

IMPORTANT FACTORS INFLUENCING THE NP ROLE

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LEGAL DIMENSIONS OF THE ROLE

LEGAL AUTHORITY FOR PRACTICE

State Nurse Practice Act—Rules and Regulations

- Authority for NP practice is found in state legislative statutes and in rules and regulations. The Nurse Practice Act of every state customarily authorizes the Boards of Nursing to establish statutory authority to define who may be called a nurse practitioner (title protection); what they may do (scope of practice); restrictions on their practice; the requirements a NP must meet in order to be credentialed within the state as an NP (educational, certification, etc.); and disciplinary grounds for infraction of regulations. (See www.ncsbn.org for a listing of state nursing board requirements). In many states, legislative acts may specifically require that an NP develop a collaborative agreement with a physician, describe what types of drugs might be prescribed, or define some form of oversight board for NP practice.
- Statutory law is implemented in regulatory language. The rules and regulations for each state may further define scope of practice and practice requirements, and/or restrictions.
- Beginning in 1999, the National Council of State Boards of Nursing (NCSBN) began implementation of an interstate compact for nursing practice to reduce state to state discrepancies in nursing requirements to practice. The Advanced Practice Registered Nurse (APRN) Compact addresses the need to promote consistent access to quality advanced practice nursing care within states and across state lines. The Uniform APRN Licensure/Authority to Practice Requirements, developed by the NCSBN with APRN stakeholders in 2000, establishes the foundation for this APRN Compact. Similar to the existing Nurse Licensure Compact for recognition of RN and LPN licenses, the APRN Compact offers states the mechanism for mutually recognizing APRN licenses/authority to practice. A state must either be a member of the current nurse licensure compact for RN and LPN, or choose to enter into both compacts simultaneously to be eligible for the APRN Compact. To determine which states participate, view the state compact map at www.ncsbn.org/nlc/index.asp.

NURSE PRACTITIONER PROFESSIONAL PRACTICE

Licensure

- “A process by which an agency of state government grants permission to individuals accountable for the practice of a profession to engage in the practice of that profession and prohibits all others from legally doing so” (US DHEW, 1971).
- The purpose is to protect the public by ensuring a minimum level of professional competence. “This regulatory method is used when regulated activities are complex, require specialized knowledge, skill and independent decision-making. The licensure process includes the predetermination of qualifications necessary to perform a legally defined scope of practice safely and an evaluation of licensure applications to determine that the qualifications are met. Licensure provides that a specified scope of practice may only be performed legally by licensed individuals.

Licensure provides title protection for those roles. It also provides authority to take disciplinary action should the licensee violate provision of the law or rules in order to assure that the public health, safety and welfare will be reasonably well protected” (NCSBN, www.ncsbn.org/regulation/nlc_licensure_aprn.asp, accessed 09/18/04).

Certification

- “A process by which a non-governmental agency or association certifies that an individual licensed to practice as a professional has met certain predetermined standards specified by that profession for specialty practice” (US DHEW, 1971).
- The purpose is to assure the public that an individual has mastery of a body of knowledge and has acquired the skills necessary to function in a particular specialty. Some certifications are required for entry into practice (e.g. required for licensure within a state, and thus have a regulatory function); some certifications denote professional competence and recognize excellence.

Accreditation

- “The process by which a voluntary, non-governmental agency or organization appraises and grants accreditation status to institutions and/or programs or services which meet predetermined structure, process and outcome criteria” (US DHEW, 1971). The purpose is to ensure that the organization has met specific standards.

Scope of Practice

- Defines a specific legal scope determined by state statutes, boards of nursing, educational preparation, and common practice within a community. For example, ANPs are not legally authorized to care for children. The state might require an NP to have formal educational preparation in pediatrics. Broad variation exists from state to state.
- General scope of practice is specified in many published professional documents (e.g., *Scope and Standards of Advanced Practice Registered Nursing* [ANA, 1996]). In addition, many organizations have completed role delineation studies that attempt to qualify the core behaviors that all APNs must possess, as well as the core knowledge and behaviors required of individuals in a particular specialty. For example, core knowledge for a PNP will be inherently different than that of a GNP. It is critical that these statements about specific scope and standards exist so that everyone—including nurses—will have access to materials to which they can refer when there are specific questions related to role. This is especially important when the traditional role of nurses is being changed or “advanced” at an uneven rate through changes in state law. As the nurse practitioner role has expanded into new practice settings, including hospice, hospitals, and home care, it is important that core knowledge as well as state law protecting NPs in these practice settings expand also, providing the legal authorization and title protection necessary for these practice settings.
- Prescriptive authority is recognized as within the scope of practice for nurse practitioners in all 50 states, though there is significant variability from state to state. This has created inherent difficulty in collecting data related to NP prescribing practices. A comprehensive update of legislative requirements and recent changes is published in the January issue of the *Nurse Practitioner Journal*. Data collected by Nurse Practitioner Alternatives, Inc., since 1996 have documented stability within prescribing patterns by NPs. Data from 2004 document that the majority of NPs possess their own Drug Enforcement Administration (DEA) number (72%), write between 6 and 25 prescriptions in an average clinical day (79%), recommend between 1 and 20 over-the-counter (OTC) preparations in an average clinical day (90%), and manage between 25% and 100% of their patient encounters independently (97%) (www.npedu.com).

Standards of Practice

- Authoritative statements by which the quality of practice, service, or education can be judged (e.g., *Scope and Standards of Advanced Practice Registered Nursing* [ANA, 1996]).

- Professional standards focus on the minimum levels of acceptable performance as a way of providing consumers with a means of measuring the quality of care they receive. They may be written at the generic level to apply to all nurses (for example, following universal precautions), as well as to define practice by each specialty.
- The presence of accepted standards of practice may be used to legally describe the standard of care that must be met by a provider. These standards may be precise protocols that must be followed, or more recommendations for more general guidelines.
- *Healthy People 2010 Objectives* and *WHO “Health for All”* are, respectively, national and international policy statements that describe the objectives to be met to help all individuals to obtain a level of health that will permit them to lead socially and economically productive lives. It is anticipated that over time, these objectives will form the basis for international standards of practice.
- The National Organization of Nurse Practitioner Faculties (www.nonpf.com) in partnership with the American Association of Colleges of Nursing (www.aacn.nche.edu), developed *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women’s Health*, published by HHS’s Health Resources & Services Administration Bureau of Health Professions Division of Nursing in April 2002. This document outlines what an NP in each of the specialty areas should be able to do. See www.nurse.org/acnp/clinprac/np.comp.spec.areas.pdf.

CLIENT RIGHTS

Confidentiality

- The patient and family have a right to assume that information given to the health care provider will not be disclosed. This has several dimensions:
 - Verbal information—The health care provider shall not discuss any information given to them during the health care encounter with anyone not directly involved in providing this care without the patient’s or family’s permission.
 - Written information—Confidentiality of the health care encounter is protected under federal statute through the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Administrative Simplification provisions of HIPAA require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Information may be accessed at www.cms.hhs.gov/hipaa/default.asp?.
 - The individual’s right to privacy is respected when requesting or responding to a request for the patient’s medical record.
 - The statute requires that the provider discuss confidentiality issues with patients or parents in the case of a minor, establish consent, and clarify any questions about disclosure of information.
 - The provider is required to obtain a signed medical authorization and consent form to release medical records and information.
- Exceptions to guaranteed confidentiality occur when society determines that the need for information outweighs the principle of confidentiality. Examples might be when records are released to insurance companies or to attorneys involved in litigation, or in answer to court orders, subpoenas, summonses; in meeting state requirements for mandatory reporting of diseases or conditions; in cases of suspected child abuse; or if a patient reveals an intent to harm someone.

Informed Consent

- Informed consent is the right of all competent adults or emancipated minors (age 18 or younger who are married, a parent, or self-sufficiently living away from the family domicile) to accept or

reject treatment by a health care provider. (Some states may have laws concerning birth control or abortions that apply to patients younger than 18.)

- The clinician has the duty to explain relevant information to the patient so that the patient might make an appropriate decision. This information usually includes diagnosis, nature and purpose of proposed treatment or procedure, risks and benefits, prognosis, alternative methods of treatment along with risks and benefits, and even the remote possibility of serious harm.
- It must be documented in the medical records that this information has been provided.
- Informed consent does not absolve the NP from allegations of malpractice should it occur.

Care of Minors

- In most jurisdictions, minors under the age of 18 cannot receive health care services without permission of a consenting adult who is a parent or legal guardian.
- Exceptions to this rule may be made in some jurisdictions in the case of an emancipated minor, a pregnant minor, or in matters pertaining to sexually transmitted diseases and birth control.

Advance Directives

- When a patient is incapable of making decisions, an individual's preferences may be expressed by way of a written living will or a health care durable power of attorney when they are still competent.
- Living wills are written documents prepared in advance in case of terminal illness or nonreversible loss of consciousness.
 - Their provisions go into effect when:
 - The individual has become incompetent
 - The patient is declared terminally ill
 - No further interventions will alter the patient's course to a reasonable degree of medical certainty

Durable Power of Attorney for Health Care

- Individuals can identify in writing an agent to act on their behalf, should they become mentally incapacitated. The decisions of the designated agent are:
 - Binding
 - Not limited to the circumstances of terminal illness
 - Flexible enough to carry out the patient's wishes throughout the course of an illness
 - Often accompanied by a durable power of attorney over financial issues as well

Ethical Decision-Making

- Moral concepts such as advocacy, accountability, loyalty, caring, compassion, and human dignity are the foundations of ethical behavior.
- The ethical behavior of nurses has been defined for professional nursing in an American Nurses Association policy statement (ANA, 1988).
- Ethical behavior incorporates respect for the individual and his or her autonomy. Thus, no decision is truly ethical if the caregiver does not involve the patient in decision-making to the full extent of the patient's capacity.
- Duty to help others (beneficence), avoidance of harmful behavior (nonmaleficence), and fairness are also foundational components of ethical behavior.

Quality Assurance

- A system to evaluate and monitor the quality of patient care and the quality of facility management.
- Formal programs provide a framework for systematic, deliberate, and continuous evaluation and monitoring of individual clinical practice. Programs promote responsibility and accountability to deliver high-quality care, assist in the evaluation and improvement of patient care, and provide for an organized means of problem solving. Thus, a good program identifies educational needs, improves the documentation of care, and overall reduces the clinician's exposure to liability.

- Programs identify components of structure, process, and outcomes of care. They also look at organization effectiveness, efficiency, and client and provider interactions.
- May be implemented through audits, utilization review, peer review, outcome studies, and measurements of patient satisfaction.

NURSE PRACTITIONER LEGAL AND FINANCIAL ISSUES

Liability

- Sources of legal risk
 - Patients, procedures
 - Quality of medical records
- Risk reduction or management
 - Activities or systems designed to recognize and intervene to reduce the risk of injury to patients and subsequent claims against health care providers.
 - Malpractice insurance—does not protect a clinician from charges of practicing outside their legal scope of practice. Universally recommended that all clinicians carry their own liability insurance coverage so they will have their own legal representation and attorney to advocate for them.
- Malpractice
- Negligent professional acts of individuals engaged in professions requiring highly technical or professional skills
 - The plaintiff has the burden of proving four elements of malpractice
 - Duty—The clinician has the duty to exercise reasonable care when undertaking and providing treatment to the patient when a patient–clinician relationship exists.
 - Breach of duty—The clinician violates the applicable standard of care in treating the patient’s condition.
 - Proximate cause—There is a causal relationship between the breach in the standard of care and the patient’s injuries.
 - Damages—There are permanent and substantial damages to the patient as a result of the malpractice.
- National Practitioner Databank
 - The Health Care Quality Improvement Act of 1986 established a databank to scrutinize members of the health care profession and list those practitioners who have had a malpractice claim asserted against them.
 - Currently very few NPs are listed in the National Practitioner Databank. There is very little history of successful litigation against NPs.

Reimbursement

- NPs are reimbursed as primary care providers in some form for their services under Medicare, Medicaid, Federal Employee Benefit Plan, Champus, Veterans and Military programs, and federally funded school-based clinics.
- Private insurance plans may elect to reimburse for NP services even if not mandated to by state law. In some states, the insurance code may be interpreted rigidly to exclude reimbursement of NPs.
- Managed care organizations (MCOs) have frequently excluded NPs from being designated as primary care providers and allowing their own caseload. Thus, in many MCOs the only employment arrangement left open to NPs is that of being a salaried employee. The contributions of an NP, as a salaried employee, are often not visible and may be credited to their collaborating physicians given them a “ghost” provider status. Without a legitimate method to document services provided and revenue generated, NP job security is often at risk. A recent focus of legislative activity by many state NP organizations has been to enact state law that allows for NPs to be impaneled as primary care providers in both health maintenance organizations

(HMOs) and preferred provider organizations (PPOs). These efforts have led to opposition from state medical organizations.

- There is considerable flux in state and national policy on what services and procedures NPs may bill for, and whether they will be paid directly. Incorrect billing places the health care provider at risk of fraud and abuse charges, whether they knowingly violate the law or are just ignorant of the regulations.
- NPs must be aware of specific regulations and policies for patient care services. Resources include Health Care Financing Agency bulletins, etc. See www.hcfa.gov.

Performance Assessment

- The National Practitioner Data Bank (NPDB) and Health Integrity and Protection Data Bank (HIPDB) are maintained by the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHP), Division of Practitioner Data Banks (DPDB). Developed as a result of the Health Care Quality and Improvement Act of 1986, the NPDB/HIPDB are a flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB is intended to direct inquiry into a practitioner's licensure, professional society memberships, malpractice payment history, and record of clinical privileges, with a goal of improving the quality of health care. NPs may perform a self-query by visiting www.npdb-hipdb.com.
- Other programs monitoring and comparing health quality include the Health Plan Employer Data and Information Set (HEDIS[®]) developed by the National Committee on Quality Assurance (NCQA). HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. See www.ncqa.org/programs/hedis.

Current Trends

Some of the topics dominating NP discussion about their future involve:

1. Fiscal Issues

- Growing competition in job market for NPs as numbers of NPs has increased and NPs have begun to directly compete with physicians and physician assistants.
- Reimbursement struggles with Medicare, private insurance.
- Increasing costs for malpractice insurance. Many states have launched legislative initiatives in the area of medical tort reform in an attempt to hold down malpractice premiums.
- Beginning in May 2005, as a result of HIPAA, the Center for Medicare and Medicaid Services (CMS) will begin implementing a requirement that providers obtain a National Provider Identifier (NPI). All health care providers are eligible to be assigned NPIs. Information may be obtained at www.cms.hhs.gov/hipaa/hipaa2/default.asp.
- Growing concerns over reimbursement fraud and abuse issues as well as coding issues, in the areas of both overbilling and underbilling, particularly for Medicare patients.

2. NP Education

- Recognition of the need to ensure quality of NP education, faculty, and curriculum has led to efforts by the National Organization of Nurse Practitioner Faculties (NONPF) and the American Association of Colleges of Nursing (AACN) to promulgate core competency statements. These can be viewed at www.nonpf.org/finalaug2002.pdf.
- In addition, the NONPF and the AACN, along with numerous NP professional organizations, NP accrediting bodies, and educational organizations, have jointly promulgated criteria for evaluation of nurse practitioner programs. In combination with accreditation standards for graduate programs and for specialty areas, the criteria provide a basis for evaluating the quality of nurse practitioner programs. Documents may be viewed at www.nonpf.org/evalcriteria2002.pdf.

- As an alternative to researched-focused doctoral degrees, the American Association of Colleges of Nursing, working with the National Organization of Nurse Practitioner Faculties (with input from other groups), has developed recommendations for a Practice Doctorate in Nursing, which will be the degree associated with practice-focused doctoral nursing education. It is suggested that the practice doctorate in the future is to be the graduate degree for advanced nursing practice preparation, including but not limited to the four current APN roles: clinical nurse specialist, nurse anesthetist, nurse midwife, and nurse practitioner. A transition period would be planned to provide nurses with master's degrees, who wish to obtain the practice doctoral degree, a mechanism to earn a practice doctorate in a relatively streamlined fashion with credit given for previous graduate study and practice experience. The transition mechanism would provide multiple points of entry, standardized validation of competencies, and be time limited. The draft also recommends that current APNs would not be required to obtain a DNP. See www.aacn.nche.edu.

3. Practice Environment

- Health disparities—There is growing recognition of disparities in the health services and outcomes of different populations in the United States. The National Center on Minority Health and Health Disparities (NCMHD) at the National Institutes of Health (NIH) is a government organization with a mission to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. See <http://ncmhd.nih.gov>.
- Health literacy—Now recognized that one of the largest contributors to health outcome is the ability of a patient and family to understand and act on health information. Both the Institute of Medicine (IOM) and the Agency for Health Care Research and Quality (AHRQ) have launched efforts to quantify and offer solutions to the problems that result from inadequate health literacy. The IOM report may be viewed at www.iom.edu/report.asp?id=19723; the AHRQ study can be found at www.ahrq.gov/news/press/pr2004/litpr.htm.
- Patient Bill of Rights—In 2004, both the Senate and the House passed different versions of a Patient Bill of Rights. These bills are an attempt to insure that patients have access to their provider of choice and have access to independent external appeals process to address health plan grievances. The bills have not yet been approved by a joint committee, or been sent to the Office of the President for signature. It is critical that NPs monitor legislation in this area to ensure that the rights of nonphysician providers are protected.
- There is increasing attention being paid to preparing registered nurses to gain disaster education so they might be prepared to assume emergency roles during a time of mass casualties from either natural disasters or terrorist attacks. Because some other countries have had more experience with dealing with terrorism, the International Nursing Coalition for Mass Casualty Education has been established and headquartered at the Vanderbilt School of Nursing to help US nurses profit from their experience and to identify the educational competencies for registered nurses responding to mass casualty incidents. They desire to improve the ability of all nurses to respond safely and effectively to mass casualty incidents through identification of existing and emerging roles of nurses, ensuring appropriateness of education in mass casualty incidents, and helping to understand response frameworks and ensure collaborative efforts. All NPs are expected to prepare themselves to play a larger role in delivery of care during a time of disaster. Information of the objectives and work that has been done toward a uniform curriculum in this area may be obtained through www.incmce.org.
- Direct-to-consumer advertising—Patients frequently present to the office already having formed their diagnosis and wanting specific treatments. NPs are required to become knowledgeable about the newest product on the markets in order to appropriately counsel and treat patients.
- There is greater recognition of the use of complementary and alternative medicine by consumers. Research suggests that 40–50% of patients are currently using a form of complementary or

alternative (CAM) therapy today, despite the fact that there is little research on which to base treatment regimens. NPs as providers need to learn about common CAM treatments and particularly about how some of the herbal products interact adversely with prescription drugs. The National Institutes of Health have established a center to begin research on these popular preparations. Until that time, it is suggested that providers need to move cautiously in prescribing these preparations for their patients. See www.nih.cam.gov.

- Since release of the Institute of Medicine's report *To Err Is Human: Building A Safer Health System* (www.iom.edu/report.asp?id=5575), there has been increased attention on changes all health care providers should make to decrease medical errors. In response, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (www.jcaho.org) has issued a list of abbreviations that should not be used in health care, and the Institute for Safe Medication Practices (ISMP) has published a list of dangerous abbreviations related to medication use that it recommends should be explicitly prohibited (www.ismp.org). The list of banned abbreviations includes many symbols traditionally used on patient charts and in writing prescriptions.

Professional Organizations

- Participation in professional organizations is important because nurse practitioners acting as a group can have more influence over our profession and can do things individuals cannot do.
- State organizations—Every NP should belong to their state NP organization. State organizations work diligently to monitor and affect laws and regulations affecting NP practice. In addition, these associations provide a group of peers for discussion and continuing educations.
- The American College of Nurse Practitioners (ACNP) is focused on advocacy and keeping NPs current on legislative, regulatory, and clinical practice issues that affect NPs in the rapidly changing health care arena (www.nurse.org/acnp).
- The National Council of Gerontological Nurse Practitioners (NCGNP) is the professional organization that advocates for geriatric nurse practitioners who deliver health care in a variety of settings.
- The National Organization of Nurse Practitioner Faculties (NONPF) is an organization of nurse practitioner educators who are instrumental in setting standards for nurse practitioner education. The NONPF has developed Core Competencies describing the domains of practice with critical behaviors that should be exhibited by all entry-level NPs. Originally written in 1995, the revised standards became available in 2000 to reflect the current NP practice. See www.nonpf.com.

THEORY AND PRINCIPLES OF FAMILY-FOCUSED CARE

The traditional family nurse practitioner (FNP) provides primary and secondary prevention to individuals across the life span living in single, nuclear, or extended family networks. Today's family consists of those who identify themselves as family members, not limited by walls, genetic, or legally defined relationships. Friedman (1998) defines family as "two or more persons who are joined together by bonds of sharing and emotional closeness and who identify themselves as being part of the family" (p. 9).

Family members may either live together or within close proximity in a common community, and participate in educational, social, and religious experiences. Families may form as an outgrowth of kinship bonds with others in the community or as a result of culturally specific extended family networks. Due to changes in society, family members often share multiple instrumental and expressive tasks that are often overlapping and subject to communication and negotiation (Hanson, 2001). Family forms are varied, and the FNP will interact with nontraditional and multicultural family forms such as the gay and lesbian family, the single parent family, the Asian or African American extended family, and the family with adopted children or stepparent families, as well as traditional legal families.

Family-focused care is the specialized role of the family nurse practitioner. FNPs acknowledge that the family process is an interaction between family members that serves to promote mental and physical health, prevent disease, and restore health in times of illness. FNPs provide a comprehensive psycho-

social approach to caring for individuals that fosters health-promoting lifestyles among family members. The FNP interacts across the interdependent roles of individual, family, and community to act as advocate, case manager, coordinator, counselor, expert provider of care, and case finder.

The FNP assesses family structure and dynamics in order to assist individuals to maximize their health given the realities of their personal health history, family health history, psychosocial history, genetic makeup, cultural and religious values, traditions, and social and economic context. The FNP teaches family members to recognize the influences of their family health patterns and risks; to utilize family members as resources for knowledge and support during periods of health; to maintain psychosocial ties with their family of origin; and to assume functions that help optimize health in family members by utilizing resources in the community.

The FNP role is interpreted as a unique NP role. It is not, as some would suggest, an adult NP plus pediatric NP plus geriatric NP role, but requires mastery of a unique constellation of knowledge and tasks surrounding the care of an individual within a family context. The FNP is not expected to have the depth of knowledge of NPs practicing in the specialty areas but is expected to know something about many different diseases and processes affecting the individual throughout the life span. As such, the FNP will work closely with physician colleagues in the diagnosis and development of the initial treatment regimen and be prepared to refer frequently to specialists.

Family Theory: Assessment and Intervention

In general, family theory serves as a basis for assessing and coming to understand the structure, development, and function of families through the process of family assessment. Authors such as Friedman (1998), Wright and Leahy (2000), and Hanson (2001) have developed family assessment tools. Family theory is grounded in general systems theory, including structural functional theory, family systems theory (Bowen), family development theory, (Duvall) child development theory, (Havinghurst, Erickson) and other social science theories including communication, stress, and interactional theory.

Theoretical Basis for Family Theory

General Systems Theory

- The theory provides a framework that explains the dynamic structure and function of the family within the context of a unified whole. The family performs activities reflected by the actions of interacting parts or subsystems. The major principles of systems theory adapted from Hanson (2001), Friedman (1998), and Wright and Leahy (2000) include:
 - Each system has its own characteristics, and the whole is greater than the sum of the parts, rather than just the sum of the characteristics of individual parts of a system.
 - All parts of the system are dependent on one another, even though each part has its own role within the system.
 - Families are organized in such a way to enable the interdependence and interactivity of its members.
 - Each family system has mechanism for exchange of information within the system and between the system and the broader environment.
 - Boundaries exist within family systems that are either open, closed, or operate at random.
 - Family systems change over time; they respond individually and as a whole to change occurring in the internal and external environment. With change, families become more complex, reflect adaptation, and differentiation of its members.
 - Change occurs through feedback processes that allow for circular interaction within the family system rather than a linear cause and effect pattern.
 - A change affecting one part of a family manifests itself as change in the whole family system.
 - Families strive for homeostasis or a predictable steady state that reflects a balance between change and stability.
- The value of systems theory lies in understanding that families are composed of interacting parts that are in constant interaction with each other and the larger environment and that change in

one part of the family is reflected in change in the family as a whole. As families expand and grow, experience stress and illness, their ability to be changed and yet maintain homeostasis reflects the health and coping strategies of the family to adapt to change. Families that resist change or cannot restore homeostasis after change may demonstrate poor coping strategies. Stress and illness may trigger dysfunctional coping patterns or dysequilibrium. Families with closed boundaries may resist help from resources during periods of dysequilibrium.

Structural–Functional Theory

- Families are social systems that form interdependent and independent relationships both within and outside the family referred to as subsystems. Structure describes relationships within families such as the husband–wife subsystem, the parent–child subsystem, sister–brother subsystem.
- Internal family subsystems function as a microcosm of society reflecting the larger sphere of human needs. Rank order within families is a component of structure, such as the ordering of children in birth in the family or the ages if they are adopted or are stepchildren.
- Function includes the tasks that families carry to provide members with the need for safety, reproduction, education, parenting, sexual expression, economic security, transfer of cultural traditions and inheritance, social support, play, relaxation, and health promotion opportunities.
- Suprasystems form outside the family and reflect functional needs not met within the family. Relationships with teachers, schools, religious, civic organizations and the health care system, and friends are examples of suprasystems that meet needs not met by interactions within the family system. Multiple relationships are formed through suprasystems that reflect family values, beliefs, and emotional boundaries. By obtaining an ecomap, the FNP can visualize family members relationship with systems outside of the family unit (Wright and Leahy, 2000).
- Principles of structural functional theory adapted from Friedman (1998), Hanson (2001), and Wright and Leahy (2000) include:
 - Families are social systems with instrumental and expressive functions that include activities of daily living, communication, social support, role acquisition, values, beliefs, problem solving, and relationships.
 - In optimal functioning families, members take on predictable roles that meet the instrumental and expressive needs of its members.
 - Families are composed of small numbers with characteristics of small group behavior.
 - Families are social systems that carry out functions necessary to meet the need for orderly transfer of wealth, procreation, and education of members of society.
 - Individuals adopt norms, values, and cultural traditions that are learned as part of the process of family socialization.
- Disease or ill health can interfere with the family’s ability to carry out its internal functions and meet the responsibilities it has formed in relationships with systems outside the family. Families with multiple unmet needs may experience guilt, stress, dysfunction, and poor coping strategies during periods of stress and illness.

Developmental Theory

- Developmental theory explains human growth and development according to authors such as Erikson, Piaget, and Havinghurst. The concept of development was further applied to the sociological study of families by Duvall in 1977 and Duvall and Miller (1985). The model outlines the eight consecutive stages in the family life cycle that offers a predicative overview of the activities that occur in families over time and serves as a basis for anticipatory guidance when assessing and teaching families (see Chapter 3).
- According to Duvall, families pass through eight chronological stages, like child development theory; success in one task sets the stage for success in subsequent tasks. Failure in one task leads to frustration or delays in subsequent task or stages in the family life cycle. The stages supported by Duvall’s model below are adapted from Friedman (1998):

- Beginning family
- Childbearing family (oldest child up to 30 months of age)
- Family with preschool children (oldest child is 2½ to 5 years of age)
- Families with school children (oldest child is 6–12 years of age)
- Family with teenagers (oldest child is 13–20 years of age)
- Launching center family (grown children leaving the home)
- Family with middle-aged parents (empty nest, up to time of retirement)
- Family with old age and retirement
- Underlying assumptions include:
 - Families change overtime due to the influence of environmental conditions.
 - Developmental tasks are the aims though not completed at one time and may be overlapping with other developmental tasks.
 - Families demonstrate different forms of membership across developmental stages that perform age-related functions.
 - Families bring with them an experience of their past as well as current circumstances.
 - Families share common developmental processes with other families.
 - Families express developmental milestones in a variety of ways (adapted from Friedman, 1998; and Hanson, 2001).

Communication Theory (Friedman, 1998; Hanson, 2001; Wright and Leahy, 2000)

- Communication theory emphasizes the interaction of individuals that includes both verbal and nonverbal communication between members of a family.
- Communication functions include emotional support, shared information, and instruction.
- The content of message must be appreciated within the context of the sender is time-bound.
- Communication that lacks clarity may lead to family dysfunction or poor coping strategies.
- Communication conveys values and beliefs between members and the external environment. Communication with clarity and congruence promotes positive behavior within the family.

CASE STUDIES

Case 1. Joan Davies graduated from a family nurse practitioner program five years ago and has worked part time in college health center since graduation. She is now accepting a job as an FNP in a family practice setting and has been asked to cover the prenatal clinic one day a week, in addition to providing regular family practice care. The collaborating physician assures her that he will provide her with direct supervision during the first six to eight weeks of her experience and that he will be present in the clinic while she is seeing patients.

1. Is Joan Davies legally authorized to provide care to prenatal women? To children?
2. Should she accept this assignment? If so, why or why not?
3. What standards of care should she follow in providing care to prenatal patients?

Case 2. Lee Ann Rose is a 14-year-old who presents in the clinic for a physical exam and immunizations. She is alone and reports that her mother is working and does not know that she has come to the clinic. Lee Ann reports that she must have the exam and immunizations for school. The school has advised you in writing that Lee Ann's immunizations are not up-to-date, and that she cannot return to school until a record is provided to validate her updated immunization history.

1. What are the legal issues presented in this case?
2. What ethical principles will guide you in making a decision regarding this case?

Case 3. Alice Jamison is a 49-year-old African American mother and grandmother. She has three children living at home, and the oldest daughter, in high school, now has a baby. Alice reports that she is very angry with her teenage daughter, who does not want to help out around the house or care for her baby. Alice feels like there is chaos all the time and she complains of having frequent stress-related headaches.

1. What theoretical model will assist you in planning an intervention for Alice?
2. What additional information would you like to obtain?
3. How can you best help her today?

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