

Testing the Fate of APRN Practice?

The ANA and other nursing groups meet to discuss a controversial Texas proposal.

When Lauri John, PhD, RN, CNS, graduated from nursing school in 1978, she began working in an area that, to this day, captures her interest: oncology nursing.

“Cancer patients present with so many issues, and within the broad category of ‘cancer,’ there are hundreds of diseases that affect every cell, organ, and system of the body,” said John, a Texas Nurses Association (TNA) member. “By focusing on oncology nursing, I felt that there would always be new things to learn and new opportunities for me to advance.”

And advance she did. After working for several years as an oncology staff nurse, John took on the advanced practice registered nurse (APRN) role of an oncology clinical nurse specialist. (The four major APRN subcategories are clinical nurse specialist, nurse practitioner, certified nurse midwife, and certified nurse anesthetist.)

“I wanted to pursue advanced education, so I could better address the complex issues that cancer patients and their families face, maximize patients’ lives, and identify and seek solutions to improve overall care through policy and research,” said John, now an assistant professor of clinical nursing at the University of Texas at Austin.

John believes that oncology and other clinical nurse specialists play a crucial role. But now she fears there’s a movement afoot that could lead to the demise of the clinical nurse specialist role that’s specialty-based.

Last summer, the Texas Board of Nurse Examiners (BNE) proposed regulatory changes to limit the number of APRN titles it recognizes for legal practice in Texas. Among those 17 titles proposed for elimination are nurse midwife, adult nurse practitioner, and gerontological clinical nurse specialist. Absent from the list, for example, are titles in oncology, emergency, and palliative care.

John is not alone in her concerns about what the proposal eventually could mean for APRNs nationwide. Last December, the ANA and the American Association of Colleges of Nursing (AACN) assembled representatives from 60 nursing organizations to discuss the state of APRN education, certification, and licensure.

“Professional nursing needs to develop a roadmap that will show what we believe is needed to bring cohesiveness to advanced practice nursing,” said Lynn Wieck, PhD, RN, and president of TNA. “But we don’t want to stifle the natural evolution of advanced practice, which generally is based on meeting patients’ needs.”

THE TEXAS MEASURE

In August 2004, the Texas BNE published proposed regulatory changes that it hoped to implement in January 2005. (It later postponed action for six months given ongoing national discussions.) In its written rationale, the BNE reported concerns about the increasing number of “subspecialty” areas in which nurses want board authorization. It also stated that the APRN task force of the National Council of State Boards of

Nursing (NCSBN) had similar concerns.

Essentially, the BNE reported concerns about its obligation to maintain patient safety. For example, nurses who received educational preparation in what it called a “subspecialty” might not be able to recognize and treat the wider range of diseases and conditions commonly presented by patients. The BNE also wrote of APRNs prepared in one narrowly focused area taking positions outside their specialty.

Responding to those concerns were many nurses, including Wieck, who testified at a fall 2004 BNE hearing.

In her testimony, she said that TNA understood the BNE’s concerns about potential patient safety issues and having inadequate resources to regulate an increased number of narrow specialties. But Wieck also said that TNA disagrees with the board’s approach of limiting the specialties to a subset of currently recognized titles.

“I understand that the current proliferation of titles and credentials after nurses’ names can be confusing,” Wieck said. “But patients’ needs are changing all the time. So will it make sense in the year 2050 to limit nursing roles and opportunities to these same 17 titles?”

She also said that these issues are so complex that they should be addressed on a national level, instead of Texas passing regulations that could spur other states to do the same.

In her testimony, John took issue with defining oncology nursing as a subspecialty. She said a more accurate portrayal of a subspecialty would be

radiation oncology or surgical oncology.

“Ceasing to recognize oncology as a specialty would open the door for generalist APNs to practice in an area in which they do not have specialized education and training,” John testified. “Oncology APNs have the specialized knowledge and expertise that is required in the management of cancer treatment, cancer complications, and treatment side effects.”

She said it would be a disservice to patients to eliminate oncology and other specialty-based roles. She also believes that the vast majority of clinical nurse specialists are ethical and would not risk endangering patients by practicing outside their area of expertise.

TNA member Angela Clark, PhD, RN, FAAN, is a clinical nurse specialist in cardiopulmonary and diabetes care and the president of the National

Association of Clinical Nurse Specialists.

She was outraged that the Texas board staff would describe certain educational programs and certification exam groups as “novel” specialties, such as oncology, diabetes care, and wound care.

“The ‘S’ in ‘CNS’ stands for specialist,” Clark said. “You can’t be a specialist and generalist at the same time.”

She believes that forcing clinical nurse specialists into more general roles could harm patients. For example, under the Texas proposal, an oncology APRN would be recognized under the title of a medical–surgical clinical nurse specialist.

“But if I pass the general med–surg certification exam, am I qualified to give chemo?” Clark asked.

Clark said the Texas proposal is already being felt. She knows

of two CNS programs in Texas preparing parent–child clinical nurse specialists that already have closed in anticipation of the proposed changes.

She also said that if the impetus for change is based on questions about patient safety and APRN practice, where are the harm data to support those concerns?

Hospice and palliative care nurses also are worried about what the changes might mean.

During discussions with the Texas board and in meetings with the NCSBN, there seemed to be a difference of opinion about what constitutes a specialty and subspecialty, said Judy Lentz, MSN, RN, NHA, executive director of the Hospice and Palliative Care Nurses Association and president of the American Board of Nursing Specialties. She noted that the ANA has a longstanding definition for a specialty, which specifies

it must be research-based and have standards of care.

“The BNE talks about wanting nurses to have broad knowledge, but there is no specialty that is broader than palliative care,” Lentz said.

The way Texas determined which titles it would recognize seems arbitrary, with some being population-based, such as pediatric nurse practitioner, and others being disease-specific, such as psychiatric-mental health clinical nurse specialist, said Cyndi Miller Murphy, MSN, RN, CAE, executive director of the Oncology Nursing Certification Corp.

WHAT'S NEXT

Those who attended the December ANA-AACN meeting agreed they need to iron out the inconsistencies in advanced practice. For example, New York schools may offer APRN pro-

grams that are not offered—or recognized—in Texas.

“The way advanced practice has grown is like the tail wagging the dog,” said Karen Macdonald, MS, APRN, BC, chairperson of the Commission on Certification for the American Nurses Credentialing Center, an affiliate of the ANA. “But how do you put a halt to graduate programs that have been in existence for 35 years? And how do you not allow a program to begin if it’s needed?”

State nursing boards also differ in their APRN requirements.

There are some who believe nurses should pass a certification exam for any APRN role.

“Certification exams validate the authority to practice in advanced practice roles,” said Geraldine “Polly” Bednash, PhD, RN, FAAN, executive director of the AACN. “Yet, a critical mass of APRNs practicing in an emerging specialty is needed before core

competencies and an exam can be developed.”

Currently, a task force has been formed to continue work on the APRN issue.

“Our hope is that when we’re done, we will create a plan that shapes education, regulation and practice and that all groups can have consensus around when we meet at the next ANA-AACN stakeholders meeting in the spring,” Bednash said.

One suggestion that Karen Ballard, MA, RN, director of special projects for the New York State Nurses Association, opposes would require APRNs to pass a second licensure exam. States do not regulate an MD’s specialty practice through additional licensure, she said. Similarly, the state can establish general parameters for APRN practice, and just as physicians are allowed to be board-certified in specialties, so should APRNs. ▼