Advanced Practice in Nursing: Conceptual Issues

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Rasch, R.F.R., & Frauman, A.C. (1996) Advanced practice nursing: Conceptual issues. Journal of Professional Nursing, 12(3): 1-7.

Abstract:
The issue of defining advanced practice nursing roles is increasingly a subject of national discussion and debate. Central to this discussion has been the issue of merging nurse practitioner (NP) and clinical nurse specialist (CNS) roles and the tendency for the term "nurse practitioner" to replace that of "clinical nurse specialist" in denotation of these roles. The authors note the lack of any attempt to use a broader conceptual approach in these discussions. In this article, the development of each role is reviewed, and the strengths and weaknesses of each role in current practice and education are evaluated. The authors conclude that inadequate justification exists for continuing both roles, but that the answer is not in simply replacing the CNS with the NP. Ongoing careful and thoughtful dialogue should be used to guide the merging of these two roles.
Index words: Advanced practice nursing; Clinical nurse specialist; Graduate nursing education; Nurse practitioner

Article:

The issue of defining advanced practice nursing roles is increasingly a subject of national discussion and debate. Much of the impetus for this debate has been the increasing tendency for advanced practice in nursing, in both primary care and inpatient settings, to carry the label of nurse practitioner (NP), rather than that of clinical nurse specialist (CNS) (Sawyers, 1993; Schroer, 1991). The long-standing demarcation between the roles of NP and CNS is dissolving, and the traditional separation of these roles by practice setting is no longer the case (Fenton, Rounds, & Anderson, 1991; Goksel, Harrison, Morrison, & Miller, 1993; Kitzman, 1983; Kitzman, 1989; Nemes, Barnaby, & Shamberger, 1992; Sawyers, 1993; Schroer, 1991; Stamoulis, Plante, & Pender, 1992). Moreover, as the roles of CNS and NP have undergone evolution and change, with boundaries between the roles becoming less distinct, the societal need for two separate advanced practice nursing roles has become less and less clear. Nurses in these merged roles are beginning to present their practices at conferences (Borgmeyer, 1994; Kaufman, 1994; Knaus, 1994), and although some problems continue to be identified, the roles are by and large working in the settings in which they are being tried. These settings include an inpatient pediatric service staffed by advanced practice nurses and an orthopedic specialty practice in which the advanced practice nurse has responsibility for both office and inpatient visits (Borgmeyer, 1994; Kaufman, 1994).

Although this, evolution has not gone unnoticed (Patterson & Haddad, 1992; Pearson, 1985; Ridenour, 1991), to date discussion of the future of advanced-practice nursing has largely centered on organizational issues, such as the merger in 1992 of the ANA Council of Clinical Nurse Specialists and Council of Primary Care Nurse Practitioners (Hawkins & Rafson, 1991; Ridenour, 1991), role function issues (what kinds of care is provided by whom (Kitzman, 1989; Mezey, 1986; Mezey, 1993) and professional autonomy issues, such as prescriptive authority for nurses in advanced practice (Safriet, 1992).

Each of these advanced practice roles (NP and CNS) was originally conceived and implemented after careful and thoughtful planning by nurse scholars (Ford & Silver, 1967; Ford, 1979; Peplau, 1965; Reiter, 1966). However, the further development of the roles is now being driven by the disparate and arbitrary practice needs

of clinical settings and the hit-or-miss practice of filling nursing positions with any available nurse (Barnie, Durham, Gruber, Finnegan, & Tealey, 1991; Patterson & Haddad, 1992; Sawyers, 1993; Shrorer, 1991). Shortages of resident physicians, especially in pediatrics, have added impetus to this trend. The movement toward health care system reform, as well as marketing issues, are influencing this evolution as well.

Lacking in discussions of the issues surrounding advanced nursing practice has been any attempt to address them using a broader conceptual approach. Some basic questions needing to be addressed include the following: What is a nurse practitioner/What is a clinical nurse specialist? Is there a difference? What is the difference between a CNS and an NP? How are their practices different? Is there a need for two separate advanced practice nursing roles in a rapidly changing health care system? Even more basic questions include: What is advanced nursing practice? and What is the appropriate preparation for an advanced practice nurse irrespective of role title? The purpose of this article is to review the parameters of the problem and to present these conceptual questions for ongoing discussion.

The roots of the current state of affairs lie in the historical origins of the two roles, and their sometimes parallel, sometimes divergent, evolution over time. Traditionally, the NP has practiced in primary care or ambulatory settings, and the credential for practice has been certification and/or licensure beyond the registered nurse, rather than advanced education. The NP has generally provided a broad range of patient services (Kitzman, 1989). The practice has largely proceeded without collaboration with other nurses, and sometimes with, sometimes without, collaboration with physicians.

The CNS, on the other hand, has customarily practiced in an institutional setting, sometimes only with inpatients; she or he may, however, see patients returning to outpatient clinics after hospital discharge for ongoing care. The CNS credential has been a master's degree in a nursing specialty, with, in some circumstances, the additional requirement of certification or special licensure (Kitzman, 1989). However, the services provided by the CNS have been ill defined, and differ widely from institution to institution (Baker 8c Kramer, 1970; Girard, 1987; Kitzman, 1989). Collaboration with other nurses, primarily other CNSs and staff nurses, and with physicians has traditionally been an integral part of the role (Kitzman, 1989).

The differences between the two roles may be most typified by the mechanisms commonly used for payment. Typically, the CNS is in a salaried position funded by either the institution or a physician practice. The nurse practitioner, particularly in primary care, may be paid by salary generated by patient fees or on a fee-for-service basis resembling that for physician practice. She may also own a share of the practice and receive remuneration through profits.

Nurse practitioners have maintained a greater visibility and recognition with physicians and the public, in part because of the controversies inherent in the introduction of the role. In the past, nurse practitioners were seen as substitute providers in a time of national physician shortage. Contention arose over what traditional physician tasks could be legally assumed by nurse practitioners and which of those tasks required changes in nurse licensure. This controversy resulted in rigid and rigorous educational requirements and standardized advanced practice credentialing. The result has been a standardized product: the consumer knows what an NP is able to do whether in hiring or in using services provided.

Historically, the NP had to be something of a crusader to establish her practice because of restrictive medical and nursing practice acts. In thinking through the arguments in favor of NP practice as opposed to "delegated medical practice," NPs have been forced to define their role, and to clearly delineate the nursing practice inherent in their role (Griffith & Robinson, 1993; Griffith & Thomas, 1991).

Although the original impetus for the development of the NP role was a shortage of physicians, especially in underserved areas and in the care of poor people, maldistribution of physicians continues to influence advanced practice nursing. There is certainly no longer a shortage of physicians; if anything, an oversupply exists (Study shows nurse practitioner care, 1993). However, there continue to be gaps in primary care services in rural areas

and with poor or uninsured families. And, because of a variety of influences, increasing attention is being paid in schools of medicine to preparing primary care physicians. Partly as a result of these efforts, there is a scarcity of resident physicians in inpatient settings, coupled with a drive to reduce the work hours of those physicians, resulting in less physician coverage in those settings. It is becoming unacceptable for residents to be caring for patients after going without sleep for 36 to 48 hours. The resulting gaps in inpatient care are increasingly being filled by nurse practitioners or other nurses in advanced practice roles.

On the other hand, role functions of the CNS have been a source of confusion and ambiguity since the inception of the role. It is not unusual to find, in a single institution, CNSs functioning as head nurses, unit directors, assistant head nurses, or supervisors; providing staff development; assigned to formulate new policies and procedures; or working on implementing the unit project of the month. In addition, CNSs are often made responsible for paperwork mandated by accrediting agencies such as nursing care plans and assessments, with little input from staff nurses. They may also wind up covering for absent staff or just being assigned to staffing part of the time. Providing complex patient services or direction for intricate patient problems often takes a back seat to these other responsibilities. This diversity of role functions may be, in part, a result of the highly specialized nature of CNS practice; each CNS is drawing on a body of clinical knowledge that is almost unique to her subspecialty (Girard, 1987). However, much of this ambiguity is caused by a lack of understanding by administrators and CNSs them-selves about the focus of the role.

Because of the previous need to prepare master's graduates for diverse role functions (Boyd et al, 1991), including teaching, research, and management as well as advanced practice, the educational preparation of the CNS has often been fragmented. Because of the paucity of nurses prepared at the master's level, CNSs were rapidly siphoned off into teaching (staff development and academia), administration, and even research. These roles, notably, are not practice roles, another reason perhaps for widespread acceptance of the nurse practitioner as a practice role, while the CNS role has not been dearly understood. At the same time, many nurse practitioners, as graduates of certificate programs, did not have the credential of the MSN and thus the only option open to them was to continue in advanced practice.

Recently however, tasks expected of the CNS in institutional settings have included functions tradition-ally associated with the nurse practitioner role, such as admission histories and physical examinations, minor surgical procedures and other treatments, as well as modification of medication and treatment regimens. In addition, specialized nursing practice is undergoing dramatic change, with increasing use of technology in homes and other ambulatory settings requiring advanced practice nurses with the expertise to manage patients in this situation. These changes in expectations have had the effect of broadening CNS practice with increasing involvement in direct patient care.

This continuing evolution is cumulatively contributing to the blurring of the roles of NP and CNS. As these roles have moved toward merger in terms of functions and settings, there is a growing awareness that instead of continuing with parallel roles, or, perhaps merging into a new role with a new title, what may happen is the eclipse of the CNS role by the NP role or even the total substitution of the NP role for all of advanced nursing practice (Goksel, Harrison, Morrison, & Miller, 1993; Kaufman, 1994; Knaus, 1994; Nemes et al, 1992; Stamoulis, Plante, *8c* Pender, 1992). However, there is some evidence that a new term may be emerging. In a 1993 *Image* article, Griffith and Robinson use the term nurse specialists to include CNSs in oncology, rehabilitation, enterostomal therapy, orthopedics, nephrology, and critical care, as well as school nurses, nurse practitioners, and nurse midwives. Other institutions are using the term advanced-practice nurse (Borgmeyer, 1994; Hawkins Rafson, 1991; Knaus, 1994; Patterson & Haddad, 1992; Safriet, 1992).

Paradoxically, however, as a result of parallel evolution, some of those involved with both advanced practice roles have become entrenched in their divergent positions, forming a major stumbling block to progression in the further development of advanced practice nursing. An example can be found in Kitzman's (1989) discussion of the titling of a merged advanced practice role. Nurse practitioners and CNSs in clinical practice, as well as

educators preparing students for both roles, sometimes do not recognize and fail to respect or even to understand the functions and skills of nurses in the other advanced practice role.

Education for Advanced Practice Nursing

What is the appropriate preparation for an advanced practice nurse irrespective of role title? Most nursing educators answering this question would cite content that is now usually found in the graduate curricula of either nurse practitioner programs or CNS programs. Faculty in clinical specialty programs are beginning to take a critical look at the content of their programs, in part because of the increasing number of students who are applying and enrolling in nurse practitioner graduate programs (National League for Nursing, 1993) rather than in CNS programs. In a well-meaning desire to meet the needs of students, faculty have moved toward changing CNS programs to nurse practitioner programs, with often little thought to the implications of that change for education and subsequent clinical practice. Little work has been done in identifying the common content needed for advanced practice nursing.

Programs preparing CNSs have often reflected the ambiguity in the CNS role with curricula that respond to every passing fad and include a potpourri of content to prepare them to be all things to all people. There has often been resistance to the identification of the specific technical skills needed for advanced practice in the clinical specialty, such as hemodialysis or suturing, and incorporating knowledge of those skills into the curriculum. Also frequently missing in master's curricula, particularly for the CNS, are advanced content in pathophysiology, patient management, and pharmacology. Advanced assessment skills are often missing entirely or addressed in a cursory fashion.

Nurse practitioner education, now almost always within a graduate nursing program, still often bears an uncomfortable resemblance to the nondegree granting programs that preceded them. Programs often place little emphasis on research, either by not using research findings in content or by only grudgingly including statistics, research methods courses, and thesis in the curriculum. When research content is addressed, links to advanced nursing practice are not made, so that the students find the information virtually unusable. Additionally, conceptual content, including content related to understanding concepts and theories of advanced practice and primary care, is often completely lacking. Content related to acquiring knowledge about patients through techniques other than interviewing, physical examination, and laboratory testing, such as observations, projective techniques, and play techniques with children, also is often neglected in assessment courses.

NP education has focused on the management of the pathology associated with illness. Too often, NP faculty have assumed that the generalist undergraduate education their students have received has pro-vided them with the necessary skills to help patients formulate an effective response to illness. Only in contrast with physician education has NP education seemed to provide skills related to helping patients deal with their illness on a long-term basis. As NPs become increasingly involved with patients with serious illnesses, the knowledge of how to help patients in their responses to their illness and its treatment will be essential.

Further confusing educational issues for advanced practice is the ambiguity of student goals. Some students are truly interested in becoming nurse practitioners and practicing in a primary care setting, whereas others are interested, purely, in the credential of nurse practitioner, and have no intention of providing primary care services after graduation. Often, student goals are simply to get a better job with better hours and higher pay, without an understanding of how primary care differs from their current practice, and while still maintaining a strong interest in inpatient specialty practice.

An additional confounding factor in education for advanced nursing practice is faculty preparation, interest, and research. Frequently, faculty have an interest in a clinical area that is far narrower than the knowledge required for advanced clinical practice. Basing programs to prepare advanced practice nurses on narrow faculty interests would fail to encompass the scope of advanced clinical practice, and it is unlikely that graduates of these programs would be prepared for competent practice. Hence, faculty need to have broad clinical knowledge including assessment skills, advanced knowledge of pathophysiology, pharmacology, diagnostic technology,

and clinical management skills. Additionally, faculty should be showing these skills with the students in advanced practice settings. Confining learning to the classroom setting alone is not adequate for advanced clinical practice.

Nurse practitioners working in primary care settings have typically not dealt with patients who were seriously and/or chronically ill; increasingly their practices will include such patients and will cross into non-primary care settings. For example, a nurse practitioner working in a specialty orthopedic practice with responsibilities for both inpatients as well as follow-up home care will require expertise in helping patients and their families to cope with all the concomitant problems of major illness (Kaufman, 1994).

There is common knowledge beyond basic nursing practice needed for advanced nursing practice, regardless of setting or patient population. This content includes diagnostic reasoning and management theory, pathophysiology, disease management, symptom management, pharmacology, behavioral management, emotional care, family care, and conduct and interpretation of diagnostic imaging and laboratory tests. Every advanced-practice nurse should have a bag of tricks in these areas, with specific specialty knowledge added on to these basics. Nurses in advanced practice need to have skills sufficient to independently manage nursing care, regardless of setting or patient population.

Therefore, all nurses preparing for advanced clinical practice need a thorough grounding in assessment skills, including competence interviewing patients from a variety of backgrounds and developmental levels. Advanced physical assessment skills are the necessary foundation for making clinical judgments about patient needs. This includes not only expertise with the otoscope and ophthalmascope, but also expertise with using Allen's test and the hepatojugular reflux and the ability to discern the difference between an opening snap and a grade three murmur.

Patients often have multiple problems other than their admitting diagnosis; for example, the patient with a hip replacement may, and probably does, have co-existing cardiac disease, which will require careful monitoring by someone other than the orthopedic surgeon. Knowing which diagnostic technology to use and how to interpret the results is also critical not only to diagnosis, but also to ongoing management of patients.

Intimate knowledge of the pathophysiology of the conditions incurred in clinical practice and the options for managing those conditions is key to advanced nursing practice. This management includes not only the care directly provided by the nurse or her designee, but also the care to be provided by the patient and/or family. Techniques may include medication, treatments, or patient teaching about diet, exercise and other lifestyle changes, as well as technological interventions such as dialysis, cardiac monitoring, suctioning, oxygen therapy, and others. Whether the nurse in advanced practice prescribes medications independently, administers those medications, or monitors their use, knowledge of advanced pharmacokinetics and current drugs in use is essential.

Patients with these kinds of complex needs also require assistance with symptom management, wound healing, comfort measures, techniques for coping with illness by both patient and family, sick role issues, and knowledge of how to help patients and families manage the complex regimens required by many serious illnesses, and advanced practice nurses must know how to provide that care. Even patients with less complex needs may require nursing care for management of problems such as fever or nausea.

This content is extensive, may result in lengthening master's degree programs, and may be overwhelming in its variety and scope; however, all advanced practice nurses will need some skills in each of these areas if important services to patients are not to be lost. Although nurses with advanced preparation will continue to specialize and may become highly expert in the care of one group of patients, knowing how to help patients and families with all of these needs is necessary.

There does not seem to be adequate justification for continuing two completely distinct advanced practice nursing roles. However, simply supplanting the CNS with the NP is not the answer. In the same way that these two roles were originally and carefully conceived, proceeding with ongoing thoughtful dialog, rather than responding with haste to the perceived health care trend of the moment, is needed to guide the merging of these roles. This reconceptualization requires looking at practice, educational preparation, and even research in new ways. Analysis of the commonalties and differences in these roles, the patient needs that must be addressed, and design of curricula to address these needs will lead to functional, satisfying roles for advanced-practice nurses. Truly merging these roles, preserving the best of each in a reconceptualization of the advanced-practice role, will ensure that patients receive optimal nursing care.

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