

THE CLINICAL NURSE SPECIALIST AND NURSE PRACTITIONER ROLES: ROOM FOR BOTH OR TAKE YOUR PICK?

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Accepted for publication April 2006

ACKNOWLEDGEMENTS

The authors wish to acknowledge the support provided by the Australian Research Council and Eli Lilly Australia. This support has made this work possible.

Key words: advanced practice, clinical nurse specialist, expanded practice, nurse practitioner, nursing roles

ABSTRACT

Objective:

The aim of this paper is to contribute to pertinent discussions regarding advanced practice nursing roles. In particular discussion will focus on the potential implications for the developing nurse practitioner (NP) role on the existing clinical nurse specialist (CNS) roles.

Setting:

The literature presented originates primarily from the United States of America (USA), United Kingdom and Australia. Specific emphasis is placed on the psychiatric/mental health nursing context.

Primary argument:

Amidst the confusion in terminology to describe and explain advanced, expanded or extended nursing roles, and to distinguish between the clinical nurse specialist and the nurse practitioner, there is a need to establish clarity. The need for both clinical nurse specialist and nurse practitioner roles has been hotly debated in the USA.

Conclusions:

The roles of clinical nurse specialist and nurse practitioner may be complementary but fulfil different functions. It is therefore important that both roles be maintained and implemented in response to consumer and health service needs.

INTRODUCTION

In December 2005, the Productivity Commission released its report on the Australian Health Workforce (Australian Government 2005). This document has emphasised the need for reform within the health care system in order to ensure an adequate supply of health care professionals and address the serious issue of unmet health care needs (Gardner and Gardner 2005). Nursing roles, including but not restricted to nurse practitioner (NP), have been identified as an important contributor to necessary reform.

The identified need for reform is largely attributed to the changing composition and complexity of health care services. More specifically, the need for a strong multidisciplinary team approach to meet the needs of service users has been identified as essential. The skills and accessibility of the nurse practitioner (NP) is arguably highly suitable to the contemporary health care environment (Gardner, Gardner and Proctor 2004).

The development of the NP role has many potential benefits to the nursing profession, however the need for clarity regarding nursing roles becomes all the more urgent. The opening statement of the National Nursing and Nursing Education Taskforce Specialisation and Advanced Practice Discussion Paper: *A select analysis of the language of specialisation and advanced nursing and midwifery* (2006) succinctly describes the numerous terms used to denote the many different nursing roles:

An important contribution to understanding what nurses and midwives can do is consideration of the plethora of terms used to described advanced practice and specialisation. These terms include generalist, specialist, advanced, extended, expanded as well as less commonly used titles such as endorsed, enhanced, amended or maximised (Heartfield 2006, p.4).

It is not just the number of terms, but the variation in the meanings ascribed to them that is problematic. For example, advanced nursing and NP are now often used

interchangeably with little consideration of the potential impact on other advanced nursing roles (Elsom, Happell and Manias 2005). The aim of this paper is discuss the relevant literature pertaining to the clinical nurse specialist (CNS) versus the NP debate. While this debate remains in its infancy in Australia, this situation is likely to change in the foreseeable future as the NP role develops further. Although the main emphasis of this discussion relates to psychiatric/mental health nursing, it is likely to have relevance for all nursing specialties.

Advance practice has been defined by some authors in terms of the degree of autonomy enjoyed by the nurse in the form of extended and expanded practice roles (Daly and Carnwell 2003; Torn and McNichol 1998); whereas for others the scope of clinical practice is less important in defining advanced practice than the level of expertise of the nurse in performing identified nursing tasks (Manley 1997).

The lack of uniformity in definitions and terminology is particularly evident in the Position Statement on Advanced Practice Nursing published by the Royal College of Nursing Australia (RCNA 2000). The RCNA definition of advanced practice nursing states that it *utilises extended and expanded skills* and further, that *advanced practice nurses may work in a specialist or generalist capacity* (2000, p.1). The RCNA (2000, p.1) also asserts that *advanced practice nursing forms the basis for the role of nurse practitioner* and that *the nurse practitioner role is an expanded form of advanced practice nursing*.

In order to provide clarity to this problem, Daly and Carnwell (2003) developed a framework to overcome some of the existing confusion surrounding higher levels of nursing practice and the terminology used to describe them. They explain the concepts of role extension, role expansion and role development as a means to describe and categorise the changes in skills and boundaries of practice in nursing. Role extension is described as the inclusion in a nurse's role of a skill or responsibility which was not previously a nursing role and which typically has been regarded as the domain of another profession, for example, medicine, as in the case of the nurse practitioner role.

Role expansion occurs when additional skills and responsibilities are added to a specialist role giving greater autonomy and accountability while maintaining the core elements of nursing practice. The additional skills and responsibilities may also have been traditionally regarded as part of the domain of another profession. Educational preparation and assessment is more formalised than with role extension. Role development incorporates elements of both extension and expansion but includes greater clinical autonomy as a result of a demand to redress existing shortcomings in the provision of health care or for improved patient care. 'This advanced role would logically build on specialist practice and be coherent, with the development of expert practice

based upon an extended period of professional experience' (Daly and Carnwell 2003, p.161).

DISCUSSION: CLINICAL NURSE SPECIALIST (CNS) VERSUS NURSE PRACTITIONER (NP) DEBATE

Gardner and Gardner (2005) argue that the confusion between the terms advanced practice and NP has contributed to difficulties in defining and articulating NP roles both in Australia and internationally. However the authors do not articulate the potential implications of this situation for other specialist nursing roles such as CNS. In the United States of America on the other hand a large volume of literature has been generated in the last decade about whether there should be a single advanced nursing practice role or whether there is a continuing need for both CNS and NP roles.

In order to further explore this debate from an Australian perspective a literature review was undertaken. CINAHL, Medline and Psych-Info data bases were searched using the search terms: advanced practice, expanded practice, clinical nurse specialist, nurse practitioner, nursing, psychiatric and mental health. Manual searches were conducted of all articles located through this process.

The predominance of this theme during the 1990s is reflected in the dedication to the topic of book chapters (Hamric et al 2000, Romaine-Davis 1997) and editor's introductions (Wolbert Burgess 1998). Although this debate has emanated from developments in the USA, it has important implications for the Australian context. The establishment of clinical nurse specialist positions in Australia is a relatively recent occurrence that was driven, to a large extent, by industrial processes. Nursing unions argued successfully for the creation of a clinical career pathway that would enable nurses to progress professionally without having to leave the bedside to take up positions in education or nursing administration.

Although there are some variations in focus, clinical nurse consultant roles in Australia have notable similarities with clinical nurse specialist positions in the United States of America as they are described in literature. Another parallel is seen in that the nurse practitioner role has emerged in both countries after the clinical nurse specialist had been established. It is predictable therefore that the conditions that generated the debate about whether the two advanced practice nursing roles should be blended will also emerge in Australia. An obvious example of these conditions is the current pressure on universities to rationalise postgraduate course offerings (Department of Education Science and Training 2002). The relatively small number of nurses seeking to undertake postgraduate studies at the masters level to prepare as NP or CNS may influence universities to choose one pathway over the other or to develop more

generic or blended programs in an attempt to meet the needs of both roles.

The majority of the published literature pertaining to the debate consists of commentary and position papers (Paisley 1998; Bjorklund 2003) but there are a few notable studies that have attempted to shed light on this much vexed issue by examining and comparing the two roles (Lincoln 2000; Mick and Ackerman 2000). The main arguments emerging from the articles are that the CNS role should be maintained and developed (Ebken 1998; White 2000); that the CNS role has outlived its usefulness and should be replaced by either the NP role (Davidson 1999) or the implementation of a blended advanced nurse practitioner role (Busen and Engleman 1996; Dunn 1997; Moller and Haber 1996; Quaal 1999; Wright 1997); and that both roles should continue to develop as they offer unique qualities in advanced nursing practice (Cukr 1996; Mick and Ackerman 2000; Mick and Ackerman 2002).

White (2000) describes an education program developed to prepare psychiatric mental health clinical nurse specialists and supports the continued development or re-development of the CNS role over the more favoured NP role. She views the NP as providing episodic mental health care in the context of providing broader primary health care whereas the CNS specialises in the care of mentally ill members of the community.

Moller and Haber (1996) present five main reasons for the need to blend the NP and CNS roles. The first is the need for recognition of title. Moller and Haber argue that the title of CNS is not well understood by legislators or the general public whereas NP has gained some recognition. Second is the fact that the NP has become more marketable with a public which demands safe and effective health care rather than being overly concerned with speciality care provided by elite clinicians. Third, identity issues have been further confused by the differing approaches to titling adopted by the various state regulatory authorities. This is further complicated by the adoption of different titles in association with the granting of prescriptive authority. Fourth, the fact that education programs for CNSs and NPs have traditionally emphasised different aspects of advanced nursing practice, does not mean that this needs to continue. Fifth, there remains confusion as to the real differences between CNSs and NPs in psychiatric-mental health nursing. This confusion is partially attributable to the concurrent existence of NPs who may have been prepared for primary health care practice but who now practice mainly in mental health nursing, and specialist psychiatric mental health NPs, some of whom were originally prepared as CNSs.

Quaal (1999) argues that the CNS role is outgrowing its usefulness as a result of changes in health service delivery, lack of third-party reimbursement and role ambiguity. She argues that the roles have developed concurrently and have contributed to each other's development. She further contends that the roles are

'professionally indistinguishable' (p.2) and that the advanced practice registered nurse (APRN) was the logical outcome of the inevitable merging of the CNS and NP roles.

The contention that the NP role evolved in response to physician shortages is advanced by Dunn (1997) who further claims that this was seen by some, particularly influential nurse educators, as an undesirable development. These nurse educators favoured the CNS as a nursing role and tended to view the NP as a quasi-medical role. As a consequence, the development of the CNS role and educational programs designed to prepare nurses for this form of advanced practice were more uniform than NP programs which tended to develop sporadically in response to local needs (Mick and Ackerman 2002). Dunn (1997) contends that there is evidence of a need for both CNS and NP roles and that many of the historical differences have largely disappeared as health care systems have changed over the years. Although the CNS has traditionally been associated with specialised acute care and the NP with generalist primary care, there are many areas of skill and knowledge that are shared between the two advanced practice roles.

On the contrary, Cukr (1996) argues that the roles of CNS and NP are different, having developed as a result of different historical forces (market, education, etc) and that both should be maintained. According to Cukr, the CNS of today is focussed primarily on quality of care issues at a system wide level rather than as an individual practitioner. The NP by contrast, offers advanced practice nursing as a cost effective alternative to physician care, especially in underserved populations. She points out that pressure on schools of nursing to rationalise course offerings and declining interest in CNS courses has led to the proliferation and dominance of NP courses at the expense of CNS courses.

Using a different approach to highlight the differences between clinical nurse specialists and nurse practitioners, Mick and Ackerman (2000) conducted a small scale study (n=18) comparing CNS and NP self-assessed clinical expertise and their valuing of a range of advanced practice role tasks. They found that the CNSs ranked their expertise higher in all domains of the Strong Model of Advanced Practice (Ackerman et al 1996). The Strong Model, so called because it was developed by advanced practice nurses and faculty of Strong Memorial Hospital, identifies five domains of advanced nursing practice: direct comprehensive care; education; research; support of systems; and publication and professional leadership. It is not surprising that the CNS in this study self-rated themselves more highly than did NPs since the Strong Model clearly focuses on domains of practice that are traditionally associated with the role of the CNS rather than that of the NP.

Lincoln (2000) replicated a study published in 1994 by Williams and Valdivieso, which compared CNS and NP roles in South Carolina. In this replication a large scale

survey was conducted of 610 CNS and NP practising in Minnesota. Lincoln concludes that there remain significant differences between the roles and that there is no evidence of a trend toward blending of the roles.

Paisley (1998) conceptualised the NP-CNS debate in psychiatry as a division of the mind from the body in that the CNSs have tended to be viewed as experts in psychotherapies whereas the NPs are seen as more prepared in neurobiology and physical treatments. She further argues that this division has been shown to be contrary to the interests of patients. In conclusion she contends that the role confusion which currently exists between the CNS and NP; between basic and advanced psychiatric, nurses; and between psychiatric nurses and other health professionals; need to be addressed.

CONCLUSION

It is a matter of conjecture as to whether the emergence of advanced and expanded practice nursing roles in Australia will lead to the same level of preoccupation with this issue as has been observed for over a decade in the United States of America. Certainly several of the conditions that generated the debate also exist in Australia. The NP role emerged after the CNS roles were already established. Furthermore, it would be more cost-effective for universities if a single graduate program for advanced nursing practice could be developed. It is also possible that nurses who were attracted to CNS positions will be attracted to NP positions for similar reasons, that is the desire to advance their nursing careers whilst maintaining a largely clinical role.

At the present time there is no tangible evidence that the questions of whether nurse practitioners will replace clinical nurse specialists or whether there is a need for a single advanced nursing practice role are of concern to the Australian nursing profession. However the fact that the establishment of these roles in Australia is a relatively recent phenomenon by comparison to the United States of America, provides the Australian nursing profession with an opportunity to learn from the experience of others and to plan for, and take control of, the direction in which it develops.

It has become clear that there exists a notable lack of uniformity in the definitions of such terms as expanded, extended, specialist, and advanced practice. It is important for the nursing profession in Australia to critically reflect on the terminology, in particular, advanced practice, which has the danger of being seen as synonymous with medical practice.

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