Reflections on the Continuing Evolution of Advanced Practice Nursing

Charlene M. Hanson, EdD, RN, CS, FNP, FAAN
Ann B. Hamric, PhD, RN, FAAN

While the concept of advanced practice nursing (APN) is still relatively new, distinct patterns of evolution from specialty practice to advanced practice nursing are evident over the last 100 years. The purpose of this article is to describe 3 stages in this evolutionary process, as well as discuss several internal and external issues that represent challenges facing APN educators and clinicians who seek to strengthen advanced practice in the current healthcare system. We clarify our definition of advanced practice nursing, and note the critical need for cohesion within the profession regarding the definition and core competencies of advanced practice. Our aim is to suggest a preferred vision for advanced credentialing. We encourage dialogue among our nursing colleagues to move this agenda forward.

The growth and development of nursing specialties has, from its earliest inception, been an interesting and challenging journey. Early in the 20th century, nurse midwives and nurse anesthetists laid the formative foundations for what we now know as advanced practice nursing.1,2 Four distinct advanced practice nursing (APN) roles evolved from these early beginnings—the nurse midwife (CNM), the nurse anesthetist (CRNA), the clinical nurse specialist (CNS), and the nurse practitioner (NP). New roles continue to emerge or morph into new configurations. As two individuals who have actively participated in the growth of the CNS and NP roles, we have a keen interest in the evolution of advanced practice nursing. While the concept of advanced practice nursing is a relatively recent development, distinct patterns can be seen in the evolution of specialty practice into advanced practice over the last 100 years.

The purpose of this article is to describe these patterns and some current issues that need to be addressed to strengthen advanced practice nursing. First, we describe three stages evident as specialties develop and mature into advanced practice. Then, we clarify our definition of advanced practice nursing, based on our own APN model that has evolved over time.3 Finally, we address internal and external issues that present challenges to the continuing evolution of advanced practice nursing.

It is important to note at the outset that the various evolutionary paths of the specialties we will describe are not more or less valuable than those evolutionary paths that have resulted in advanced practice nursing. As Hamric stated, it is critical to understand that this definition [of advanced nursing practice] is not a value statement, but a differentiation of one group of nurses from other groups for the sake of clarity within and outside of the profession. . . all nurses, whether their focus is clinical practice, educating students, conducting research, planning community programs, or leading nursing service organizations, are valuable and necessary to the integrity and growth of the larger profession. However, all nurses, particularly those with advanced degrees, are not the same, nor are they necessarily APNs.4

HISTORICAL PATTERNS IN THE EVOLUTION OF APN ROLES

While specialties in nursing have existed since the 1900s, specialization in nursing is different from advanced practice nursing, which is a relatively recent development in the history of the profession. Indeed, the phrase “advanced practice nursing” only began to appear in the literature in the 1970s and 1980s.5 Every specialty in nursing is not necessarily advanced practice nursing, as is clear when considering nurse educators, nurse administrators, or expert clinicians who have not attained graduate degrees. A number of authors have noted patterns in the evolution of nursing specialties to an advanced practice level.6,7 Roughly three discernable stages can be seen in this evolution (see Table 1).

Stage 1—Specialty Development in Practice Settings

In the first stage, changes in patient needs, new technology, and changing opportunities within the workforce begin to occur within practice settings, driving the development of a specialty focus. For example, the advent of anesthetic agents provided the groundwork for the CRNA role; a lack of pediatric residents created an opportunity for neonatal NPs to develop.8 Nurses have historically responded to unmet needs in the health care system, particularly when patient needs were not addressed.

Charlene M. Hanson is a Professor Emerita at Georgia Southern University, Statesboro, GA.
Ann B. Hamric is an Associate Professor at University of Virginia School of Nursing, Charlottesville, VA.
Reprint requests: Dr. Charlene M. Hanson, Georgia Southern University, P.O. Box 8158 Statesboro, GA 30458.
Email: cmhanson@georgiasouthern.edu.

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Hanson and Hamric...................................................................................................................................

Table 1. Three stages in the evolution of advanced practice nursing

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>Specialty develops in practice settings</td>
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<tr>
<td>2.</td>
<td>Organized training for specialty begins</td>
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<tr>
<td>3.</td>
<td>Knowledge base grows; pressures mount for standardization and graduate educational programs emerge</td>
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Often, this meant that nurses took over activities that were not valued by physicians, or took on additional tasks in settings where there was an insufficient physician supply. In this way, over time, definable specialties begin to develop as nurses in more and more settings attain on-the-job skills and expand their practice to encompass these new skills. In the initial coalescing period, the specialty may not be seen as exclusively a nursing role. For example, the development of the clinical research nurse coordinator specialty seems to be in this phase of evolution. Currently, clinical research coordinators are not exclusively registered nurses, although the literature includes at least one call for this role to be an APN role.9

Stage 2—Organized Specialty Training

In the second stage, the specialty progresses to the point that organized training develops for nurses. Initially, specialty training programs were institution-specific and essentially consisted of a paid apprenticeship with some organized classes. In much the same way that nursing education began with on-the-job training in hospitals, early specialty education was characterized by an apprenticeship model. In the earliest specialties of anesthesia and midwifery, hospitals developed specialty training programs. In the case of NPs, continuing education departments within schools of medicine and nursing were the primary developers. As more nurses received training, longer and more formalized educational programs provided certificates to those nurses who completed the programs. These “certificate programs” were not standardized, and quality was uneven. A current example of a specialty in this phase of evolution is the parish nursing role. A variety of formal and informal educational programs have developed for nurses interested in this specialty including some housed in theology schools.10

Stage 3—Standardization and Emergence of Graduate Education

The third stage develops as the specialty’s knowledge base grows and the scope of practice of the nurses with specialty training expands. There is growing recognition of the additional knowledge and skills needed for increasingly complex practice in the specialty.7 It is not unusual to see APNs in other roles migrate into an evolving role and expand the specialty by infusing it with their APN core competencies. Their activities make the specialty “look” like advanced practice, and create new calls for evolution to this level. The third phase is characterized by pressures for standardization of education and skills involved in the specialty. In the past 30 years, this phase has been coupled with pressure to move certificate-level training programs into formal graduate-level educational settings, both as a means of increasing standardization and to raise the status of the specialty to an advanced practice level.

Growing recognition that educational preparation must be adequate to meet the expectations that will be placed on the practitioner, coupled with increased regulatory oversight by state boards of nursing, have contributed to this third evolutionary phase. Mandated education at the master’s level is now the expected norm for advanced practice nursing. By the late 1990s, three of the central advanced practice specialties (CNS, NP, and CRNA) required master’s level educational preparation. At the current time midwifery is in a transitional period. Not all midwives are nurses and not all nurse-midwives are prepared at the master’s level. At the same time, the American College of Nurse-Midwifery’s new joint statement of practice relations between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives is a potential breakthrough for advanced practice in its clarity and simplicity.11 In these contradictions, midwifery presents a troubling prospect for advanced practice nursing that will be discussed in a later section of this article.

The CNS role was the first to develop the expectation of master’s preparation, with specialties such as psychiatry and oncology leading the development of a cadre of master-prepared APNs who moved the specialty forward. Current calls for master’s level preparation in the specialty of wound/ostomy/continence nursing12 indicate that this specialty is moving into the third phase.

COMMENTARY

We believe that each of these phases is part of the natural evolution towards advanced practice nursing that occurs as a practice specialty matures.

Interestingly, however, not all specialties evolve into advanced practice nursing, so this is not an inevitable progression. Dietetics was an early nursing specialty that matured into a separate discipline. Some specialties have evolved away from clinical practice as a central defining focus. Administration is an early example of this, as organizations grew in complexity and in the knowledge base needed for effective management. The focus of administrative practice is now clearly on the nursing workforce and managing within organizations rather than on clinically-based practice with patients and their families. A more contemporary example is community/public health13 which should properly be considered a specialty rather than advanced practice nursing. The competencies listed in the current description of this specialty include such functions as monitoring the health status of a community, mobilizing community partnerships, and developing policies and plans, rather than the APN competencies noted below. In like manner, nurses in continuing education and staff development have identified a number of competencies for their specialty that are quite distinct from APN competencies.14 It is not always clear whether a given specialty will evolve into an advanced practice nursing role. Thus, it remains to be seen whether specialties in the first two phases, such as parish nursing, will evolve into an APN-level specialty.
REFLECTIONS ON THE CONTINUING EVOLUTION OF ADVANCED PRACTICE NURSING

Before raising issues that must be addressed for the continuing evolution of advanced practice nursing, we need to clarify our understanding of the concept. Hamric and associates developed a two-part definition of advanced practice, based on three seminal documents: ANA’s Nursing’s Social Policy Statement, the National Council of State Boards of Nursing’s Position Paper on the Regulation of Advanced Nursing Practice, and the National Organization of Nurse Practitioner Faculties’ Advanced Nursing Practice Curriculum Guidelines and Program Standards for Nurse Practitioner Education, and the APN literature (e.g., Davies and Hughes, Patterson and Haddad, and Spross and Baggerly). The first part of the definition is the following:

Advanced nursing practice is the application of an expanded range of practical, theoretical, and research-based therapeutic skills to phenomena experienced by patients within a specialized clinical area of a larger discipline of nursing.

The second part of the advanced practice definition is characterized by a constellation of primary criteria and core competencies (see Figure 1). These core competencies, listed in Figure 1, are also consistent with the American Association of Colleges of Nursing’s Essentials of Master’s Education for Advanced Practice Nursing.

The primary criteria of graduate education, national certification, and patient-centered practice are necessary but not sufficient requirements for defining a nurse as an APN. A critical definitional feature of advanced practice is the central competency of direct clinical practice. As noted above, the provision of direct practice separates APNs from some other expanded nursing roles. Six additional core competencies that further define advanced practice nursing include expert guidance and coaching, consultation, ethical decision making, collaboration, research skills, and clinical and professional leadership. Figure 1 also demonstrates that advanced practice nursing is embedded in practice environments, which present critical elements that must be managed for APNs to succeed. Over time the key concepts in the APN definition continue to be refined and operationalized by persons and groups closely aligned to advanced practice.

ISSUES INVOLVED IN EVOLVING APN ROLES

We submit that a number of issues must be addressed for a given nursing specialty to evolve to an advanced level of practice and become incorporated into the larger arena of advanced practice nursing. As we move to strengthen advanced practice nursing, it is helpful for the profession to address these important issues in a unified and proactive fashion, rather than in the somewhat haphazard way that many roles have historically developed. These issues are outlined in Table 2.

Clarity Regarding APN Definition and Core Competencies

Issues within the nursing profession as advanced practice evolves include the need for clarity regarding the core competencies of advanced practice nursing, particularly a patient/family-focused practice with direct clinical practice as the central competency. The core competencies need to be visible in APN practices and explicitly taught to APN students. Addressing this issue requires an agreement both within and without the profession that a developing APN specialty constitutes an advanced nursing role. Such agreement has been elusive in some cases, as can be seen in the early years of the NP role. A current case in point is the APN case manager. The majority of incumbents in case management roles are not APNs. Differentiation of the APN level of case management roles is not yet the norm for this role, as evidenced by the differing activities and responsibilities assumed by case managers and the varying opportunities for education and certification outside the nursing profession.

Table 2. Issues to be Addressed in Evolving APN Specialties

| 1. Clarity regarding advanced practice nursing definition and core competencies |
| 2. Internal cohesion in promoting advanced practice |
| 3. Standardization of curricula for competency at an advanced practice level |
| 4. National APN certification and credentialing |
| 5. External issues facing APN specialties |
| 6. Clarifying the blended CNS/NP role |

The second component of this issue is the patient/family-focused nature of APN practice. The profession’s hard-won consensus on the centrality of direct clinical practice competency for advanced practice nursing needs to be supported in evolving APN roles. In contrast to the development of the community/public health specialty, leaders in the primary care NP role have held fast to the primary criterion of a direct patient/family-focused practice, even as they have incorporated expanded community-oriented competencies such as community assessment into their educational programs as a framework for competent patient care. This critical focus helps determine whether the specialty will evolve into advanced practice nursing. Specialty groups need to consider whether the specialty’s growth is best served by a direct patient/family focus and move toward advanced practice nursing, or whether some other focus should be paramount. It is important to reiterate that this is an issue of clarity, not of value. As Cronenwett noted, “the title ‘advanced practice’ will have meaning only if it is used consistently to refer to advanced clinical practice, rather than being inclusive of other advanced roles in the profession, such as in research, education, and administration”. All roles, whether specialty or advanced practice, are valuable and vital to the profession’s continued development.

The Need for Internal Cohesion
A related issue is the imperative for all nursing leaders to continue the work to organize a cohesive vision that allows advanced practice nursing to speak and negotiate with one voice. As Safriet noted, for a profession to succeed, it must have internal cohesion and external legitimacy at the same time. Ongoing efforts by some leaders to privilege one APN group over others, while undoubtedly well intentioned, will continue to delay the work of clarifying advanced practice nursing. Examples include conflating the NP role with advanced nursing practice, so that only NPs are seen as legitimate APNs. Another recent example was an editorial claiming that only certain APN practice represent advanced nursing. According to Fulton, “CNS practice is the essence of what characterizes the advanced practice specialty. CNS practice provides the core. . . While other advanced practice nurse groups practice largely as an extension of another discipline, primarily medicine, CNSs are committed to forging ahead on the defined path of nursing”. It is so important that APN leaders give attention to their language choices. Statements that distinguish rather than disparage selected APN groups are necessary to build the internal cohesion needed to promote advanced practice nursing to the public and other healthcare providers. All APNs are nurses first, and all should be learning advanced nursing therapeutics along with advanced medical therapeutics in their specialties. Nursing’s unfortunate history of rejecting the nurse anesthesia specialty should not be repeated. Organized medicine in particular is eager to point to nursing’s internal disunity as an indication that APNs are not qualified to offer their services directly to the public. All APN groups need to stand together and work together to promote advanced practice nursing in all its varied forms.

The current issues within nurse midwifery are causing chasms within the APN world. The movement of the American College of Nurse Midwives to include midwives who are not nurses but who complete a certified midwifery program that is not nurse driven makes for confusion. It will be a true test for APN leaders to work collaboratively with ACNM to work out an interdisciplinary model which embraces master’s-prepared nurse-midwives while honoring midwives who, though competent, are not nurses. It is a professional imperative for ACNM leaders to differentiate the competencies expected of APN midwives from those expected of midwives who are not nurses or who lack graduate degrees. This differentiation is necessary to drive different certification and regulatory requirements for APN midwives versus other midwives.

Standardizing APN Curricula for Competency at the Advanced Practice Level
For APN roles to prosper, standardization of curricula for competency at an advanced practice level is imperative. The core master’s knowledge base articulated in the AACN’s Essentials of Master’s Education for Advanced Practice Nursing together with the seven core competencies of advanced practice nursing described in the above model, form the basic framework of advanced practice nursing curricula. Much progress has been made in the graduate educational arena to lead the APN student toward clinical competency, but more remains to be done. We strongly believe that programs that only prepare students for expanded medical skills do their students and the nursing profession a grave disservice—advanced nursing competencies in the specialty as well as APN role content are equally essential to preparing APNs ready to enter the tumultuous health care arena with a clear sense of their role. Programs that provide both clinical and APN role preparation enable their students to articulate the differences between their skills and those of physician extenders, as well as help them to emphasize the value-added components that advanced nursing brings to patient and system outcomes. Educators must ensure, and students must demand, that APN programs possess the quality and competence to enable their graduates to compete successfully in the difficult milieu of the current health care system.

The issues surrounding doctoral education for advanced practice nursing are multifactorial and a full discussion is beyond the scope of this article. However, recent articles advocating a clinical doctorate or professional doctorate raise important issues. We note that these calls for doctoral preparation are not new; indeed, Snyder advocated doctoral preparation, namely the DNS degree, for CNSs. This idea never caught on, in part because of shifting marketplace realities. In today’s milieu there is the question of the marketability of doctorally-prepared APNs in the current economic climate. Likewise, cost constraints in higher education would make transitioning master’s programs to the doctoral level for all APN specialties very challenging. Additionally, the profession’s looming critical faculty shortage would undoubtedly create pressures to employ these APNs in faculty positions, much as has happened with DNS graduates.
While it is true that many APNs in complex practice environments need and desire further clinical education, and while there is a pressing need for APN faculty to acquire doctoral preparation to meet university requirements, the confusions around curricular issues at both the master’s and doctoral levels and the credentialing and certification difficulties that a new degree could foster may be difficult to overcome. Concern about variability in curricula and standards has been repeatedly voiced over the past 25 years, and remains the key issue to be addressed, in our view. Standardizing and improving the quality of master’s level curricula for adequate APN preparation seems preferable to developing a different level and degree preparation in the current healthcare environment. Data are lacking that doctoral education is needed for successful APN practice, and standardizing the expectation that all APNs should be prepared at the master’s level has been a challenge that is still not fully met (the CNM role being the most recent example of this lack of consensus). State regulatory groups continue to struggle with establishing standards for APN licensure, particularly the credentialing of individuals who do not possess the master’s degree or national certification. Lack of consistency within the profession’s leadership only further complicates these regulatory issues. Adding more doctoral titles to the existing ones threaten to confuse policy makers and nurses alike, at a time when advocacy for and clarity surrounding advanced practice definitions and preparation are critical.

At best, it will be important to clearly define the competencies that would undergird the new clinical APN level, a sound clinical curriculum, and careful dialogue with credentialers and certifiers of APNs. Clinical doctoral programs would need to work for and enhance all APN roles, not just the NP role (as noted above, the NP is not synonymous with advanced practice nursing). It will be important for new research to emerge that clearly shows the difference between master’s- and doctorally-prepared APNs. The one study that examined this issue, Sterling and McNally,36 did not find clear differences between these APNs. We agree with Minnick and Halstead’s recommendations that nursing “adopt a voluntary moratorium on new degree names until a consensus can be reached. . .[and] convene a consensus panel through American Association of Colleges of Nursing sponsorship that would endorse degree-naming conventions.” 37. The suggested “DNP” degree is particularly confusing, given the use of various specialty NP designations (such as GNI for gerontological NP) in clinical settings. Fitzpatrick notes, “As nurse leaders and educators, we must face the reality that we, individually and collectively, have created some of the current confusion in nursing education.” 38 It is critical that we eliminate this confusion and not repeat the past in considering the clinical doctorate for advanced practice nursing. NONPF and other organizational partners have set the stage to ensure quality educational outcomes. It is now time for national dialogue to progress, through leadership and unification.39

Finally, from an educational perspective, the move toward Web-based and other distance learning modalities for APN education raises different issues of maintaining quality and educational standards. These modalities can enhance and enrich APN education if properly structured. In an increasingly technology-sophisticated world, it is important for nursing educators to take full advantage of this technology to enhance learning. However, faculty responsibility for maintaining quality control is paramount. APN programs in particular require constant oversight by clinically astute APN faculty to meet the need for clinical competence in APN graduates. In all of these various educational changes, collaboration between accreditors of nursing programs, certifiers of APN graduates, and state and national regulators and certifiers requires the highest level of leadership to maintain balance and integrity within the profession.

APN Certification and Credentialing

Newly evolving roles that have reached Stage 3 need to establish national certification and credentialing to standardize and solidify their APN level of practice. It is certain that the issues of certification and credentialing will escalate in importance as patient outcomes and standardized practice guidelines gain prominence in the health care arena. The National Council of State Boards of Nursing (NCSBN) examined the structure of APN regulation and licensure and recently wrote a Position Paper entitled “Regulation of Advanced Practice Nursing,”38 which as been shared with state boards of nursing. One issue needing clarification in that work is the designation of specialty versus sub-specialty APN roles. An example pertinent to this issue relates to CNS certification. CNS specialties such as oncology, critical care, and diabetes appear to be considered as “sub-specialties” in the NCSBN Position Paper. However, testing these CNSs on general medical-surgical competencies would not accomplish the purpose of certifying their specialty knowledge base to ensure the public’s safety. The National Association of Clinical Nurse Specialists (NACNS) questions whether certification for CNSs is achievable or desirable and suggests certification only for those CNSs who want to expand their practice outside of nursing.39 This position represents a problem for states who need to regulate APNs overall. Lyon40 noted that one possibility for dealing with CNS regulation would be to develop a “core” CNS certification examination to test core CNS competencies for legal recognition, with subsequent sub-specialty certification when such examinations are available. This idea can be expanded into a modular concept, with different certification examination modules developed and required for core APN competencies and modules testing different APN roles, such as primary care NP, CNS, and acute care NP. We agree with Lyon that the most important consideration as states move forward to uniform regulation is the assurance that unnecessarily restrictive requirements will not be placed on any APN, whether CNS, NP, CRNA, CNM, or others. Regulations need to enable and strengthen APN practices and reduce barriers preventing public access to APN services. On the other hand, the value of certification is diminished as more and varied APN specialties and sub-specialties and certification options emerge. Educators and regulators need to craft common ground to deal with this tension and ensure that the APN credential is recognized and valued in the interdisciplinary milieu.
**Clarifying the Blended CNS/NP Role**

The blended CNS/NP is an advanced practice nurse who, while blending the roles and competencies of the NP and CNS, is distinct from either of them. These APNs possess expert specialty skills in direct management of patients with complex acute and chronic illnesses across settings, as well as skills in staff development and system improvement. They cross settings, managing their patients in collaboration with nursing and medical colleagues in acute care settings, in clinic settings, in nursing homes, and in home care. As such, blended CNS/NPs provide enhanced continuity of care for patients with such complex chronic problems as spinal cord injury, pediatric diabetes, and congestive heart failure. These APNs take a smaller case load of patients for direct management than do NPs because they are also engaged in developing nursing staff to care for their patient population, and effecting system change to support these patients’ needs. Examples of blended CNS/NP roles have been described in oncology, geriatric, and pain management practices by Skalla and Hamric in a congestive heart disease practice by Palidichuk, Brass-Mynderse, and Kaliangara. Figure 2 depicts the unique and blended CNS and NP competencies possessed by the blended role APN.

As can be seen from Figure 2, the blended CNS/NP possesses core APN competencies in addition to the primary management skills of the NP and the staff development and system change skills of the CNS. Additional competencies that help distinguish this role include expert specialty practice focused on a complex population, a practice that crosses settings, and explicit dual educational preparation as both a CNS and a NP.

**External Issues Facing APN Specialties**

Issues external to the nursing profession also have a major impact on APN specialties and help to direct the decision making process vis a vis advanced practice. Legal and regulatory requirements that promote recognition and strengthen patient/consumer access to APN-level practice are of paramount importance. Continued vigilance to assure reimbursement and prescriptive equity is an ongoing stressor for many APNs. Marketplace forces in these areas profoundly affect the role, education and practice of APNs.

Certainly, the crisis surrounding the nursing workforce must be considered. New APN roles that support and mentor hospital nurses and replenish the graying nursing faculty ranks clearly need to be encouraged. Unprecedented population growth, increasing diversity, and a citizenry that is aging and living with complex chronic disease all point to the need for more APNs to fill the gaps in the current workforce and to create innovative new roles for the future. This may mean looking at advanced practice through a new lens that opens doors for evolving roles and creates alliances with other disciplines. The multidisciplinary advanced diabetes manager is such an example.

Identification of the unique niches that evolving APN roles fill within the structures of health care organizations and practices is one important way to assure the viability of APN roles. An example of such a unique niche is the growing interest in practice through a new lens that opens doors for evolving roles and creates alliances with other disciplines. The multidisciplinary advanced diabetes manager is such an example.

It is important to understand this role as a distinctive practice with a distinct job title and not as a term for any APN who has had dual educational preparation as both a CNS and a NP. It is the practice of the specific competencies listed above that defines the blended CNS/NP role.

Because there is considerable confusion in educational and practice settings about the blended CNS/NP role, it may be helpful to list some of these confusions. We would submit that the blended CNS/NP role is **NOT:**

- A CNS who has returned to school for an NP credential and is practicing as an NP, whether in a primary care or acute care setting. If these APNs are functioning as NPs, they should be titled as such. In particular, the acute care NP (ACNP) role is not the blended CNS/NP role, particularly given the ACNP’s focus on direct clinical practice. Dual educational preparation alone is not sufficient to define blended role practice.

- A graduate of an educational program that has homogenized the distinctive features of the CNS and NP so that neither role is clearly taught. Preparation for a blended CNS/NP role requires that students have completed coursework and clini-
cal experiences for both CNS and NP roles, and are eligible to sit for both certification exams.
- A specialty NP that crosses settings but has a strictly patient-focused practice. If an APN is not performing the CNS competencies at the nurse and organization spheres of influence, she is not functioning in a blended role. NP programs do not prepare students for CNS competencies.
- The only possible alternative in evolving advanced practice roles. There are certain patient populations and settings that could greatly benefit from a blended role APN but there continues to be a need for discrete CNS and NP roles as well.

Why is it so important to clarify and develop the blended CNS/NP role? Recent changes in the healthcare system dictate deliberate and thoughtful changes in the preparation of APNs to more effectively address the needs of complex chronically and acutely ill patients who have exacerbations of chronic illnesses. The complexity of the healthcare system increasingly requires the skills of both the CNS and the NP to manage growing populations of specialty and chronically ill patients across settings. Continuity of care has assumed major importance as hospital length of stay decreases, as patients are moved rapidly through a maze of settings and providers, and as patients are cared for across the intensive care/hospital/clinic/home continuum. Blending the direct patient management skills of the NP with the CNS’s skills in nursing staff and system spheres of influence maximizes this practitioner’s ability to meet expanded responsibilities for the more complex health problems experienced by many patients and population groups.

Although they do not use the term, it appears that Mundinger and colleagues are referring to the blended CNS/NP role as the independent cross-site nursing role for which they are advocating doctoral preparation. It is premature to assert that doctoral preparation is necessary or even desirable for all APN roles. However, given the expanded competency set necessary for blended CNS/NP practice, the profession may wish to carefully consider whether the clinical doctorate is the appropriate educational preparation for this evolving APN role.

TWO VISIONS FOR THE FUTURE
At least two visions of the future are possible to discern in the present turbulence in the healthcare system. In the first, advanced practice nursing fades as a definable level of practice and merges into “mid-level provider” status along with physician assistants (PAs) and others. In this bleak (from our perspective) vision, physician substitution becomes the primary activity of APNs, and the emphasis in outcomes is on medical outcomes such as the diagnosis and cure of illness only. Advanced practice is seen as the addition of medical skills, with APNs substituting for residents and primary care physicians. Advanced nursing skills are not developed in graduate programs or valued by practitioners. One risk in this scenario is that with an increase in both the medical and PA workforce, opportunities for APNs will dwindle. Given the projected oversupply of physicians, if APNs are seen as strictly substitutes for physicians rather than as value-added complementary providers, APN roles could become extinct or at least superfluous. Of even greater concern in this bleak future is the lack of growth of nursing disciplinary knowledge. In addition, this career path would send a very negative message to aspiring nurses.

In the second and clearly preferable vision, advanced practice nursing is increasingly recognized for the value-added nursing complement to medical care that APNs provide, that patients desire and need and that new and potential nurses see as a career development goal. This is not to say that APNs do not need to engage in diagnosis and treatment of health problems within their scope of practice. Clearly, this expanded scope of practice is critical to APN roles. But in this second vision, APNs become preferred providers of care based on the important holistic and family-centered focus that they bring to patient and/or family interactions. The lay press supports the trend that patients are moving into more self-directed care that can be appropriately coordinated by an APN provider. In this vision APNs are prepared within a graduate nursing curriculum that teaches both core clinical and medical competencies within the specialty as well as strengthens nursing skills to a higher level of expertise. New APN specialties emerge and are deliberately shaped to possess core APN competencies and meet standardized requirements for certification and regulation—this standardization increases public understanding and acceptance of advanced practice nursing.

CONCLUSION: CREATING OUR PREFERRED VISION FOR THE FUTURE
For advanced practice nursing to continue to evolve as a unique phenomenon in healthcare it is necessary to look carefully at the way APNs are educated and credentialed for practice. To this end, the need to adhere to core competencies and to standardize APN curricula and national certification exams are a critical imperative. Attention to these basic structures will place APNs in a positive position to be able to negotiate the legal and regulatory issues that will continue to be an integral part of our future. The evolutionary patterns evident in the development of APN specialties portend a wealth of future opportunities for advanced practice nursing. There are many opportunities and challenges to be faced as this ongoing evolution continues. Some of these opportunities and challenges date from the earliest APN groups, the anesthetists and midwives. We have described some trends and issues that shed light on the process, with a goal of strengthening advanced practice nursing in the larger practice arena. One final imperative for all nursing leaders is to continue the work to organize a cohesive vision of advanced practice nursing. Nursing’s internal cohesion on the definition and evolution of advanced practice nursing is critical to achieving the external legitimacy needed to ensure that APNs survive the current turbulence in the complex and ever-changing healthcare marketplace.

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