EDITORIAL

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Editor

One Giant Step Back

The recent publication of a draft vision paper titled "Future Regulation of Advanced Practice Nursing" by the National Council of State Boards of Nursing (NCSBN)[a] sent waves of decidedly uncomfortable and all-too-familiar feelings through me. This vision, three years in the making, includes a recommendation that, for regulatory purposes, clinical nurse specialists (CNSs) would no longer be classified as advanced practice nurses (APNs), thus limiting the definition of advance practice to nurse anesthetists, nurse midwives, and nurse practitioners (NPs). NCSBN argues that CNSs do not practice "independently"—independent practice being defined as the ability to make medical diagnoses, treat disease, and prescribe medications. What is wrong with this picture???

As my reaction to the document began to take shape, I went looking for an editorial that I had a vague memory of writing years ago about advanced practice nursing (Carroll-Johnson, 1994). As I read the thoughts and feelings that were going through my mind 12 years ago, I felt something akin to déjà vu mixed with a profound sadness that comes from many years marveling at nursing's uncanny ability to turn on itself in a misguided effort to turn itself out and make a statement in its own favor. To my mind, so much of my 1994 editorial could have been written just yesterday. I hate it when that happens.

I have a great deal of respect and admiration for all categories of APNs. I spent a recent weekend at an APN meeting with a number of NPs and CNSs and, for the first time in a long time, felt hopeful about nursing's future. These were smart, accomplished, strong, self-possessed young professionals who represented the very best of nursing. The NP role, in particular, has grown steadily and importantly in the past 10 years. NPs are now integral parts of modern medical practices. They function independently and provide comprehensive care to increasingly larger numbers of clients. Nevertheless, NPs practice from a primarily medical model. They are nurses practicing in an advanced way but are oriented to the diagnosis and treatment of medical rather than nursing diagnoses. Much the same can be said for nurse anesthetists and nurse midwives. The public also sees these nurses performing much like physicians and finds it easy to accept that they are "advanced." The irony involved in the NCSBN "vision" overwhelms me. In trying hard to "bring uniformity, simplicity, and clarity to the regulation of APRNs," as stated by Nancy Chornick, RN, PhD, CAE, director of practice and credentialing at NCSBN (quoted in Thew, 2006, p. 8), NCSBN is turning its back on the one truly **nursing** role in the cadre of APNs.

CNSs, to my mind, have always embodied the real essence of the practice of nursing in its purest sense—as clinicians, educators, and consultants. They are the clinical mentors, the teachers of tomorrow's bedside nurses, those who care for the person behind the disease. They understand the conceptual and theoretical underpinnings of nursing, translate nursing research for bedside nurses, advocate for their colleagues and patients, and attend to the myriad small and large circumstances that affect the lives and daily course of those committed to their care. Of course, CNSs practice independently, but most often they practice within a hospital structure where they are just another nurse on the payroll. Their value is not so easily measured in dollars and cents, and their worth to an institution is often only a reflection of indirect measures, such as improved patient satisfaction, lower rates of complications and sentinel events, higher nurse retention rates, or increased levels of staff nurses with specialty certification.

Is it unfair of me to note that the three roles that NCSBN has retained as advanced practice nursing have reimbursement capabilities in ways that the CNS role does not? Is this about defining APN based on the power of the almighty dollar? Research has been telling us that quality nursing care and the impact of having a CNS save healthcare dollars in all sorts of ways, but these savings do not show up directly in the bottom line, do they? Shortsighted hospital administrators see only the bigger salaries and more expansive (and less controllable) scope of practice of these APNs. They often do not offer them support or appreciation, nor do they use them to their best or full capacity. Will these same hospital number crunchers, in collusion with nursing's own NCSBN, now find it easier to just throw CNSs away because they do not show a positive line item ledger balance?

As it has before when the need presents itself, the Oncology Nursing Society Board of Directors has written a specific and strong response to NCSBN[b] on our behalf. I urge each of you to read this document and understand the issues. The NCSBN vision paper should have been forward thinking, expansive, and, yes, visionary. Instead it is shortsighted, polarizing, stereotypical, and malignant. The deadline for comments has passed, but each of us needs to monitor future developments because we all will be affected directly or indirectly. This is not the first and will not be the last time nurses will need to fight for recognition and credibility. These internal struggles sap our strength and divert us. NCSBN needs to fight for **nursing** care and stop "simplifying" their regulatory efforts to the point where the entire essence of what it means to practice advanced **nursing** is lost.

[a] *Available at www.ncsbn.org/regulation/nlc_licensure_aprn.asp*

[b] *Available at www.ons.org/clinical/professional/QualityCancer/documents/NCSBNresponse.pdf*

References

Carroll-Johnson, R.M. (1994). Whose practice is it anyway? [Editorial]. *Oncology Nursing Forum, 21,* 811.

Thew, J. (2006). Draft plan reclassifies clinical nurse specialists. *Nurseweek* (California ed.), *19*(6), 8.

Digital Object Identifier: 10.1188/06.ONF.511