# From "First Aid Rooms" to Advanced Practice Nursing: A Glimpse into the History of Emergency Nursing

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## Abstract:

The purpose of this article is to provide a brief history of the development of advanced practice emergency nursing in the United States, noting its roots in the "First Aid Rooms" of the Henry Street Settlement and focusing on its formal inception as a nursing specialty in the 1970s. The development of the Emergency Nurses Association is also highlighted. The program at the University of Virginia is used as an example of what was occurring throughout the nation. Data are analyzed within the context of the social and political environment of the United States during this era as well as within the context of the history of healthcare.

**Keywords:** advanced practice nursing | clinical nurse specialist | emergency nursing | history | nurse practitioner

## Article:

Since the inception of the "First Aid Room" at the Henry Street Settlement (HSS) in the late 1900s under the direction of nursing leader Lillian Wald, nurses have been providing emergency care for patients when no physician was available (Buhler-Wilkerson, 2001). By the mid-20th century, most of this care was done in small emergency rooms (ERs) throughout the country by registered nurses (RNs) who simply chose ER nursing as their specialty. By the 1970s, however, the specialty of emergency nursing had emerged and nurses could obtain advanced education in this area and work as a nurse practitioner (NP) or as a clinical nurse specialist (CNS) in the ER. Although much has been written about NP and CNS history in general (Hamric, 1989; Keeling & Bigbee, 2005), little attention has been paid specifically to the history of advanced practice nursing in the emergency department (ED). The purpose of this article is to provide a brief history of the development of advanced practice emergency nursing in the United States. The program at the University of Virginia is used as an example of what was occurring throughout the nation.

## THE “FIRST AID ROOM”

According to historian Karen Buhler-Wilkerson, a combination of factors including “innovative analysis, circumstantial opportunity, and adaptive problem solving” led to the development of the HSS's first aid rooms at the turn of the 20th century, where poverty-stricken immigrants on the lower east side of New York City increasingly turned to the HSS nurses for “advice or care of fresh cuts and bumps, old wounds, eczema, burns, local infections, small accidents and conjunctivitis…” (Buhler-Wilkerson, 2001, p. 109). There, under the leadership of Director Lillian Wald, the HSS nurses cleansed and dressed wounds, applied eye ointments for conditions like trachoma, treated minor burns with salves and bandages, and attended patients with minor illnesses like colds and sore throats. The immigrants poured through the doors: mothers would stop by with children, working people would come by in the evening, and all received nursing care. By 1900, “demand was so great that three first aid rooms were opened” to respond to the immigrants' needs. (Buhler-Wilkerson, 2001, p. 109). And, in an attempt to avoid criticism from the medical community for running a dispensary (practicing medicine without a license), Wald and her colleagues claimed that the nurses were not dispensing medications and were treating only such cases as “might be attended to by a member of the family if the mothers had sufficient leisure or sufficient intelligence” to do so. (Buhler-Wilkerson, 2001, p. 109; Keeling, 2006). By 1904, however, after some criticism from the local medical community, Wald's colleague Lavinia Dock insisted that the HSS nurses get standing orders, endorsed by the local medical society, for emergency treatments and medicines. Protected by these standing orders, the HSS nurses cared for “between ten and twenty-three thousand patients in first aid rooms each year” for the next 15 years (Buhler-Wilkerson, 2001, p. 110).

As the century progressed, these types of first aid rooms and other dispensaries across the nation closed, and patients turned to modern hospitals for care. Despite the fact that hospitals were growing in size and complexity and becoming increasingly dependent on technology, for most of the first half of the 20th century few hospitals had ERs as they are known today. In fact, according to one researcher, sometimes the ERs was just a room in the basement where undertakers would bring in injured patients (Fadale, 2000). By the 1950s and 1960s, however, there was a dramatic increase in the number and use of hospital ERs and the number of patients turning to them for care. According to one historian, these ERs were staffed by minimally trained physicians, [or] unsupervised residents or nurses backed up by doctors on call from home (Zink, 2006). Others describe three types of ERs that predominated in the 1960s: (1) the 24-hr comprehensive emergency facility equipped to render complex and comprehensive care, (2) the limited ER with an on-call resident, and (3) the provisional ER unit, a small hospital that depended on an RN to make the initial assessment, call a physician, and give care until the physician arrived (Anonymous, 1970). In some cases, nurses staffed other areas of the hospital until patients presented to the ER for care, at which time the nurses would report to the ER (Anonymous, 1970).

However, although nurses were left to diagnose and treat patients on their own in ERs before a doctor arrived, organized nursing was defining the scope of practice in such a way as to limit their ability to function. In fact, the American Nurses Association's (ANA) 1965 model definition of nursing had serious implications for ER nurses' practice. Of particular significance

was the fact that in that definition, the ANA limited nurses from the acts of diagnosis and prescription. According to the ANA definition:

> The practice of professional nursing means the performance for compensation of any act in the observation, care and counsel of the ill … or in the maintenance of health or prevention of illness…or the administration of medication and treatments as prescribed by a license physician…. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures. (ANA, 1965, p. 1474)

For nurses caring for patients in small ERs throughout the country, this often meant that they were working outside their legal scope of practice. In fact, because nurse practice acts did not cover ER nurses for the de facto diagnosis and treatment they were initiating in the absence of a physician, the legal limits of practice were a frequent topic of concern. A solution was on the horizon however as the nursing profession was increasingly focused on specialization in practice. The ability to specialize in emergency nursing and work in an expanded role would soon be an option.

## SPECIALIZATION IN NURSING

The nurse specialist title was designated in psychiatric nursing, with the first Master's CNS program in 1954 at Rutgers University in New Jersey. Over the next decades, concurrent with the rise of specialization in medicine, increasing numbers of nurses chose to specialize as well, and the term “clinical nurse specialist” was coined (Hamric, 1989). Initially, nurse specialization was based upon accomplishment. Nurses learned from each other or from physicians (Lynaugh & Brush, 1996). In fact, physicians often provided the first courses in advanced nursing practice. For example, both the American Academy of Orthopedic Surgeons and the American College of Surgeons' (ACS) Chicago Trauma Committee sponsored postgraduate courses for ER nurses (Rosenthal, 1970), the first by the ACS in 1966 (Dover, 1977). At one conference, Dr. Harold Wiggins, noted the surgeons' rationale for providing the training, stating “…with the national doctor shortage, you ER nurses are often the first to render help” (Rosenthal, 1970). By 1970, the pattern of physicians teaching ER nurses was well established. That year the Committee on Trauma of the ACS offered its 4th Annual Post Graduate Course for ER nurses (ACS, 1970). Prior to this time, however, two major federal initiatives in the 1960s would set the stage for the standardization of educational requirements for CNSs and NPs and the incorporation of these roles into EDs.

## FEDERAL FUNDING AND NURSING EDUCATION

Prior to 1960, with the exception of the clinical specialist in psychiatry, Master's level education in nursing prepared nurses to be educators and administrators rather than clinicians. However in the 1960s, with increasing specialization in medicine, a decrease in the number of physicians working in primary care and a concurrent increase in specialization in nursing, the Surgeon General asked a consultant group to investigate future directions for nursing. In their 1963 report, *Toward Quality in Nursing: Needs and Goals*, the consultants noted the need for a 194% increase (3,000) in nurses with Master's or higher degrees by 1970 (Kalish & Kalish, 1978). The report also recommended that the federal program of Professional Nurse Traineeships double

within 5 years and expand to include preparation of nursing specialists in clinical fields (Kalish & Kalish, 1978). The outcome, the Nurse Training Act of 1964, authorized $50 million for the continuance of existing traineeship program to increase graduate nursing student with preparation for positions such as clinical specialist (H.R. Res. 10042, August 12, 1964, Cong. Rec., p. 610). From 1965 to 1971, $68 billion was awarded to 48,000 nurses to prepare them for positions as teachers, supervisors, administrators, or clinical specialists. With this funding, increasing numbers of nurses returned to graduate school. Nonetheless by 1972, only 2.9% of all nurses were prepared for the Master's degree or above (Kalish & Kalish, 1978). This would change however with the ANA taking a formal stance on the importance of Master's education for clinicians. In 1974, the ANA Congress for Nursing Practice published educational standards, describing the CNS and NP roles, and requiring a Master's education for the CNS. Moreover, the ANA also attempted to define the expanded scope of nursing practice (ANA, 1974).

## FEDERAL FUNDING AND INCREASED USE OF EMERGENCY ROOMS

Another federal initiative would also affect nursing—in this case, the initiative would affect the use of ERs for primary care and the nurses' role within that system. The 1965 Medicare and Medicaid legislation signed by President Lyndon B. Johnson under his Great Society program provided health services for the elderly and the poor by providing copayments for their care to hospitals (H.R. Res. 6675). Meanwhile, many physicians in private practice would not accept the government's payments (Dover, 1977). As a result, patients increasingly turned to hospital ERs for care. According to a 1970 article on ER nursing, “Many people who cannot find a doctor when they don't feel well go there [to ERs] for the attention they want immediately” (Anonymous, 1970). In large cities, the author estimated that up to 90% of the patients were “simply using it as a doctor's office” (Anonymous, 1970). In fact, writing in 1970, Emergency Department Nurses Association (EDNA) co-founder Anita Dorr noted that ER visits had “increased as much as 175%, yet approximately 50% are non-emergency cases” (Dorr, 1970, p. 1). As another author noted a few years later, “many Americans were abandoning traditional patterns of health care in favor of the attentions of the local hospital emergency department…” (Dover, 1977). When these Americans turned to the ER, they often found a nurse rather than a doctor as the front line provider.

## THE IDEA OF THE NURSE PRACTITIONER

It was in this sociopolitical setting that the idea of the NP began to take shape—albeit at first in the area of pediatrics rather than emergency care. In 1965, seeking “to bridge the gap between health care needs of children and families' ability to access and afford primary health care,” Assistant Professor of Nursing Lorretta Ford, PhD, RN, and Henry Silver, MD, opened a 4-month long pediatric nurse practitioner (PNP) program at the University of Colorado Medical Center (Ford, 1979, p. 517). Their intent was to educate graduate pediatric nurses to provide healthcare services in rural clinics, essentially expanding the nurse's role in well-child care (Brush & Capezuti, 1996). According to Ford, “I was well aware of the unmet health needs of people of all ages in the community and confident that nurses could be prepared to meet those needs by facilitating access and promoting continuity and coordination of care” (Ford, 1979, p. 517).

The demonstration project, the first of its kind, was funded by the Commonwealth Foundation, and was designed to prepare professional nurses to provide comprehensive well-child care and to manage common childhood health problems. The idea was that the NP would work in a collaborative, collegial relationship with the physicians, not as a physician substitute. The program, which certified RNs as PNPs without requiring a Master's degree, emphasized health promotion and the inclusion of the family in pediatric care. Nurse practitioner students learned to take health histories and complete physical examinations. They also learned how to devise a list of differential diagnoses and to order laboratory tests, X-rays, and electrocardiograms to "rule out" certain conditions in order to determine a working diagnosis.

Pediatric nurse practitioners' skills could be used in a variety of settings. The original intent of the Colorado program was to prepare NPs to work in underserved rural areas of the country, but the idea soon took hold and programs opened across the country. According to Ford:

> Although the initial goal … was to prepare nurses on the master's level for expert practice, teaching and clinical research, that intent was altered in order to accommodate the pressing societal demands for health care. Shortly thereafter, came an explosion of quickly generated, short-term continuing education programs (some of which were devoid of academic standards) and products of variable quality. All of these programs used the name "practitioner." Hence, adult nurse practitioners, school nurse practitioners, family nurse practitioners and others came into being before the first pediatric nurse practitioner project was completely evaluated. (Ford, 1979, p. 517)

In short, many programs awarded students an NP certificate after a few months of training. Students were not required to complete a Master's degree in nursing, yet they would work in an expanded "advanced" role after they received the certificate.

The federal government was interested, and in the early 1970s, Health, Education and Welfare Secretary Elliott Richardson established the Committee to Study Extended Roles for Nurses, and charged it with evaluating the feasibility of expanding nursing practice (The Secretary's Committee to Study Extended Roles for Nurses, 1971). The committee concluded that extending the scope of the nurse's role was essential to providing equal access to healthcare for all Americans. According to a 1971 editorial on the topic in the *American Journal of Nursing* (*AJN*), "The kind of health care Lillian Wald began preaching and practicing in 1893 is the kind the people of this country are still crying for…" (Anonymous, 1971). The committee's report, published in November 1971, urged the establishment of innovative curricular designs for NP education in health science centers and increased financial support for nursing education (Geolot, 1990). The report called for expanded responsibility for nurses to collect medical data and make clinical decisions. It gave voice to the need for enlarging the role of the nurse to provide equal access to health services for all citizens (The Secretary's Committee to Study Extended Roles for Nurses, 1971). This committee noted nurses already were or could be trained to take histories, collaborate with physicians, work under protocols for care, and prescribe rehabilitation measures (Kalish & Kalish, 1978). It also urged national certification for NPs, and developed a model nurse practice law that could be applied throughout the nation. In response, with mounting concern over the restrictive 1965 ANA definition of nursing practice, the ANA counsel suggested the following addendum to state nurse practice acts:

> A professional nurse may also perform such additional acts, under emergency or other special conditions, which may include special training, as are recognized by the medical and nursing professions as proper to be performed by a professional nurse under such condition, even though such acts might otherwise be considered diagnoses and prescription. (New York State Nurses Association mailings to State Nurse Associations as cited in Weiss, 1995, p. 28)

Despite the cumbersome language, the addendum's meaning was clear—NPs could diagnose and prescribe—as long as these acts were done under "special" conditions. Relevant to this discussion, ERs across the country, particularly in rural underserved areas, met this definition.

## A SPECIALTY ORGANIZATION FOR EMERGENCY NURSING: THE EDNA

In 1970, two nurses, Anita Dorr and Judith Kelleher, working independently on opposite sides of the United States, both formed specialty organizations to support education and networking in emergency nursing. Dorr, working in Buffalo, NY, formed the Emergency Room Nurses' Organization, while Keller and her colleagues formed the EDNA in California. On December 1 of that year, the two joined and incorporated as the EDNA. The name EDNA was chosen because of Judy Kelleher's assertion that these were "departments," not rooms. Effective January 1, 1985, EDNA was renamed the Emergency Nurses' Association (ENA) to reflect that emergency nurses worked in a variety of settings, not just in EDs.

Within 2 years, the need for certification in ED nursing was beginning to emerge as a concern. In fact, the issue was discussed at the October 6, 1971 meeting of the regional representatives of the EDNA (Murphy, 1972). During these early years of the organization, its aim also expanded. In her presentation to participants at the Eight International STEP Forum on April 30, 1974, Kelleher (EDNA President at the time) spoke to this expansion, noting that: "Through the Emergency Department Nurses Association (EDNA) the Emergency Nurse has been able to identify needs peculiar to the practice, to speak on these issues intellectually, to initiate changes in the scope of practice and to achieve the status of a recognized nurse specialist" (Kelleher, 1974). In February 1975, the EDNA Board of Directors appointed an ad hoc committee on certification that developed a plan for certification endorsed by the ANA. According to the ad hoc committee's report to the EDNA, having this endorsement lent credibility and prestige to their organization. Indeed, the EDNA and its certified members would be "recognized and accepted as leaders" (ENA, 1975).

Such certification would also support the ER nurses legally. As one assistant director for emergency services stated, "Certification will assist hospitals in that they will have legal backing for nurse's actions. As long as a copy of the nurse's certification is in their records and the nurse practices the standard of care specified, both hospital and nurse are legally safeguarded if anything untoward happens" (Dover, 1977, p. 5). This legal backup was needed. Early in the development of the EDNA, the president was challenged on scope of practice issues and the intent of the organization. In fact, Dorr responded to Dr. Michael Miller's request for information on the EDNA's avowed objective for securing responsibility and permission for ER nurses to perform minor procedures, "…at no point is there an avowed objective for securing

responsibility and permission to perform minor surgery. Realistically, however, Emergency Department Nurses are at the present time performing all types of emergency procedures and dependent on the type of facility they are working in are performing procedures not necessarily minor" (Dorr, 1971). A year later, at the first annual conference of the EDNA in 1972, 67% of ER nurses surveyed replied that they did not have standing orders for resuscitation, defibrillation, starting intravenous drips, and monitoring patients like coronary care unit nurses did, yet they were performing these tasks. And, although 100% of the respondents noted that they did not feel an emergency nurse must have a Master's degree to be recognized as a "nurse specialist" or a "nurse practitioner," many expressed interest in becoming clinical specialists and NPs (EDNA, 1972).

The first nursing skills list developed for the Core Curriculum included "ordering and gross interpretation of appropriate lab and x-ray studies…drawing and interpreting ABGs…and maintenance of airway by exophogeal (esophageal) or tracheal airway" (EDNA, 1974). All were outside the usual bounds of nursing's scope of practice. Indeed, these were tasks and decisions usually made by the physicians.

## EMERGENCY NURSE PRACTITIONERS AT THE UNIVERSITY OF VIRGINIA

Shortly after the inception of a PNP program in Colorado, the Robert Wood Johnson Foundation provided grants to several universities to open NP programs. Later, other universities sought federal funding to incorporate NP education into their Master's programs in nursing. Among these was the faculty at the University of Virginia, where internist Dr. Reginia McCormick developed an adult NP program in 1970 and Assistant Professor of Nursing Barbara Brodie and pediatrician Jake Lohr opened a PNP program within the nursing school's Master's program, funded by the Division of Nursing, in 1972. Shortly thereafter, Denise Geolot, RN, MSN, and Richard Edlich, MD, Director of Emergency Medical Services at the University of Virginia opened an emergency nurse practitioner (ENP) program, reportedly the second in the nation (A. Keeling, October 17, 2005, communication with Barbara Brodie, PhD, RN, FAAN, The Madge Jones Professor Emeritus, The University of Virginia School of Nursing).

Concurrent with this program was a federal initiative to expand primary and emergency medical services (EMS). Part of the federal effort included money for EMS training and for ambulances, as rescue squads previously used cars from funeral homes. The government was concerned about EMS and money available for training, because they realized that the "golden hour" of trauma care (the time in between when the patient is found to when they are treated at the hospital) was critical. The EMS money that the government offered went toward four main areas: (1) a standard emergency phone number 9-1-1, (2) emergency medical technician development, (3) highway hospital signs, and (4) regionalized hospitals including trauma and community hospitals.

Moreover, in 1973, standards for basic life and advanced life support were created and recommended at the National Conference on Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care. In 1975, the first CPR class was held at the University of Virginia Medical Center. Among those in attendance included Dr. Denise Geolot and Dr. Richard Edlich. Dr. Geolot obtained her Bachelor's of Science in Nursing from the University of

Virginia, and went on to become a CNS in cardiac care at the University of Colorado. She returned to the University of Virginia, obtained her PhD, and taught senior nursing students acute care nursing and leadership. Dr. Richard Edlich was a plastic surgeon, an "expert in burns," who was the Director of the University of Virginia Emergency Department. At the CPR class, Edlich approached Geolot, asking her whether she wanted to "be apart of an amazing opportunity," to which she at first replied, "No." He envisioned that every RN in the ED should be an ENP because he believed that it was important to always look toward the future. Edlich looked at the overall emergency medical system, and believed that emergency medicine should encompass total care and that each and every patient should have *everything* available to them (D. Geolot, personal communication, February 4, 2006).

Around that time, a study was performed that looked at EDs in Virginia, and it was found that approximately one third of hospitals have no ED physicians, and a significant number of these physicians lacked training. After more discussion, Geolot agreed to work with Edlich to establish the University of Virginia ENP program, turning to the team at Allegheny Hospital in Pittsburgh, PA, to see how their program was designed (D. Geolot, personal communication, February 4, 2006).

In creating the program, their goal was to "equip emergency nurses with skills required to provide both primary and acute care in an expanded role in an attempt to meet the health care needs of the surrounding rural communities" (Widhalm, 1981). In 1974, nearly 35,000 patients were being treated annually in the ED by an undersized staff that was inadequately trained in emergency medicine. Edlich believed that the rescue squad personnel were equally less prepared for the emergency patients they were handling on a daily basis. In 1974, rescue squad personnel were required to have an advanced first aid course developed by the American Red Cross, and had citizen band radios in their "antiquated" vehicles that would transmit messages to University of Virginia police officers who would then pass on information to the ER (Edlich, 2000).

The educational objectives set forth for the ENP program were divided into cognitive and psychomotor. The *cognitive objective* stated that ENPs must utilize a minimum level of knowledge that allowed them to develop a diagnosis on the basis of history and physical examination, and then prepare a logical plan that included triaging and managing the patient's emergent or nonemergent health problems along with appropriate follow-up. The *psychomotor objectives*, which were incorporated within the cognitive objective, included being able to perform the correct treatment and necessary basic and advanced life-support techniques (Geolot, Alongi, & Edlich, 1977).

Publicizing the program was one of Geolot's top priorities. According to Geolot, she sent out fliers and put advertisements in the *AJN* to promote it. In addition, she discussed the University of Virginia ENP program at the EDNA conferences and at the Virginia Nurses Association meetings. The EDNA and Emergency Physician's Group also became involved in promoting the program. Eventually, news about the program spread and ER nurses from around the country applied for admission (D. Geolot, personal communication, February 4, 2006). Only seven students were needed to launch the first program, and priority was given to applicants who had a formal commitment to work with an emergency physician preceptor upon graduation, as well as

applicants who were from areas where new emergency medical systems were being established (Geolot et al., 1977).

Applicants were required to have at least 2 years of experience as an RN and an academic and professional record that proved their potential as future advanced practice nurses. It was recognized by the Joint Committee of Virginia State Board of Nursing and Medicine as an approved NP program, and gave graduates the opportunity to receive state certification as well as 14 hr of graduate credit from the University of Virginia's School of Nursing (Geolot et al., 1977).

The ENP program was one of two NP programs offered at the University of Virginia in 1976, the other program, its predecessor, was the PNP program. The faculty chosen for the program included CNSs, emergency medical technicians, biomedical engineers, health planners, and physicians. In the following year, 1977, the adult nurse practitioner (ANP) program was introduced, and more courses were added to the ENP curriculum, as well as a required 3-month preceptorship (University of Virginia, 1978).

One skill that was specific to the ENP program was soft tissue wound care. Patients who presented with traumatic injuries and lacerations that required bleeding control were at risk for developing a serious bacterial infection. A protocol was created at the University of Virginia that provided guidelines for ENPs to care for soft tissue wounds under physician supervision. A study was performed at the University of Virginia that evaluated the ENPs' performance on the basis of patients who followed up with their care, and the incidence of gross infection. Of the 100 patients included in the sample, 25% of their wounds required tape for closure, and 75% required sutures. It was found that there was a 1% incidence of infection, identical to that found in a study in which physicians treated patients using related protocols (Buchanan et al. 1979). Other tasks performed by ENPs depended on the acuity of the patient, and like suturing, tended to be more medically focused (Buchanan, personal communication, January 9, 2006).

Graduate credit was given from 1975 to 1978, as there was no national NP certificate program. Upon completing the requirements, graduates had the option of obtaining their Master's degree, were able to apply to the Board of Nursing for Virginia Emergency Nurse Practitioner Licensure, and were approved emergency medical technician and CPR instructors (Geolot et al., 1977). The certificate program was closed in 1982 when the family nurse practitioner program became a post-master's degree option (Brodie, 2000). By 1979, there were four National League of Nursing accredited ENP programs in the nation, and by 1981, there were six (Budassi & Barber, 1981).

In 1984, the ANA House of Delegates passed a resolution which stated that by 1990, NP programs should all be incorporated into graduate-level education. This requirement was later extended to 1992 by the ANA Cabinet on Nursing Practice (ANA, 1985).

## ACCEPTANCE BY COLLEAGUES

Emergency nurse practitioner Leslie Buchanan, speaking of the NPs' acceptance within the ER setting at the University of Virginia, noted that: “We were readily accepted by patients, and never really had trouble with physicians.” Most of the time, the physicians and other nurses were

curious about the role. The ENPs wore name tags, and always introduced themselves explaining that they were advanced practice nurses who worked alongside the physicians. They were looked upon as spokeswomen for advanced practice nursing, and asked to be lecturers and give presentations at conferences to educate others about their role. Specifically, the lectures would focus on physical assessment at the ED or EDNA meetings. As part of "defending" their role, ENPs would also speak at hospital conferences and at panels (Buchanan, personal communication, January 9, 2006).

The ED nurses at the University of Virginia developed an understanding of triaging certain patients to ENPs, and for the most part, the relationship between the ENPs and other nurses was said to be a very respectful one. Patients were triaged in layers: emergent, nonemergent, and express care. The ENPs were transitioning into an already established group, where they had to delineate their role and make it nonthreatening to their peers. As Leslie Buchanan put it, "It was not that ENPs thought that they were 'better' nurses; they just had a different role. We worked together to achieve quality patient care. That was always the goal" (Buchanan, personal communication, January 9, 2006).

## BLURRING BOUNDARIES BETWEEN MEDICINE AND NURSING

As was true in intensive and coronary care units of the era, disciplinary boundaries between medicine and nursing blurred in the ENP role. "At the time, there were no clear cut rules, the nurse practitioner role was very vague and open, which made it hard to practice beyond the boundaries of nursing, however, we did collaborate with physicians in practicing certain aspects of medical management," offered Leslie Buchanan (Buchanan, personal communication, January 9, 2006). Some of the course content (like pathophysiology) and skills (like physical assessment) had not yet been incorporated into the undergraduate nursing curriculum. Medical management was also somewhat of a mystery to ENPs, as they did not have a good understanding of it because it was so different from nursing (Davies, personal communication, January 14, 2006).

Indeed, some thought of NPs as "physician extenders," much like the physician assistants who were gaining in popularity during this time. Dr. Odin Anderson contended that at first, the NP was conceived as the "physician extender," as they were able to perform physician's tasks. However, according to Anderson, what was truly a valuable contribution of these nurses—was their "nursing" skills. By this, Anderson meant that because nurses seemed to really care about their "new and expanded role," it became a more important "complement" to medical care. Clearly, autonomy, assertiveness, and accountability were incorporated into the nursing skill set.

## INCREASING NUMBERS AND EDUCATIONAL OPPORTUNITIES

In response to an increased focus on primary care and the decrease in medical residency programs in subspecialties, NP numbers increased from 16,000 in 1979 to 60,000 in 1995 (Hughes, Sampson, & Sulivan-Marx, 2003). Acute care nurse practitioner (ACNP) programs, developed in the early 1990s, further added to these numbers. The ACNP programs also provided emergency nurses with the option of an alternative route for their education—one that would prepare them to meet the needs of acutely ill adult patients.

In August 1994, the University of Texas–Houston School of Nursing admitted their first class of ENPs to provide care for patients with nonurgent, urgent, and emergent complaints including life-threatening situations (University of Texas–Houston School of Nursing, 2005). Since that time, three additional ENP programs and one post-Master's urgent and emergency care certificate program have been developed (Cole & Ramirez, 2005). Upon completion of the programs, students may sit for the family nurse practitioner or ACNP board examination.

In 1999, the EDNA adopted the *Scope of Practice for the Emergency Nurse Practitioner.* Since the inception of NPs in the ED, the role has evolved to provide "high quality and cost effective care to persons who seek health care for nonurgent, urgent, or emergent conditions in a variety of emergency settings, including emergency departments" (Cole, Ramirez, & Luna-Gonzales, 1999). Besides certification as an NP, the EDNA *Scope of Practice* recommends certification as an emergency nurse and verifications such as Advanced Cardiac Life Support, Trauma Nursing Core Course, Emergency Nurse Pediatric Course, and Basic Cardiac Life Support (Cole et al., 1999). The scope of practice for the NP in the emergency care setting is also influenced by state nurse practice act and local hospital practice agreements. A study by Cole and Ramirez evaluating a voluntary Web listing of NPs in emergency environments identified that 24% of the NPs worked in a rural environment and 72% in an urban/suburban environment. Of these, 50% worked in both a main ED and fast tract, with 23% only in fast tract, 21% only in the main ED, and 3% in urgent care. A Master's degree or higher was held by 96% of the NPs, and 86% were nationally certified (Cole & Ramirez, 2005).

One of the strongest proponents for the ENP role was Frank Cole, PhD, RN, CEN, who was instrumental in obtaining federal funding to expand the ENP program and to educate ENP students in rural EDs through telemedicine (EDNA, 2006). In 2006, the Board of Directors of the EDNA approved the creation of a national award, designating the Frank L. Cole Nurse Practitioner Award, to recognize excellence as an NP in an emergency setting, and named Cole as the first recipient (EDNA, 2006).

## CLINICAL NURSE SPECIALISTS

In the 1980s, the term advanced practice began to reflect graduate education in nursing (Keeling & Bigbee, 2005). The ANA's Social Policy Statement in 1980 provided clear guidance on the criteria to be a CNS:

> The specialist in nursing practice is a nurse who, through study and supervised clinical practice at the graduate level (masters or doctorate), has become expert in a defined area of knowledge and practice in a selected clinical area of nursing…. Upon completion of a graduate program degree in a university graduate program with an emphasis on clinical specialist, the specialist in nursing practice should meet the criteria for specialty certification through nursing's professional society. (ANA, 1980, p. 23)

Speaking of the CNS in the 1970s, Dr. Denise Geolot stated, "They really made a difference. The epitome of CNSs was that they were an absolute expert in the CNS role for whichever specialty they chose, and were experts on their patients. They could diagnose and treat, but unlike NPs—

could not pass medications. Sometimes, CNS' were asked to speak to ENP students as part of the core curriculum that had evolved" (D. Geolot, personal communication, February 4, 2006).

By 1986, the role of the CNS was more solidified, with five dimensions of the CNS role identified as specialist in clinical practice, educator, consultant, researcher, and administrator (Council of Clinical Nurses Specialists, American Nurses Association, 1986). Historically, CNSs have been faced with clearly defining their role in healthcare as the method of implementation and styles vary by practice setting and institution (Menard, 1986). The 1990 Emergency Nurses Association Emergency Clinical Nurse Specialist Guidelines defines the emergency CNS as "a registered nurse who, through advanced study of scientific knowledge and supervised advanced clinical practice at the Master's or doctoral level, has become an expert in emergency nursing" with the behaviors of an expert clinical, educator, consultant, researcher, and administrator (ENA, 1990). In 1995, the role functions reflected the removal of administrator and included expert clinician, researcher, educator, and consultant (American Association of College of Nurses [AACN], 1995). Today, in addition to direct patient care, CNSs also engage in teaching, consulting, research, management, and systems improvement (AACN, 2006). Today, EDs may encompass subspecialty units, and the role of the CNS has expanded. In fact, more than one CNS may be employed in the same emergency department with Pediatric and Psychiatric CNSs, each working with her respective speciality populations (Gross, 1991; Karshmer & Hales, 1997).

## CONCLUSION

Since the early 20th century, nurses have been involved in providing emergency care to patients in a variety of settings, including "First Aid Rooms" and dispensaries. Today, both NPs and CNSs are involved in the care of acutely ill and injured patients. Nurse practitioners provide direct care for patients, while CNSs work with the ED nurses to provide care to groups of patients in the department. Both are advanced practice roles, and both roles encompass support for patients and family and patient education to provide the best outcome for the patients.

It is essential as nurses that we reflect on the history of our profession and those nurse pioneers who have paved the way for us in the 21st century. Their history provides the context in which we can examine issues today—particularly those related to access to care and the expansion of professional boundaries.

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