2014b).

Recent reports show serious issues with childhood obesity, bullying, and increases in suicide attempts in adolescents aged 10 to 14 years (CDC, 2014a). The need for appropriately prepared pediatric NPs is urgent. However, few U.S. nurses gravitate toward pediatrics or the NP role. So, although the role is not new, the opportunities for nurses to care for our nation's children are abundant.

Nurse Practitioners in Transitional Care Settings

Hospital-based nurses have traditionally focused their interventions on preparing patients for discharge from

the hospital. However, the time for providing discharge teaching and answering patient and family questions is limited and often results in patients returning to the hospital because they did not completely understand their discharge instructions.

If patients were lucky enough to have a home health nurse visit them when they were discharged, these nurses often identified problems and concerns regarding the health of their patients and have had to contact the patient's physician to determine the next course of action, a step that often caused a delay in treatment. Therefore, the need for APRNs who can provide transitional care from hospital to community became particularly evident.

Several viable models of APRNs in transitional roles have been demonstrated through research efforts (Blewett et al, 2010; Hirschman & Bixby, 2014; Naylor et al, 2000). The clearly demonstrated, favorable patient-centered outcomes of Naylor's Transitional Care Model (2000) have gained significant recognition to the point of being named in the ACA as an example of a program showing substantial contributions to reducing health-care costs. However, there is still a need to further develop reimbursement systems for the services of APRNs.

Nurse Practitioners as Consultants in the Community

The NP as consultant in community health settings is another emerging advanced practice role. Long-term care facilities, nursing homes, and rehabilitation centers are settings that have few APRNs or professional nurses. However, residents in these settings often have chronic health needs that go untreated or unnoticed until they become serious. In response, some administrators have developed roles for APRNs to address health issues more quickly (Neal-Boylan, Mager, & Wallace-Kazer, 2012). More APRNs can be found in rehabilitation centers, inpatient hospice, skilled nursing facilities, and other nontraditional health-care settings. These community-based APRNs assess problems and develop plans of care in an attempt to prevent further progression of symptoms or needless suffering. Restrictions on APRNs' ability to function independently may limit the range of services they can provide. In addition, there are restrictions on the type of services for which APRNs can bill directly. However, as changes in health-care reimbursement policies continue to occur, the consultant role in the community will grow more popular.

The Psychiatric and Mental Health Nurse Practitioner

In the 1950s, the APRN role of the psychiatric and mental health nurse was conceptualized as a CNS role. With developments in the science underpinning mental health and psychiatric illnesses, emphasis shifted from a traditional psychosocial approach to care to a biopsychosocial paradigm. In the latter model, psychopharmacology assumed a prominent place in the treatment inventory. Acceptance of this movement was demonstrated by the development of national certification examinations for the psychiatric and mental health NP. Initially, there were two examinations available—adult and family (American Nurses Credentialing Center [ANCC], 2016). With the adoption of the Consensus Model (2008), the psychiatric and mental health APRN shifted to a focus on the individual across the life span. Prescriptive authority is available in 40 states for both CNSs and NPs (NACNS, 2015). However, NPs have prescriptive authority in all 50 states. For this reason, the psychiatric and mental health NP has become the only educational preparation for this APRN role. See **Box 2.3.**

A newly designed role for the psychiatric mental health NP is being developed through the University of Nebraska Medical Center College of Nursing (UNMC CON). Recognizing the needs of our citizens for both primary care and mental health services, UNMC CON has proposed a new program for an integrated family nurse practitioner/psychiatric–mental health nurse practitioner (Hulme, Houfek, Fiandt, Barron, & Mulhbauer, 2015). It is anticipated that this provider will care for patients across the mind–body spectrum in integrated mental health–primary care positions. Opportunities for APRN educational innovations will continue to emerge as nurses continue to respond to societal needs.

Women's Health/Gender-Related Nurse Practitioners

The women's health/gender-related NP role grew out of identification of the unique needs of women and initially focused on family planning, infertility, sexual dysfunction, gynecological care, perimenopausal issues, and the diagnosis and treatment of sexually transmitted infections (STIs) throughout the life span. Because of low income and the lack of resources available to many women, the role expanded to include well-woman health with a focus

Box 2.3

Adult Acute Care Nurse Practitioner in Palliative Care Profile

Rochelle is an adult ACNP working in palliative care in a university hospital. In her role, she is a member of the multidisciplinary team that includes several NPs, a pharmacist, collaborating physicians, fellows, a chaplain, a social worker, and an art and music therapist. Her role is solely inpatient, Monday through Friday, during daytime hours. She serves as a consultant for patients facing serious and often life-threatening illness to provide support in making care decisions and managing diverse symptoms with a significant focus on pain management. Billing is done under her NPI or the collaborating physician's.

Rochelle enjoys being able to tap into the expertise of her diverse team. Because she is in a university hospital, she has the opportunity to participate in daily huddles, a weekly conference including expert guest lecturers, team member presentations, journal club, and case presentations. She also feels her patients benefit from the strong collaboration of the palliative team with nursing, attending physicians, hospital social workers, and case managers.

This role is a great fit for her; however, it is very different than her former colleague's role in a rural setting across the country. Amelia joined a private practice in which she has the dual role of both palliative care and hospice NP and is the only provider of these services for the entire community. Her role includes seeing patients in the office, rounding in the hospital, making home hospice visits, and handling on-call responsibilities for evenings and weekends. Although she sometimes feels isolated and often misses the daily peer collaboration, educational, and other benefits of working in a university environment, she enjoys the intensive continuity of care that she can provide her patients in multiple settings. In her practice, she bills for all her services.

on holistic care, prevention and healthy lifestyles, mental health issues, and identification of issues such as partner violence. The women's health NP also focuses on common urological problems such as incontinence and cystitis, and performs procedures such as cystoscopy, circumcision, intrauterine device (IUD) insertion, endometrial biopsy, and obstetrical ultrasonography.

Over the years, these experts recognized a lack of providers to address men's sexual and reproductive health needs. Thus, the education and role of the women's health NP expanded to include the diagnosis of, screening for, and evaluation and management of men's issues such as STIs and fertility issues. In recognition of the effectiveness of these women's health practitioners, the Consensus Model (2008) calls for women's health practitioners to expand their population focus. The formal recognition of care to men will undoubtedly provide for future expansion of the role. Additionally, women's health NPs have increased their focus on the need of the aging woman. AACN has developed specific competencies to address the special needs of this population; these include issues such as assessing falls risk, recognizing the impact of sensory deficits, assisting with transitions of care, and advocating for the special needs of the older adult (AACN, 2010).

The National Association of Nurse Practitioners in Women's Health (NPWH) has demonstrated its leadership and commitment to health policy by partnering with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American College of Obstetricians and Gynecologists (ACOG) to update the Women's Preventive Service Guidelines (HRSA, 2016).

Women's health NPs have recently expanded into general primary care practices that need a clinician to focus on women's health issues. They have also expanded their role in specialty problem areas such as incontinence care, sexuality, and caregivers support as most often women in the family assume the role of transitioning parents into elder care after or sometimes during the time they are raising their families (Wysocki, 2014).

Acute Care Nurse Practitioner

NPs are found not only in primary care but also in specialized areas such as neonatal, pediatric, geriatric, and acute and critical care settings. The term *acute* has

always been associated with the type of facility in which patient care is provided, but it is also used to describe the patient who is experiencing either a new onset or an exacerbation between an existing illness and those patients who have complex chronic illnesses that teeter on the edge of wellness and illness (Bell, 2012). Thus, ACNPs are no longer defined by the geographical setting in which they provide care but by the patient population they serve. ACNPs provide care in a variety of settings such as hospitals, intensive care units (ICUs), long-term acute care hospitals, outpatient and inpatient hospices, specialty offices, and operating rooms. They may be practice based, such as those working on a cardiothoracic service, or unit based, such as those working in a medical ICU or cardiac step-down unit. They may also be on teams that provide care across settings such as those in hospitalist positions or on consultative teams such as acute diabetes management services (see **Box 2.4**).

A new leadership role that has emerged is director of NPs or advanced practice providers. This role has improved the work environment for NPs who had previously reported to office managers or physicians. The director of NPs is familiar with issues regarding scope of practice, licensure, and certification. He or she can serve as an advocate as well as a mentor for professional development projects such as publications and presentations (D'Agostino & Halpern, 2010). These new practice areas demonstrate the diversity of practice opportunities available to meet the needs of acutely ill patients.

Neonatal Nurse Practitioner

The neonatal NP (NNP) role is a collaborative one. Several studies have examined the quality of outcomes of care delivered by neonatal NPs compared with that delivered by medical house staff. Results demonstrated that care delivered by NPs was as good as or better than that delivered by house staff on measures of cost-effectiveness and quality. In addition, care delivered by neonatal NPs had greater continuity and consistency (Bissinger, Allred, Arford, & Bellig, 1997; Mitchell-DiCenso et al, 1996).

The supply of NNPs has rarely met the national demand for services. Consistent shortages of NNPs leave a significant gap in the team approach to care (Kaminski, Meier, & Staebler, 2015). However, the care NNPs provide is often viewed to be so specialized that few nurses seek to fulfill this role (Bellini, 2014). This shortage of NNPs is anticipated to worsen. In addition, the Accreditation Council for Graduate Medical Education (ACGME) proposes to reduce the required number of neonatal intensive care unit (NICU) hours pediatric residents must complete. This is especially concerning with an inherent shortage of providers, as it is thought that individuals who become neonatal providers are those who have trained and worked in the collaborative environment of the NICU. However, this does provide opportunities for NNPs to fill the gap.

The Pediatric Acute Care Nurse Practitioner

The pediatric ACNP was a relatively late arriver to the NP workforce. This was due in part to the strong role held

Box 2.4

Psychiatric Mental Health Nurse Practitioner Profile

Anya is a psychiatric mental health NP who is prepared at the master's level and for the past 5 years has worked with a private oncology practice supporting clients with multiple psychological problems. Her clients include late adolescents and adults undergoing cancer treatment. She is a critical member of the team, especially because she manages psychological issues that can get in the way of treatment decisions, disease management, and patient follow-through. She is also recognized by the palliative care team as a consultant and expert clinician in managing psychological issues in those facing life-threatening diseases. Although she sees clients of her own, she has helped the oncology and palliative care MD and NP providers manage issues such as depression and identify when they should consult a psychiatric mental health professional for particularly challenging cases. Although she is very satisfied with her work, she is frustrated by state requirements such as the need for a collaborating physician and limitations on her ability to prescribe certain medications.

by CNSs in pediatric settings. When the role of ACNP first started, it was a blended role of the CNS and NP in an attempt to provide comprehensive services and direct patient care to pediatric patients and their families. Now the APRN roles in pediatric acute care are distinctly separate.

With implementation of the Consensus Model (2008), CNSs and NPs must be certified distinctly in one of these roles based on their educational preparation and eligibility for licensure in the state they practice. The many responsibilities of the APRN in pediatrics include such activities as performing health histories and physical examinations; evaluating clinical data; prescribing treatments; performing invasive procedures, such as tracheal intubation and insertion of arterial lines; educating and supporting patients and families; facilitating patient discharge; participating in interdisciplinary rounds; and providing consultative services regarding such issues as wound care and infant feeding problems (Reuter-Rice, Madden, Gutknecht, & Foerster, 2016).

The pediatric ACNP can be found on specific patient care units such as the medical-surgical floor or the ICU; function in the hospitalist role; or be a member of a specialty service such as cardiology, pulmonary, oncology, transplantation, gastrointestinal, and general surgery (Reuter-Rice, Madden, Gutknecht, & Foerster, 2016). Pediatric ACNPs may also work outside the hospital setting in other areas in which acutely ill pediatric patients are found. Such areas include long-term acute care centers, centers for the management of mechanically ventilated patients, transport services, and home settings (Reuter-Rice, Madden, Gutknecht, & Foerster, 2016).

The role that each NP assumes depends largely on the specific needs of the patients cared for. The focus of the role, regardless of the geographical location in which the pediatric ACNP works, is to provide cost-effective and high-quality patient care.

Adult Gerontology Acute Care Nurse Practitioners

Acknowledging the aging of the American public and the need to properly train providers who can meet the multifaceted needs of older adults, the crafters of the Consensus Model (2008) explicitly changed the population focus of adult care NPs to adult gerontology. With this significant emphasis on the needs of older adults, educational programs had to revise their curricula to clearly address the competency requirements of the adult gerontology patient across the adult age continuum and certifying bodies had to change their examinations to cover the breadth of knowledge required to implement the role.

Similar to the roles of their pediatric counterparts, the roles of adult-gerontology ACNPs (AGACNPs) are evolving and expanding throughout the acute care setting. AGACNPs are found in traditional care settings such as emergency rooms, ICUs, step-down or progressive care units, and medical-surgical floors. Adult gerontology ACNPs also deliver care to patients outside the tertiary or quaternary care institutions in settings such as outpatient surgical centers, centers for the management of mechanically ventilated patients, long-term acute care hospitals, psychiatric evaluation centers, dialysis units, heart failure centers, and correctional facilities.

In the Kleinpell and Goolsby (2012) study of ACNP practice as part of the larger 2009–2010 National NP Sample Survey, ACNP respondents continued to develop new roles to fulfill identified needs for APRNs to manage aspects of patient care in a variety of settings. NPs were found to be practicing in specialty care areas such as the cardiology, pulmonary, and specialized neurology settings; hematology and oncology; specialty ear-nose-throat (ENT) services; a variety of surgery services; palliative care; pain management services; and others. New areas of practice for ACNPs were hospitalist roles, palliative care, and roles in physician private practices (Kleinpell & Goolsby, 2012).

Adult Gerontology Acute Care Nurse Practitioners in Specialty Practices

In tertiary health-care centers, further reductions in medical resident work hours have contributed to fragmented care and a shortage of providers. The AGACNP can provide much-needed stability and continuity, which is known to produce positive patient outcomes. Complex settings, where continuous follow-up of patients is necessary, are ideal practice areas for AGACNPs. AGACNPs can make a positive impact on the health-care delivery system by providing a continuous and comprehensive approach to the management of their patients' needs.

Acute Care Nurse Practitioners in Oncology

Oncology is one specialty area in which NP expertise for continuous and comprehensive care is crucial. Oncology settings span the cancer trajectory from high-risk cancer clinics to hospice and palliative care (Vogel, 2010; Volker & Limerick, 2007). NPs in oncology bring a

unique holistic perspective that enables them to provide expert care with issues such as pain management, symptom palliation, and sensitivity to the psychological aspects of a cancer diagnosis. NP roles in oncology are varied and can include outpatient roles in radiation therapy, chemotherapy, surgical clinics (preoperative and postoperative global care), palliative care, survivorship and prevention, and genetic counseling related to cancer risk. These NPs can also be found in ICUs as well as medical or surgical oncology units. Because of the Consensus Model, there are no longer stand-alone oncology NP programs. NPs must be prepared as either primary care or ACNPs and then can complete additional training and obtain specialty certification in oncology. See Box 2.4.

In 2007, the American Society of Clinical Oncology (ASCO) Workforce Study predicted a 48% increase in the demand for medical oncology services by the year 2020. This need far exceeds the number of medicine trainees that will be available (Erikson et al, 2009).

Nurse-Midwifery

Nurse-midwives are registered nurses who are primary health-care providers to women throughout the life span. They perform physical examinations; prescribe medications, including contraceptive methods; order laboratory tests as needed; and provide prenatal care, gynecological care, and labor and birth care, as well as health education and counseling to women of all ages. Per the American College of Nurse-Midwives (ACNM) position statement, *Mandatory Degree Requirements for Entry Into Midwifery Practice,* a graduate degree is required for entry into midwifery practice (ACNM, 2012b). All midwifery education programs provide the necessary education for graduates to be eligible to take the examination offered by the American Midwifery Certification Board (AMCB) and become CNMs. The Accreditation Commission for Midwifery Education (ACME) (formerly the ACNM Division of Accreditation [DOA]) assesses the quality and content of midwifery education programs and ensures that they reflect the ACNM core competencies.

The ACNM has mandated graduate-level education for entry into midwifery clinical practice since 2010. In the past master's programs predominated in nurse-midwifery preparation, however, many programs have discontinued their master's degree option and only offer a DNP (ACNM, 2012a).

Nurse-midwifery is recognized in all 50 states, although it is regulated by various agencies in the different states and has varying scopes of practice from state to state. The main scope of practice issue has to do with independent versus collaborative practice with physicians. Physician practices (21.7%) and hospitals (29.5%) continue to be identified as the primary employers of nurse-midwives (Schuiling, Sipe, & Fullerton, 2013). For nurse-midwives practicing in hospital settings, clinical privileges may be granted through membership in the medical staff or through other privileging routes. The purpose of requiring institutional credentialing and practice privileges is to ensure that nurse-midwives provide patient care within the parameters of professional practice that are consistent with national standards and state regulations (ACNM, 2006).

Although nurse-midwives practice predominantly in hospitals and physician-owned practices, they also practice in educational institutions, midwife-owned practices, community health centers, nonprofit health agencies, military or federal government agencies, and birthing centers (Schuiling et al, 2013). Nurse-midwives have advocated for women for years. An exciting initiative started by the American College of Nurse-Midwives in 2015 is the *Healthy Birth Initiative: Reducing Primary Cesareans Project* (http://birthtools.org/HBI-Reducing-Primary-Cesareans). The goal of this project is to set up care bundles in birthing centers and hospitals that proactively work with the laboring woman in such a way that the experience does not require the delivery of the baby via Cesarean section.

A recent consequence of nurse-midwives expanding their practices and becoming entrepreneurial is the expansion of their duties into more administrative areas such as budgeting, setting up and interpreting quality metrics, taking on human resource responsibilities, scheduling, and developing policies and procedures (Slager, 2016). As these activities become more commonplace, the educational preparation for nurse-midwives may have to include these content areas. See **Box 2.5.**

Primary Care Focus in Nurse-Midwifery

As nurse-midwives provided obstetrical care to women throughout their childbearing years, they realized that many women did not have access to primary care services. It became a natural progression for women to seek their primary health-care needs from the health-care provider they had trusted during their childbirths; thus,

Box 2.5

Certified Nurse-Midwife Clinical Profile

Siji is the practice director of a busy obstetrical, gynecological, and midwifery care program that includes nine midwives and five physicians. She is responsible for the recruitment and evaluation of staff members and serves as liaison to hospital administrators and to the professional and lay community.

As she has progressed in her role, she has assumed more administrative responsibilities including managing the practice budget, overseeing productivity, and creating a vision for the future of the practice. She has had to learn the intricacies of reimbursement because her practice accepts numerous health insurance plans, and she acknowledges a steep learning curve. Because this practice is new, she also oversees the development of marketing strategies, new practice policies and procedures, and the collection of quality measures. She finds it hard to balance this with her clinical responsibilities, but she enjoys having the opportunity to develop her administrative skills.

nurse-midwives began to provide care to perimenopausal and postmenopausal women, a natural expansion of their scope of practice. As the aging of U.S. Americans evolves in the 21st century, the number of women approaching menopause is growing. Large numbers of women are expected to seek menopausal and postmenopausal care from nurse-midwives. In response to this change in demographics and the need for greater access to primary care providers, CNMs have expanded their scope of practice to include provision of primary care to women across the life span from adolescence to beyond menopause, with a special emphasis on pregnancy, childbirth, and gynecological and reproductive health.

The scope of practice for CNMs also includes treatment of male partners for sexually transmitted infections and reproductive health and care of the normal newborn during the first 28 days of life (ACNM, 2012c). Interestingly, this scope of practice reflects the changes in the Consensus Model: the population focus of midwives from women's health to women's health/gender-related care. CNMs continue to focus on midwifery so as to not lose the essence of nurse-midwifery practice, while acknowledging those aspects of primary care that are part of the services offered to patients and their families.

Issues Related to Primary Care Practice

CNMs provide primary and preventive care in clinics and other outpatient settings. The ACNM calls for care delivered by CNMs to include all essential factors of primary care and case management. This focus on the ambulatory care of women and newborns emphasizes health promotion, education, and disease prevention and identifies women as central in providing this care (ACNM, 2012c). CNMs have also focused on the care of adolescent women, noting that they are largely a medically underserved group. They are recognized as a key component of the Patient Centered Medical Home, also referred to as the Maternity Care Home (ACNM, 2012b).

Nurse-Midwife as First Assistant for Cesarean Section

Another role of the CNM that has grown is that of the surgical first assistant. Because of obstetrical residency programs across the nation closing and cost containment resulting in fewer physicians available to serve as first assistants, CNMs have expanded their roles to fill the gap (Tharpe, 2015). Additionally, because in many cases the CNM is already present at the time of an emergency Cesarean section, a delivery can progress without interruption, resulting in better outcomes for both the mother and the newborn, when the CNM is prepared as a surgical first assistant.

Not unexpectedly, there is opposition to this expansion of the CNM role. The Association for Perioperative Registered Nurses (AORN) and some surgeons are not convinced that CNMs possess adequate knowledge to perform the first assistant role safely. In response to this criticism, the ACNM (2016) has set guidelines for those CNMs who wish to serve as a first assistant and defined the role of the first assistant in Cesarean sections as a frequently performed advanced midwifery skill requiring training and supervision in patient assessment, anatomy and physiology, principles of wound repair, and the development of basic

surgical skills such as aseptic technique and suturing. At present, each state is addressing the requirements for CNMs who practice as first assistants. Although the number of CNM–first assistants has grown substantially, this skill is not part of the Core Competencies for CNMs, and therefore requires additional education.

More recently, midwives have added the use of obstetrical and gynecological ultrasound examinations to their repertoire of skills (ACNM, 2012d). Ultrasound examinations may be performed in all trimesters of pregnancy to obtain specific information: determining gestational age, assessing fetal well-being, monitoring interval fetal growth, and measuring maternal cervical length. ACNM (2012d) recognizes the need for additional educational content, credentialing, and privileging for midwives who choose to incorporate this into their practices. ACNM is not mandating this as a required skill for all midwives but recognizes that ultrasound examinations may be a necessary tool in meeting the needs of one's patients.

As the needs of childbearing women have changed over the years, the practice and skills of the nurse-midwife have expanded to meet them. This trend will continue as additional needs are identified.

Nurse Anesthetist

CRNAs are anesthesia specialists with authority to practice in all 50 states and the District of Columbia. They administer all types of anesthesia and provide anesthesia-related care in the following categories: preanesthetic preparations and evaluation; anesthesia induction, maintenance, and emergence; postanesthesia care; and perianesthetic and clinical support functions (Department of Health and Human Services [DHHS], Public Health Service [PHS] Division of Acquisition Management, 1995). Chronic pain is a major issue in the United States. Unfortunately, access to care can be limited as pain management procedures, such as epidural steroid injections, are regulated at the state level and thus cannot be performed by all CRNAs (AANA, 2014).

Nurse anesthetists provide a significant amount of the anesthesia given for surgical procedures in the United States. These APRNs work in urban and rural settings, and provide more than 50% of the anesthesia administered in rural areas (RAND Corporation, 2010). In contrast to the high numbers of women in the other APRN categories, 41% of CRNAs are men (Rand Corporation, 2010).

The AANA serves as the guiding professional organization for CRNAs, setting the educational and certification standards and promulgating a code of ethics for CRNAs (AANA, 2005b), along with the scope of nurse anesthesia practice (AANA, 2013a), standards of nurse anesthesia practice (AANA, 2013b), and standards for office-based anesthesia practice (AANA, 2015). Nurse anesthetist students must enroll in schools accredited by the AANA, and upon graduation they must successfully complete a certification examination. As of August 2016, they must also participate in mandatory Continued Professional Certification (CPC) every 4 years (with a 2-year check-in) through the National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA) that includes 100 hours of accredited continuing education and core modules. They must also take a recertification examination every 8 years (NBCRNA, 2016).

In 1998, master's degree preparation was required for beginning nurse anesthesia practice. Although the required master's degree does not have to be in nursing, about 50% of graduate CRNA programs are located within schools of nursing (AANA, 2010). By 2022 the entry-into-practice educational requirement will be at the doctoral level.

CRNAs face significant ongoing difficulties in establishing their practice prerogatives. They face considerable pressures from anesthesiologists who have attempted to limit their scope of practice by conceptualizing the administration of anesthesia as the practice of medicine (Shumway & Del Risco, 2000). In 1982, the American Society of Anesthesiologists (ASA) introduced the concept of an anesthesia care team (ACT), a practice model requiring that all anesthetics be given under the direction of an anesthesiologist (Shumway & Del Risco, 2000).

These restrictive efforts were inadvertently fostered with the introduction of an insurance reimbursement regulation policy by Medicare in 1982. This policy attempted to reduce charges of fraud for anesthesia care by establishing specific conditions that held anesthesiologists accountable for services they claimed to perform when working with or employing CRNAs (Shumway & Del Risco, 2000). The Tax Equity and Fiscal Responsibility Act (TEFRA) regulations set specific conditions for reimbursable services that seemed to require physician leadership for the delivery of anesthesia as a standard of care. Later attempts to eliminate the necessity for anesthesiologist supervision for Medicare reimbursement of CRNA services resulted in an "opt out"

option for states (AANA, 2005a). This effort has given way to the current movement for APRN independent practice. CRNAs' quest for independent practice is a result of the Consensus Model (2008). According to NCSBN.org, CRNAs currently have the ability to provide anesthesia without physician supervision in 27 states (NCSBN, 2016).

One result of the struggle for CRNA practice prerogatives and leadership has been the establishment of the ACT as the predominant practice model. To clarify whether differences exist between CRNAs who work in ACTs and those who do not, Shumway and Del Risco (2000) evaluated personal and professional characteristics, scope of practice, work load, income, and employment arrangements in a sample of more than 400 CRNAs. They found that CRNAs who practiced in ACTs were more likely to be women, have less experience, be younger, have a master's degree, and practice in larger cities. ACT-based CRNAs also had a broader scope of practice and used more airways, regional anesthesia, and monitoring techniques, and performed more varied cases and services. They used more laryngeal mask airways and arterial catheters, and provided more anesthesia for cardiopulmonary bypass, pediatric, intracranial, and trauma cases than non-ACT anesthetists. However, they were less likely to be involved with the placement of epidural and central venous catheters and to participate in pain management and critical care services (Shumway & Del Risco, 2000).

Non–ACT-based anesthetists worked more hours per week and were reimbursed $40,000 more per year. Finally, 91% of ACT-based anesthetists in this sample were employees compared with 4% who were self-employed, whereas 49% of non–ACT-based anesthetists were employees compared with 43% who were self-employed (Shumway & Del Risco, 2000). See **Box 2.6.**

AN EMERGING PRACTICE AREA FOR ALL ADVANCED PRACTICE REGISTERED NURSES: HOSPICE AND PALLIATIVE CARE

As the number of individuals in the United States with life-limiting and serious illnesses increases, there is a need to increase palliative care services that can help to improve access and quality of life, increase patient and family satisfaction, and contain costs. In 2014, the authors of the IOM's report, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,* made recommendations that included an increase in access to care for our aging population (Meghani & Hinds, 2015). In 2010, the American Academy of Hospice and Palliative Medicine published a workforce study that demonstrated the need for up to 18,000 physicians in hospice and palliative care (Lupu, 2016).

APRNs have stepped up to try to fill the need in this growing area. Palliative care APRNs can be found across settings including inpatient, outpatient, skilled nursing and rehabilitation facilities, and in the home. Although one typically thinks of these specialists working in Primary

Box 2.6

Certified Registered Nurse Anesthetist Clinical Profile

Josh has been a CRNA for 20 years. He began his career in a large university-based medical center focusing on cardiac cases. He subsequently developed the skills and expertise to rotate through different cases including craniotomies. As outpatient surgical centers began to open in his area, he thought about transitioning to a position in the community. However, he had a friend who had been doing this for several years, and although the hours were better and the stress level lower, she missed the challenge of working with acutely ill and medically complex patients and felt unprepared to return to a high-acuity environment.

Josh ultimately decided to leave his hospital-based job and work per diem as an independent contractor. Because he is a seasoned clinician with a broad skill set and a great local reputation, he found work in many settings including a community hospital, university-based medical center, and surgicenter. He has the best of both worlds in that he can make his own schedule, experience the challenges of managing high-acuity patients, and work more independently in the outpatient arena.

Care and Oncology, there has been a shift to increase access to patients with other life-limiting illnesses such as neurological and cardiopulmonary disease. All APRNs have a role in palliative care. As nurses first, APRNs have always focused and excelled with symptom management, assessing patients' responses to treatments and ascertaining patients' goals. CNSs and NPs are the roles many people think of as being the "typical" palliative care provider; however, the palliative care APRN can also be a nurse-midwife, as these professionals are skilled in managing individuals through life transitions, pain, and anxiety, or a nurse anesthetist, who may participate in palliative sedation (Van Hoover & Holt, 2016; Wolf, 2013). Certification as an advanced practice hospice and palliative nurse (ACHPN), often a job requirement for this specialty area, is available for the CNS and the NP through the Hospice and Palliative Nurses Association (http://hpcc.advancingexpertcare.org/competence/aprn-achpn/).

FUTURE DIRECTIONS FOR ADVANCED PRACTICE NURSES

APRNs are thriving, as shown in the increased numbers of practitioners; in the expansion of practice roles and settings; in the opportunity for independent practice without physician collaboration or supervision; and with the support of major health-care organizations; for example, the Veterans Healthcare Association endorses their use throughout their health-care network (U.S. Department of Veterans Affairs, 2016).

The future for APRNs is promising but will continue to be affected by knowledge development in the biological and social sciences and in the evolving political and social climate. What effect this will have on APRN practice is yet to be seen.

3

Role Development

A Theoretical Perspective

Lucille A. Joel

Learning Outcomes

Learning outcomes expected as a result of this chapter:

- Explain structural-functionalist and symbolic-interactionist theories and how they influence role adjustment.
- Define reference groups and distinguish between normative, comparison, and audience groups.
- Evaluate role-taking and role-making in the workplace and explain the role of socialization in these processes.
- Explain the nature of second-order change and how it leads to the development of new behaviors.
- Apply the skill acquisition model to nursing (Benner, Dreyfus, & Dreyfus).
- Describe setbacks experienced by new role expectations.
- Justify the need for anticipatory socialization during the educational process.
- Discuss challenges to socialization in the advanced practice nurse (APN) role.
- Distinguish stress and strain.

A nurse's role is constantly changing. There is no role that a nurse will serve exclusively for the entire life of a career. Role modifications depend on a theoretical body of knowledge, more of it hypothetical than empirical research. These concepts and relationships allow a comfortable paradigm shift as necessary, with an awareness of the elements of continuity from here to there.

A THEORETICAL PERSPECTIVE ON ROLE: AN OVERVIEW

There are two diametrically opposed theoretical perspectives in the behavioral sciences that provide a context for the study of role performance: structural-functionalist theory and symbolic-interactionist theory. Structural-functionalist theory is based on the assumption that roles are more or less fixed within the society to which they are attached and that opportunities for individuals to alter patterns of social interaction are limited. In contrast, symbolic interactionist theory proposes the more individualistic perspective, that people do not merely learn responses but organize and interpret cues in the environment and choose those to which they wish to react (Conway, 1988).

Structural-functionalist theory subordinates the individual to the society; it is deductive in its analysis of role. All situations that arise within a society do so because they fill a social need. One such example is the division of labor. The more complex a society, the more differentiated its labor source will become, readjusting and reconstructing over time. Specialization becomes guaranteed, and associates and assistants are created to share in a domain of the work. This concept is dramatically displayed by the division of labor and reordered roles within the health-care delivery system, each role creating its own cadre of technologists, technicians, associates, and assistants. Why should nursing be different?

Altruism also plays a major part here because individuals subordinate their will to the social order. The social forces in a given society validate the roles and the associated behaviors of the individual. Consensual validation is the vehicle for both the maintenance and change of these norms. In many instances, norms are codified by government; in others, they continue to exist in veritable limbo, changing or resisting change according to time and place. A continuing debate exists about the relationship between the fixed norms of a society and the individual's perception of those norms. Often there is no route to interpretation of the social norm except cues offered by others in the situation, and often those cues may be misleading. From another perspective, where may nonconformity be tolerated, to what degree, and in what areas of social participation? Examples abound both professionally and in life. Consider for a moment the immigrant family whose children are schooled in the United States and socialized to the prevailing culture in this country. Are their new ways accepted at home and to what extent? Must they change the way a chameleon does from place to place or jeopardize belonging or perhaps even sustenance? To what extent can advanced practice nurses (APNs) feel confident in establishing their personally preferred values, attitudes, and behaviors in a new role or employment situation? See **Box 3.1** for cues that may predict limits on flexibility in defining role behaviors.

In contrast, the symbolic-interactionist view emphasizes the meaning that symbols hold for actors in the process of

Box 3.1

Cues That May Predict Limits on Flexibility in Defining Role Behaviors

- Highly precise and detailed job descriptions
- Management by memorandum in situations in which personal communication would have sufficed
- Guarded interdisciplinary boundaries that hamper smooth operation
- A hierarchy that is an obstacle to work rather than a facilitator
- Policies, procedures, and documentation systems that are cumbersome and even inconsistent with current practice
- Absence of staff nurse autonomy in caring for patients
- Organizational relationships designed for supervision, as opposed to reporting
- Absence of inventiveness and creativity
- Verbalized discontent from staff, but no evidence of any attempt to change things
- High turnover rate among employees
- Maintenance of a "screen" for attitudes, values, and behaviors not supported by historic antecedents

role development, rather than the constraints presumed to be exerted by the social structure. The interactionist sees the formation of role identity as inductive and complex. The role is a creative adaptation to the social environment and the result of the reciprocal interaction of individuals. It is the product of self-conception and the perspective of generalized others. To facilitate communication toward these ends, symbols are essential, and they must be social and hold the same meaning for each actor in the process. In other words, self-identity is shaped by the reflected appraisals of others, and it is desirable that individuals' self-perception should be highly congruent with the way they are perceived by others and the way they see themselves as being perceived by others. Should these pieces show a poor fit, an individual could waste a lifetime of effort creating evidence that justifies his or her personal view of self.

Many have rejected the structuralist approach because it seems limited in accounting for the wide variation in roles and behaviors that we see today. Yet, it is impossible to ignore the effect that the culture and the "collective conscience" have on our development of identity and role behaviors. There is recent interest in building conceptual frameworks that are inclusive of both the interactionist and structural perspectives, and promise a greatly enlarged understanding of role development. This eclecticism characterizes this chapter's discussion.

ROLE DEVELOPMENT

The concept of reference groups and the process of socialization are central to role development. Reference groups are the frame of reference for the process of socialization. Through socialization, individual behavior is shaped to conform to the standard of the group in which one chooses to seek membership.

Reference Groups

Reference groups convey a standard of normative behavior in terms of values, attitudes, knowledge, and skills. For an individual, this may be a group to which he or she belongs or aspires to belong. In moving toward a standard that is either consciously or unconsciously desired, discussion of several reference groups is in order, including normative groups, comparison groups, and audience groups. The normative group sets explicit standards and expects compliance, and it rewards or punishes relative to that degree of compliance. The church, community, and family are good examples of normative groups. The behaviors that are expected may have wide or narrow latitude, but somewhere there is a "bottom line."

The comparison group sets its own standards and becomes a comparison group only when an individual accepts it as such (Lum, 1988). The nursing staff of a Magnet facility may be a comparison group, demonstrating longevity in employment and satisfaction with work, seeking upward mobility through education, and so on. The nursing staff and their leadership in other facilities may aspire to these qualities, making it a comparison group for them.

The audience group is a collective group whose attention an individual wishes to attract. The audience group holds certain values but does not demand compliance from the person for whom they serve as a referent (Lum, 1988). In fact, the audience group may not even be aware of this individual. To be recognized, the individual takes note of the group's values and plays to that audience for attention. Staff nurses may observe that physicians value being able to proceed with the treatment of their patients unencumbered by the bureaucratic constraints of health care. Administrators are overwhelmed by the cost factors in health care. Nurses are best positioned if they are aware of these values and attitudes, and try to minimize the obstacles they represent to these groups. In other words, they play to the audience through either word or deed.

Socialization

Socialization refers to the learning of the values, attitudes, knowledge, and skills that enable the behavior prescribed for a specific social position or role. The fact that these components are society-specific indicates that there are social norms involved. Values are ideas held in common by members of a social structure that prioritizes goals and objectives (Scott, 1970). Values are generally the abstract but relatively stable aspects of a person's belief system. Attitude is the tendency to respond to social objects or events in a favorable or unfavorable way. Opinion is defined as expressed attitude. Behaviors are observable

social acts performed by an individual. Attitudes guide judgment and subsequently behavior, but this assumption of a relationship between attitude and behavior is controversial.

Operationally, the concept of socialization refers to individuals acquiring the necessary knowledge and skills, as well as internalizing and shaping the values and attitudes of a particular social system, in preparation for fulfilling a specific role in that system (Lum, 1988). This process is no less true for the roles of nurse and APN than it is for the role of mother, father, husband, or wife. Further, whereas some roles or statuses have highly specific role prescriptions, others are extremely vague and open to wide variation of interpretation. This latitude may be observed in the setting in which the role is played out, the society in which it is placed, or both. Harmony among these systems enhances role execution. There is often significant discrepancy between the public, professional, legal, and institutional definitions of the role of the nurse. Even if the society and role occupant are bound by the legal role as defined, discrepancies among the other definitions cause problems in recruitment, retention, job satisfaction, and more (Harley-Wilson, 1988).

Socialization is a continuous and cumulative process that evolves over time through role-taking and role-making, both of which are techniques of role bargaining. Social behavior is not simply a learned response. It depends on the processes of interaction and communication. To be successful, role-taking requires skill in empathic communication. The individual must project him- or herself into the circumstances of another and then step back to imagine how he or she would feel in the other's situation. If there is accurate determination of the motives and feelings of the other, the actor can modify his or her own behavior to sustain or alter the other's response (Hardy & Hardy, 1988a). The process here is unidirectional. For example, the APN "reads" his or her peers and supervisor as seeing staff development as the major focus of the APN role, although she or he may have preferred to carry a significant personal caseload of the most complex patients. Staff development is accepted as the priority, but the APN takes on cases as vehicles for teaching at every opportunity.

Put in another way, the less desirable activities are accommodated (first-order change) and even eventually assimilated (second-order change), becoming an integral part of the role. First-order changes are *behavioral shifts* that do not permanently achieve a desired result. Old preferences keep returning the way antagonists do because we shift our behaviors, but not the core values or attitudes causing the behaviors. Second-order changes are *permanent attitude shifts that cause new behaviors* (Watzlawick, Weakland, & Fisch, 2011). The "old ways" stay gone and are not replaced by a new version (such as giving up alcohol and starting a nicotine or work addiction).

In contrast, role-making is bidirectional and interactive, with both actors presenting behaviors that are interpreted reciprocally for the purpose of creating and modifying their own roles. This process is analogous to a dance, with each partner seeking to complement the other while maintaining his or her own uniqueness. For example, the APN notices surprise from the physician when suggesting a modification in treatment for a patient. The APN supplies cogent and sophisticated reasoning, and the physician agrees, although skeptical of this behavior. Over time, the physician becomes comfortable with the APN's prescriptions and actually looks for the clinical input. Both role-taking and role-making depend on success in reading role partners correctly. This skill is enhanced by broad social experience, rehearsal of the role anticipated, the recentness of those experiences, attentiveness to role behaviors, and good memory skills. These skills can be developed and honed during the educational experience (Ter Maten-Speksnijder, Grypdonck, Pool, Meurs, & Van Staa, 2015).

Equally challenging as internalizing role behaviors is the movement from one role or subrole to another. This process is described in **Box 3.2.** Not only must one learn new behaviors, but one must break from old ones. Inadequate socialization predicts marginalization or the inability to either remain in a previous role or move on to another. A case in point is the nurse who hangs on to the periphery of a system, never quite becoming part of it or bothering to know the personalities involved and refusing to assimilate nursing with the other aspects of life. This is particularly common in people who try to juggle multiple aspects of life, keeping each separate—obligations everywhere, multiple lists of things to do, each with a first-place priority, a comprehensive plan nowhere. The wiser strategy is to integrate the dimensions of life, with professional colleagues becoming personal friends, family participating in workplace and professional events, and so on (one list with one rank ordering of priorities).

Box 3.2

Socialization as a Continuous Process

Break From Previous Roles

Minimize previous advantage.
Break previous peer relationships.
Convert previous peer relationships into friendship relationships.
Maintain a portfolio or clinical log reflecting on your evolving practice, values, and attitudes.

Establish a New Peer Group

Clarify new responsibilities that accompany changed status.
Consider the values, attitudes, knowledge, and skills that will contribute to success.
Develop new peer group associations.

Move to the New Role Prescription (Accommodation)

Provide role rehearsal opportunities.
Review benefits of mastery.
Consider a mentor.
Identify support systems among role partners.*

Assimilate Role Behaviors

Be aware of change of self-concept.
Recognize the rites of passage as more than symbolic.
Create opportunities for success.
Treat failure as a learning experience.
Move on to process and outcome evaluation once the role is established, although not matured.

*A role partner may hold the same role or a role that is reciprocal but definitely has role expectations of the primary role occupant.

Role Acquisition

Knowledge and skill acquisition are important aspects of role implementation in nursing, both for the entry-level registered nurse and for the APN. This is not to ignore the essential part played by attitudes and values (the belief system), but to acknowledge that knowledge and skill are expected of professionals by the public (audience group), leadership in the field (comparative group), and peers (normative group). The skill acquisition model, developed by Dreyfus and Dreyfus (1977) and later applied to nursing by Benner (1984), tells us that even experts perform as novices when they enter new roles or subroles, although they proceed to acquisition at a quicker pace. This pattern is verified by several authorities, including Brykczynski (2000) and Roberts, Tabloski, and Bova (1997). In observing APN students, they report periods of regression, anxiety, and conflict before the incorporation of new role behaviors. This is not unexpected, and an analogy can be drawn from work with groups. It is common that in the beginning of a group or when a new member is introduced into an established group, there is a loss of confidence among individual members. The introduction of a person into a milieu with new role expectations is a temporary setback, even when some of the behaviors have been well established in a previous role. The regression and loss of confidence are often followed by anger directed toward faculty and preceptors whom they see as guilty of not giving them enough knowledge or skill. In many ways, they are grieving the role they had previously mastered and responding to the anxiety over moving on.

Anticipatory socialization should be a planned goal during the student period and not left to chance. Ample opportunity should be provided for students to get to know APNs who may just be beginning their careers (peer group) and to participate in discussions with seasoned APNs regarding practice issues (accommodation). Both of these goals may be accomplished through the state nurses association, especially if there is a forum or division on advanced practice. Other experiences should be incorporated in the educational program, such as the opportunity to dialogue with employers and practicing APNs about their expectations of the role. **Box 3.3** contains a format for the participation of APNs on a panel describing their practice and role development for students. These anticipatory experiences should facilitate the period of resocialization as a graduate.

It would be remiss not to mention the clinical competency of faculty. Clinically competent faculty are necessary to give credibility to the program and to narrow the gap "between education and practice" (Brykczynski, 2000, p. 121). The best of all worlds would be for faculty to teach using their own panel of patients. Although this is often impossible, it is still necessary for faculty to maintain their clinical skills to be able to critique practice and provide the proper oversight for preceptors (Moore & Watters, 2013).

Box 3.3

Questions to Guide Advanced Practice Nurse Participation in a Panel on Advanced Practice

- How did you find your first position after graduation?
- What job-seeking strategies would you advise new graduates to use in today's market?
- How do any or all of the following fit into your specific position?
- What is your prescriptive authority?
- What kind of practice privileges (i.e., admitting, treating, consulting, and discharging) do you have?
- What system do you have for reimbursement?
- Do you participate in a managed-care panel?
- How have your functions or role changed over the years, and were those changes the result of the evolution of the profession, your choices, your advocacy, or the expectations of an employer?
- Have you been an active participant in developing your role? How so?
- What are the major stresses and strains in your practice? How do you handle them?
- Describe your collaborative arrangement with a physician.
- How do you show outcomes or document the value of your contribution to the practice (or to your employer)?
- How do you maintain your practice credibility?
- Do you plan to further develop your own role or skill set? If so, how?
- What were the most valuable aspects of your graduate educational preparation for advanced practice? The least valuable?
- What do you know now that you wish you had known earlier in your career?
- What is your experience with mentoring, either as mentor or protégé?
- How important to your professional development was this mentor(ed) experience?

Benner (2001) describes five levels of skill acquisition: novice, advanced beginner, competent, proficient, and expert. As one proceeds along this continuum, one becomes more involved in the process of caring, until at the expert stage, situations are recognized in terms of their holistic patterns rather than a cluster of component parts, and the context becomes somewhat irrelevant. In the early stages, new behaviors are accommodated, and they later become assimilated in the practice repertoire, until at the highest level they appear intuitive. Movement from accommodation to assimilation or from novice to expert with its intermediate steps is best accomplished through accruing experience with the opportunity to apply both practical and theoretical knowledge, and providing situations in which failure is allowed and treated as a learning experience (Roberts et al, 1997). It should be noted that Benner's model is experiential and does not consider education as a variable in distinguishing these skill levels. However, you cannot apply what you do not know. It would be interesting to use Benner's model to compare an APN and a non–master's-prepared registered nurse, both with similar experience.

It is helpful for APN students to consciously approach the socialization process knowing their normative, comparative, and audience groups, and being aware of the changes that are expected to take place in their own behaviors, values, and attitudes. Socializing experiences, provided during the course of studies, are presented in **Box 3.4.**

Socialization Deficits

One of the most compelling challenges in professional education is to provide adequate socialization. Socialization deficits are guaranteed to inhibit role performance, introducing additional stress into roles that are already by nature stressful.

APNs are increasingly prepared in programs of part-time study. In addition, the movement into the community college and university settings for entry-level education has, to some degree, diluted the intensity of the socialization experience for nursing. Off-campus living arrangements, a cohort of students who depend on full-time or part-time employment or who have family obligations, courses of study that may be protracted over many years, and so on,