Nurse Practitioners

The Evolution and Future of Advanced Practice

Fifth Edition
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We dedicate this book to our families and to Dr. Mathy Mezey and all the nurse practitioner pioneers who blazed the trails ahead of us.
Contents

7 Long-Term Outcomes of Advanced-Practice Nursing 93
Susan W. Groth, Lisa Norsen, and Harriet J. Kitzman

PART III: REGULATORY AND POLICY ENVIRONMENTS 111

8 State Health Care Reform: The Role of Nurse Practitioners in Massachusetts 113
Nancy O'Rourke

9 Consensus Model for Advanced-Practice Nurse Regulation: A New Approach 125
Jean Johnson, Ellen Dawson, and Andrea Brassard

10 Politics of Organized Opposition: A Case Example 143
Thomas A. Mackey and Lynda Freed Woolbert

11 The Idiosyncratic Politics of Prescriptive Authority: Comparing Two States' Legislative Negotiations 149
Deborah A. Sampson

PART IV: INTEGRATION OF NURSE PRACTITIONERS IN THE HEALTH CARE ENVIRONMENT 159

12 Environmental Factors Shaping Advanced Practice 161
Diane O. McGivern

13 Nurse-Managed Health Centers 183
Eunice S. King and Tine Hansen-Turton

14 The Pediatric Nurse Practitioner and the Child With Type 1 Diabetes: Partnership and Collaboration 199
Terri H. Lipman

15 Adult Health and Gerontology Nurse Practitioner Care 205
Melissa A. Taylor and Christine Bradway

16 Nurse Practitioner Contributions to HIV Care 213
Carl Kirton

17 Roles of Nurse Practitioners in the U.S. Department of Veterans Affairs 223
Karen R. Robinson
18 Ethical Issues in Advanced-Practice Nursing 239
   Connie M. Ulrich and Mindy B. Zeitzer

PART V: BUSINESS AND PAYMENT STRUCTURES FOR NURSE PRACTITIONERS 255

19 Business, Policy, and Politics: Success Factors for Nurse Practitioner Practice 257
   Eileen M. Sullivan-Marx

20 Systems of Payment for Advanced-Practice Nurses 271
   Eileen M. Sullivan-Marx and David M. Keepnews

21 Nurse Practitioners Navigating Managed Care 295
   Elizabeth Miller

22 Community-Based Health Centers: Nurse Practitioners Contributing to Access 305
   Ann Ritter

23 Quality and Safety: Critical Components of a Nurse Practitioner Business Model 317
   Kathryn Fiandt and Joanne M. Pohl

PART VI: GLOBAL HEALTH AND FUTURE CHALLENGES 335

24 Global Health and Future Challenges 337
   Helen Ward

25 The Evolution and Future of Nurse Practitioners in New Zealand 345
   Tine Hansen-Turton and Frances Hughes

26 Advanced-Practice Nursing in Ireland 363
   Kathleen MacLellan

27 One Look at the Future 375
   Diane O. McGivern, Eileen M. Sullivan-Marx, and Julie A. Fairman

28 Online Resources 379
   Sherry A. Greenberg

Index 389
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Few of us whose ideas come to fruition in their lifetime survive the journey from innovation to institutionalization. I feel both lucky and blessed to be among the few. The chaotic, uncertain social/political environment was enabling and ripe for change. Still, who would have believed that the first nurse practitioner (NP) educational demonstration project that I and pediatrician Henry K. Silver launched in 1965 would produce almost 150,000 master’s-prepared NPs 44 years later? Or that they would be indigenous to every health care delivery service, from ambulatory to acute care facilities, schools and industries, military and veteran services, and even in retail stores? Indeed, at the time, there were many nursing pundits who predicted otherwise.

Not only has the NP movement survived, but it has thrived and transformed the profession of nursing, and affected health care delivery services and the public’s perception of nurses. Its progress, potential, and problems have extended beyond the profession and gained the attention of health policymakers and politicians, due in part, to the earlier evidence-based and scholarly publications such as this and earlier editions on the evolution of the NP.

This journey has been beautifully chronicled in the past four editions of this publication, and is advanced now into the fifth edition. The list of authors in this edition reads like a “Who’s Who” in the ranks of scholarly historians, veteran researchers, expert practitioners in specialty services, new organizational initiatives, successful political and health policy leaders, astute business and financial advisors, and futurists with worldly views.

Although this is not a “how-to” book, there are plenty of lessons to be learned, not only from the experiences and insights of these authors, but also from the principles and practices that they have found to be patient-centered, effective, efficient, and economical. Each author’s
work offers a rich, thoughtful, and realistic account of her/his contribution to *Nurse Practitioners: The Evolution and Future of Advanced Practice, Fifth Edition*. The global view is presented, with the spread of the NP to different countries of the globe. (The ICN Advanced Practice Network has over 1,000 members in 54 countries, so it is apropos to note that this edition will be reaching far beyond our own national borders.)

Today, once again, we have an enabling environment. The public’s chaotic, uncertain, and strident demands for social and political changes, including health care reform, offer all advanced-practice nurses and their organizations untold opportunities. These include opportunities to gain increasing respect, recognition, and rewards as they assume the responsibilities of delivering accessible, affordable, accountable, and acceptable affable health care for all. This edition will help all nurses and other health professionals, businesses and corporations, policymakers, and the public toward this goal.

**LORETTA C. FORD, EdD, RN, PNP, FAAN, FAANP**
This fifth edition of *Nurse Practitioners: The Evolution and Future of Advanced Practice* is fortuitously timed, with the heightened focus on national health care reform. Nurse practitioners (NPs) are situated to play a major role from participation in states’ efforts to initiate smaller scale reforms, to broader population-based health promotion and disease management at the primary and acute care levels. The intensive efforts by advanced-practice nurses and their professional organizations to demonstrate their unique contributions and to standardize preparation and scope of practice make this the ideal moment to consider the history, current developments, and future possibilities. Indeed, nursing’s organizational efforts to advance health care reform and take its rightful place in the policy debate and implementation of reform was recognized by President Barack Obama in his July 15, 2009, remarks thanking nurse leaders for their role in the debate and support of change.

Not only do these developments define this period for NPs, additional changes are accelerating practitioners’ movement to the next level of operation—the pan shortage of health professionals, the limited capacity of health professional programs to meet demand, the rapid spread of disease from country to country, and the diminished economic and infrastructure capacity of many countries to meet their citizens’ needs for care and health care personnel.

The potential of NPs in this country and globally to address these challenges and improve health care are documented here, as are the obstacles to full realization of advanced-practice nursing’s ability to meet the needs of health system reform.

This edition, which features contributors recognized as foremost in their understanding and analyses of the developmental history, research base, regulatory reform, and innovations in clinical practice, will serve the readers with both a frame of reference and a current and future
estimation of NP role development and use. Students in NP programs, seasoned providers, policy makers, and other invested health professionals will gain a totally new perspective on the history of NPs, the mechanics of regulatory and financial recognition of NPs, the effects of managed care, and the opportunities for more democratic sources of care, such as community nursing centers and retail clinics, and the globalization of advanced-practice models.

This rich content is divided into sections highlighting history and research-based support for current and future practice, policy and regulation, first-person accounts of practice innovation, adaptation of the NP model to the requirements of other countries, and last, the distillation of the important policy and political questions to be considered and answered over the next few years. Several bellwether issues are presented here with clarity not found in other discussions: the effects of managed care and reimbursement systems, the creation of a regulatory model, and the future configuration of research questions that could advance practice.

The editors and contributors look forward to your comments, observations, and experiences that will additionally inform the topics presented here. There is no better time for students, providers, policy makers, and consumers to understand the past developments, their shaping of the current status of NP practice, and to use that knowledge to influence the position of practitioners in the restructuring of a more successful and effective health care delivery system.

Diane O. McGivern, PhD, RN, FAAN
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In every social and professional movement, there are highly visible leaders and many other less well-known participants who effectively create innovation and help sustain these changes over time. Four such leaders inspired the nurse practitioner (NP) role development, institutionalized education and clinical practice advancements by virtue of their academic and organizational positions, and finally, have been central to the editions of this book. Loretta Ford, Claire Fagin, Joan Lynaugh, and Mathy Mezey have, over the last several decades, propelled the NP role in ways unique and powerful, marshalling personal qualities of derring-do, sociability, farsightedness, and plain speaking.

Loretta C. Ford, EdD, RN, PNP, FAAN, FAANP, is, of course, the one who envisioned, with Henry Silver, a community health nurse with expanded skills to provide community-based care for children. Although elements of the expanded role were evident decades earlier, the articulation of the role, drive for organized educational preparation, and advocacy within professional organizations were the essential differences that Dr. Ford’s leadership made.

Claire Fagin, PhD, RN, FAAN, influenced the NP movement on multiple levels. Her expositions on the centrality of nursing to health care, on primary care, nursing’s disciplinary grounding, and the rightful place of NPs’ contribution to national health care create an extraordinary bibliography. Dr. Fagin’s academic program influence spans baccalaureate and graduate curricula. Perhaps less heralded, but extraordinarily important, was the early introduction of primary care skills into a baccalaureate program, seeding baccalaureate preparation with the skills now integral to all undergraduate education and expectations for beginning practice.

An early practitioner, faculty member responsible for master’s program development, preparation of adult NPs, and arbiter of the skills
relevant to advanced practice, Joan Lynaugh, PhD, RN, FAAN, and colleagues developed an adult primary care practitioner program and primary care teams and clinical sites for student experiences. Dr. Lynaugh established and directed NP programs before and after completion of a doctorate focused on health care history. Her collaboration with Barbara Bates, MD, resulted in texts that guided generations of students and faculty in assessment and clinical decision making. A pioneer of master’s preparatory programs, and with the eye of a historian, she has helped underscore and explain the legitimacy of the vital links in practitioner role development, particularly in relation to nurse work and with historical research mentorship of her students.

The need for geriatric nursing expertise among baccalaureate and graduate program students and practicing nurses of all preparatory levels was recognized very early by Mathy Mezey, EdD, RN, FAAN. Dr. Mezey's experience in clinical teaching, academic program development, and policy direction through important organizations and foundations has created a momentum that is currently supporting the amalgam of adult and geriatric practitioner expertise, in order to prepare a sufficient number of NPs with knowledge and skills to meet the needs of the majority of the population.

Each of these nurse leaders has provided an authoritative voice through personal style, institutional prominence, multiple organizational leadership positions, academic recognition, clinical credibility, and sustained participation in the evolutionary effort. Lastly, each of them has been a conspicuously unique contributor to this series of books, as well as hundreds of other publications. Few books have the distinction of participation by transformational leaders. Their contributions and authoritative weight have charted the development of the NP role from 1965 through 2010. We gratefully acknowledge their signature leadership and their contribution to the body of literature that supports, explores, and expands the possibilities of NP practice.
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The 4 decades of literature documenting the development of the nurse practitioner (NP) role has included some exciting personal and professional achievements, but has also promulgated some shorthand language that limits the ability of students and new practitioners to fully appreciate this pivotal development in health care. Understanding the historical developments and contemporary context is fundamental to the individual practitioner’s ability to articulate the role, advocate for policies that advance autonomy, and confidently interact with patients and other health professionals.

History is powerful, and when the recounting is accurate and nuanced, the reader becomes more engaged and, consequently, a more fluent interpreter of aspects of the current NP role development. Fairman supplies this historical context, McGivern summarizes the semantic and descriptive evolution, and Sullivan-Marx brings us up to the moment with a concise description of the current status of NPs in the broader health care scene. Taken together, the first three chapters serve as a solid and scholarly base from which the reader can delve into many other areas of the book.

Increasingly, nurses and NPs are concerned with how to successfully communicate with the public and, in particular, segments of potential consumer populations and payers. Cleary and Reinhard, speaking with
Sullivan-Marx and McGivern, describe one well-organized campaign with broad network support designed to create sustained messages to professionals, policymakers, and consumers about the importance of nurses and NPs. Several state teams in the Champion Nursing in America initiative describe their efforts, communication services, and products to promote nursing and advanced practice. While Cleary and Reinhard lead an effort to ultimately deliver messages to consumers, how do NPs successfully craft their messages to appeal to their own potential consumers? McIntyre gives us the answer. McIntyre, a media and communication professional experienced in shaping the nursing message for the public, describes how individual and practitioner groups can most effectively explain their services, target potential consumers, and tailor messages to most effectively educate different populations. The chapter is an interesting, concise, and effective guide to useful strategies.

Very often, when questioned about reasons for selecting NP programs or what they anticipate doing upon beginning practice, many students describe future practice as everything antithetical to their current generalist practice. This section will promote an understanding of the nursing component that is foundational to the practitioner role, how the role evolved, its current status and strength, and the scope of responsibilities and possibilities beyond the clinical encounter that will refine and focus new practitioners’ contributions.
At the end of the first decade of the 21st century, the nursing profession is at a critical juncture. It sits at the intersection of its own transformation and its ability to shape health care reform. Nursing is central to the key policy issues, such as the primary care workforce, health care costs, and the functioning of the health care delivery system. How the profession situates itself and clearly develops a descriptive and strategic narrative that engages the public will create the foundation for its future.

Health care reform under the Barack Obama presidency is a main legislative focus of this time period, and policy strategists, professional organizations, and industry representatives have floated numerous tactical initiatives both familiar and innovative. Policy analysts and strategists evoke the historical view at almost every turn, from comparisons with the Clinton-era attempts at reform to references to the Flexner Report on the state of medical education in the early 20th century, as lessons for our current reform efforts (Flexner, 1910). We should do likewise and take time to think about the history of nurse practitioners, how that history positioned them and created opportunities for their role in our modern health policy debates.

One of the most pressing health care issues facing the American public is also one that has been historically persistent—the difficulty
certain populations and groups have accessing quality health care services, particularly primary care and the management of chronic illness. These are very variable and historically contingent issues that also shaped the foundation of the development of the nurse practitioner movement in the 1960s. They also persistently and continuously justify and substantiate the role. Of course, people suffering from acute illnesses or emergent health issues can obtain care. But when the “well and well but worried” (Bates, 1971), especially those in rural or poor urban areas or those without health insurance, have basic health needs, seek answers to questions, or need support, they have difficulty finding qualified practitioners.

In spring 2009, The Institute of Medicine (IOM) empanelled the Robert Wood Johnson Foundation Initiative on the Future of Nursing Committee. This group of individuals, constituted from a wide array of stakeholders, including academics, practicing nurses and physicians, corporate representatives, and innovators of health care models, has been tasked with developing a “transformational” report that establishes a “blueprint for action” articulating the future role that nurses can and should play in the design and delivery of high-value care in a reformed health care system. The Committee, and the report it will produce, is propitious, and is positioned to be a watershed for the nursing profession in standing with other noteworthy reports such as the Goldmark Report, the Brown Report, the Report of the Surgeon General Consultant Group on Nursing, and the National Commission for the Study of Nursing and Nursing Education, among others (Brown, 1948; Goldmark, 1923; National Commission for the Study of Nursing and Nursing Education, 1970; U.S. Department of Health, Education, and Welfare. Surgeon General’s Consultant Group on Nursing, 1963). These historically significant reports have been forgotten by most policy makers and strategists, but they were extremely important. When considered in the broad context of the time in which they were situated, the reports stimulated a host of policy strategies that shaped the nursing profession, including federal and private funding for nursing education and development of expanded practice roles for nurses. The reports also provided evidence for enlarging the nursing workforce and set standards for the education faculty needed to train the next generation of nurses for clinical practice. This new report is well-positioned to be the next step—an innovative vision of how the nursing workforce should be employed in evidence-based, outcome-focused care to meet the health care needs of the Ameri-
can public (Robert Wood Johnson Foundation, 2008). Nurse practitioners are at the forefront of these deliberations.

Several historical factors make nursing and nurse practitioners salient participants in reform. Nursing, as a female-gendered profession with social and cultural mandates to provide a broadly defined array of care services, is situated at the fulcrum where health disparities and social justice movements are balanced. Its history illustrates this nexus through its long tradition of focusing on the issues of equity, and interceding between the dominant power of local and national governments and medical men and women, and disenfranchised groups and populations. We see this in examples such as the settlement house movement and Lillian Wald's work with others to establish the Children's Bureau in the early 20th century, midwife Mary Breckinridge and the Frontier Nursing midwifery service and school, the clinics and nurse midwifery programs of the Maternity Center Association in New York City, and the later school nurse movement (Buhler-Wilkerson, 2001; Connolly, 2008; Dawley, 2001; Keeling, 2007). Equity, to be sure, is a noble aim, but it is not a driving force of the modern health reform debates. Even so, nurse practitioners' advocacy and supporting roles position them in the tangential discussions about health care equity that will, in the long term, remain a factor shaping new programs and services.

In this current environment, much of the policy debates revolve directly and indirectly around the cost of, and payment for, health coverage. Although these issues are important, they cause us to lose sight of the systematic problems in the design of the health care delivery system that are highly amenable to strategies that involve nurses. The health care reforms undertaken by the state of Massachusetts are one example of this conflicting focus. Although the state has now achieved near-universal coverage through more inclusive eligibility benefits for Medicaid, it is struggling with increased demand for services, particularly for primary care providers (PCPs), and subsequently, increased program costs. Advanced-practice nurses as PCPs can help meet demands for services, in addition to developing, testing, and demonstrating models that promote patient inclusion into the health care system at all levels. But similar to trends in the past, there may not be sufficient numbers of nurse practitioners to fulfill the public's primary care needs, even when combined with the numbers of practicing primary care physicians. In a greater proportion than physicians, nurses are attracted
Part I  Historical and Current Social Context

to generalist, PCP roles for practice independence and satisfaction from relationships with families and patients (U.S. Department of Health and Human Services, 2004, 2006). But, similar to physicians, nurse practitioners have always and will continue to specialize along clinical, procedural, and age-based areas.

From the history of the nurse practitioner movement, we can see how the development of the role and the support earned from patients positioned nurse practitioners for this historical time and place. In my book, *Making Room in the Clinic* (Fairman, 2008a), I describe in detail the social, political, and health care environment that supported nurses’ response to patient need and to practice opportunities in the mid-1960s to the 1980s. Some of the problems patients and practitioners faced are familiar. For example, health care costs were sharply rising, especially after the passage of Medicare and Medicaid in the mid-1960s. A shortage of PCPs (due to low status and pay) and the medical specialization trend created severe access-to-care issues for many Americans in rural and poor urban areas, as well as for middle-class families. Some of the same population groups, women, children, and young adults, accessed the health care system only with great difficulty. The chronically ill and the elderly found continuity of care to be illusive, and constituted some of the fastest growing and most expensive population groups in the health care arena.

In turn, nurses were looking for opportunities to practice their skills to the fullest extent whenever and wherever possible, both stimulating and building on the new educational programs that were emerging in colleges and universities in the 1960s and 1970s. Physicians on the ground were looking for help to better serve their patients, and negotiated and collaborated in good faith to form new models and partnerships with nurses. On the other hand, both medical and nursing organizations (The American Medical Association and the American Nurses Association) pursued strategies that were, at times, incompatible with practitioner efforts and too slow to make a marked difference. They perhaps inadvertently stimulated a fragmented conglomeration of specialty organizations that were difficult to harness to generate policy consensus (Fairman, 2008a).

The nurse practitioner movement was also fed by the social movements of the time, including the women’s and civil rights movements. Many women working in the free women’s health clinics of the 1960s and 1970s labored side by side with nurses, and found their gendered
practice paradigm a comforting alternative to the paternalism they found in medicine. Many of these women later made their way into nursing and nurse practitioner education programs (Candib, 1995). Women of various racial and ethnic groups gained greater entry into nursing education programs after the Nurse Training Acts of 1975 and 1980, and through the progressive health care management structure of the United States Military and its generous support of higher education for nurses (Sarnecky, 2000).

Powerful, smart, and wise women, such as Loretta Ford, Barbara Resnick, Joan Lynaugh, and Harriet Kitzman, among many others, also ensured that innovative nursing models emerged from their synergy and collaboration with enlightened physician colleagues. Loretta Ford, with pediatrician Henry Silver, developed the earliest certificate training program for nurse practitioners at the University of Colorado (Ford & Silver, 1967). Barbara Resnick and Charles Lewis, in response to the low level of interest from medical fellows and residents in ambulatory care at the University of Kansas, implemented a medical clinic model that provided patients with a nurse-run practice (Lewis & Resnick, 1967). Joan Lynaugh and Barbara Bates set up a series of training modules—that later became the physical diagnosis text used in many nurse practitioner training programs—to educate nurses in the hospital clinics and community to work collaboratively as partners in physician practices in Rochester, New York (Bates & Lynaugh, 1973). Harriet Kitzman developed a similar model in the Rochester-area pediatric clinics, and she later went on to help shape the nurse–family partnership with David Olds (Charney & Kitzman, 1971; Olds & Kitzman, 1990). Nurse practitioners (until the early 1960s, all nurses were labeled nurse practitioners) emerged out of this contextual milieu, building a new role upon their already substantial and growing clinical care skills, honed in public health and community nursing. Working with physician colleagues and patients who understood nurses’ promise and potential, they carved out enlarged nursing territory, and education followed. Federal funding for nursing education and practice demonstration models supported this trajectory, starting with the special projects embedded in the 1964 Nurse Training Act, as did support from private foundations such as Robert Wood Johnson for programs like the Clinical Nurse Scholars, and Commonwealth Foundation (Newbergh, 2005).

These nurses were the pioneers—they practiced independently or in collaboration with physician colleagues who were available for sup-
port on site, but many times only by phone or occasional visits. From these practitioners and the media, the public learned of nursing’s capabilities and value. Nurse practitioners received broad coverage in popular newspapers and magazines of the 1970s and 1980s, as well. Look magazine published one of the earliest stories in the popular press in 1966 (Berg, 1966). The Wall Street Journal and Today’s Health referred to nurse practitioners as “super nurses,” expressing perhaps surprise at their competence, as well as recognition of their ability to provide high-quality services. By 1985, The New York Times, Washington Post, and The Wall Street Journal reported on nurse practitioners in the main or health sections, and printed letters to the editor over 150 times. McCall’s magazine, a leading popular women’s magazine at the time, ran articles about nurse practitioners starting in 1975 (e.g., Clift, 1975; Lublin, 1974; Safran, 1975).

As nurse practitioners negotiated and experimented with their physician colleagues, they created new types of practice models, both in and out of hospitals, for providing increased access to care for populations across the board. They also showed typical entrepreneurial spirit, long associated with the nursing profession, by seeking out practice areas without the constraint of institutional oversight. In public health and hospital clinics, nurse practitioners demonstrated that they could provide a different type of care and much-needed continuity, advocacy, and education to patients long ago abandoned by much of mainstream medicine for the more complex and highly acute cases. In this way, nurse practitioners became essential to a system of care fragmented by medical specialization.

Although they became crucial providers in particular places for certain populations, nurse practitioners still faced legal and political obstacles that limited patient access to services. Political action by organized medical groups at the state and national levels to restrict nurse practitioners’ practice, resources, and adequate payment kept attention on legislative battles. Physicians’ traditional normative status, their gender, higher class, and their cultural authority as scientific clinicians ensured nurse practitioners a prolonged battle to engage policy makers. As attention of the organizations was focused on territorial and contextual disputes, nurse practitioners were emboldened to develop new modes of care—nurse-managed centers, Program of All-Inclusive Care for Elders (PACE) programs, and independent practices emerged. Except in public health and home care, in which nurses have
long been recognized as essential providers, nurse practitioners fought against traditional conceptualizations of the physician as the normative authority on the public’s recovery from illness.

And, it is here—in the difference between health care and medical care—that nurse practitioners found their voice and their strategy to position themselves in the last 3 decades as essential to health care reform. Although the dichotomy that nurses care and physicians cure is not a useful way of showing nursing’s capabilities and value, embedded in this old trope is the nurses’ claim to expertise in prevention and promotion of the public’s health. Of course, nurse practitioners do diagnose and treat illnesses in the traditional medical model, but they do so from a paradigm that is flexible enough to move back and forth from medical care to a much broader nursing perspective to meet the fluid needs of patients.

As they positioned themselves from the 1960s on across multiple settings, their ingenuity and flexibility served them well and provided a standpoint for the current policy debate surrounding the primary care work force, health insurance, and emerging care models. Numerous studies have shown the high quality of care nurse practitioners provided to particular populations across time. There is little need to document efficacy and efficiency of care, except as a strategy to build on current clinical issues. This does not mean that we no longer need to test new models with different populations, but that the role in general, and the competency of nurse practitioners, already has proven salience and value. Nurse practitioners do need to be included on health maintenance organization (HMO) panels and receive equitable payment for rendering services that are comparable to physician services. Their exclusion is a legacy of the politics of health care reimbursement, our complicated payment systems, and the politics of practice. Because a service or skill has been traditionally rendered by physicians does not justify less payment to other health professionals for the same work, particularly when the quality indicators for nurse practitioners are the same or better than traditional physician-only care. Our system has become accustomed to privileging payment to physicians over any other form; discussions surrounding equitable pay for particular services (rather than by who provides the services) become a political tempest.

One argument against equitable payment is its cost—it raises the cost of health care in general by adding to, rather than decreasing, costs. Another argument against equitable payment is physicians’ traditional
explanations of expertise based on their more detailed science education. Only recently, as explored and supported by the Institute of Medicine study *Crossing the Quality Chasm*, has this traditional approach been challenged. This is a shift in the traditional paradigm of privileging professional medicine and its legislative allies to categorize ownership of skill sets. For example, clinical decision making, diagnosis, and prescription are now the domains of several different health professionals, and should no longer be considered solely in the medical domain. This is becoming increasingly true as developing nations train nurses and community health workers in assessment, diagnostic, and treatment skills (see chapters 24 and 25 in this book; Sheer & Wong, 2008).

Strategies focusing on advanced-practice nursing cannot be part of health reform without the insight, information, and guidance provided by an examination of basic nursing, which is the foundation for the nurse practitioner role. A key example of this connection is the lack of resolution in American nursing regarding entry level into general practice, with both the associate and baccalaureate entry points recognized by state licensing boards. In many ways, education level has become the proxy for power in the discussions surrounding nursing’s participation in health care reform and debates about professional status across professions. We see this in the general discussions about how much education nurses need, and how educational preparation helps define role and practice boundaries, again a discussion that shows great historic stamina. The general entry-level inconsistency intrinsically influences graduate education for advanced-practice nurses, because it means there can be no expectations for a student’s consistent knowledge and skill level on admission or after program completion. Also relevant to this discussion will be how the Doctor of Nursing Practice requirement for advanced-practice nurses, as well as the Clinical Nurse Leader role, will be integrated into health care systems and health policy debates. These models are untested and have engendered intense scrutiny from medical professional organizations, as well as nurses themselves. But again, changes in nursing education have always gained support from nursing in general with great difficulty. Across nursing’s history, the fight for nurse registration and graduate preparation in general at both the master’s and doctoral levels (PhD) has always been highly contentious.

We tend to get into difficulties in these debates when the profession locates its source of power in its education models, rather than its
practice capabilities. Although these are, indeed, linked concepts, the profession has, over time, more heavily relied on the education strategies to boost its legitimacy, rather than practice. However, conflict should not deter us from developing and testing new models of nursing education. We have done this in the past with more or less success, as nursing education entered into higher education institutions that were not always welcoming, or into programs that channeled nurses into advanced programs in the basic and social sciences and the humanities (Fairman, 2008b). As in the past, strategies for redesigning the education system to ensure an adequate supply of nurses prepared to meet health care demands, for more diverse nurse recruitment, and for retention of nurses, in general, will also have a great impact on advanced-practice nursing.

The historical roots of nurse practitioners should provide much-needed perspective to the debates over health reform now and in the future. From their history, the issues of cost containment, access to care, and workforce issues seem, perhaps, less intractable. Despite practice, reimbursement, and political barriers, nurse practitioners have created new models of care that provide relief for patients of all types and in all locations. These are important lessons. Nurse practitioners are central to the functioning of the health care system, and their history shows their great adaptability and flexibility to meet the health care needs of the nation.

REFERENCES


