OPINION

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“The Nurse Practitioner in Emergency Care: Where to from here?”

*Interview with Chris Hawkins in November 2006, followed by responses from
Prof. Malcolm Woollard and Dr. Julie Considine.*

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BW: Can you tell us a little bit about yourself?

CH: *Well, I work at the Austin Hospital as one of the Nurse Practitioners in the Emergency Department. I came out to Australia 20 years ago and I'm now an Australian citizen. I spent my first 10 years working intensive care, both in UK and in Australia and then moved into emergency care. The last three years I've worked as a Nurse Practitioner candidate in emergency care, and more recently, I've been endorsed as a Nurse Practitioner.*

BW: Can you explain the various aspects of your role and NP candidature?

CH: *The role of the Nurse Practitioner in emergency care is evolving all the time, and it's different in different Emergency Departments. Typically, most emergency nurses who've moved into the Nurse Practitioner role will look after patients who have sustained minor injuries or suffer from minor illnesses, with some moving into specialist areas, e.g. emergency care for women's health, etc. Once endorsed, a Nurse Practitioner is allowed to undertake various extended roles, whereas the candidate, it must be remembered, is a Registered Nurse in Division One and is essentially undertaking a mentored student role, so can do nothing that a Registered Nurse is not able to without passing it by a clinical supervisor, e.g. discussing the prescribing of medicines and having them co-signed.*

So what can a Nurse Practitioner do? There are five extensions to practice recognised by the Nurses Board of Victoria. The most obvious difference between an RN Div 1 and a Nurse Practitioner is the capacity to prescribe, and in Victoria that prescribing is from a defined formulary of medicines, which are sanctioned by the Department of Human Services. Nurse Practitioners are also able to request organ imaging e.g. x-rays, ultrasound, CTs, and also request pathology investigations, e.g. blood tests, histology, etc, and that may be defined within their clinical practice guidelines or it may be more broadly sanctioned. Nurse Practitioners can also formally refer a patient to a medical

specialist, similar to a General Practitioner. A Nurse Practitioner is also able to issue absence from work and study certificates, more commonly known as “medical certificates”, although there are some legal limitations to this as some Acts such as WorkCover in Victoria have not caught up with the introduction of Nurse Practitioners yet. And lastly, the capacity to admit and discharge patients from the care of the organisation they work for, or as in my case, the Emergency Department. Nurse Practitioners may not choose to activate all aspects to seek endorsement, but at the moment the Nurses Board of Victoria requires the candidate to show that they will need at least three for effective practice.

Requesting pathology is an interesting issue; the difference between what a Nurse Practitioner does in that regard and a nurse who may also have permission to request pathology and organ imaging, is the Nurse Practitioner will have a wider, more extended scope and also has an obligation to act upon results, many Emergency Department Nurse Practitioners both request tests and read them, whereas the nurses they are working beside will request tests but have no legal obligation to seek out and act upon results.

Another area is the referral to medical specialists. If the Nurse Practitioner wishes to refer a patient that is empowered by their capacity as Nurse Practitioner and also by the policies of the organisation they work for. So, other areas would include the capacity to sign medical certificates, which of course have significant social and financial implications so we have to be very cognisant of the implications of that, because the absence from work and study can be both costly to society and can compromise people's education.

BW: Which universities are offering the NP degree?

CH: *There are several different universities around Victoria and more nationally, offering Nurse Practitioner Masters programs. Some of the first to start were in South Australia, for example, the University of South Australia and Flinders University. Some offer a different specialty, for example, the University of South Australia offers a rural Nurse Practitioner Masters program, whereas the La Trobe University in Melbourne offers a Nurse Practitioner program specialising in emergency care. Others have chosen a more generic approach so the advanced education knowledge and skills are tailored to the local needs of the student/candidate, whereas the academic component has a generic flavour to it.*

Within Australia, there are many States establishing Nurse Practitioner programs. Currently New South Wales (NSW) has in excess of 50 Nurse Practitioners but by no means all of them are actually practicing, there may only be a maximum 5 or 10 at the moment, and that's because the States have chosen different ways of enacting the Nurse Practitioner role. Tasmania have none currently, Northern Territory don't have any but have the legislation in place, Queensland have a couple, Western Australia is starting to establish them, and obviously South Australia has several as well, some working in emergency care, some working in rural practice.

Currently in Victoria we have a little over a dozen endorsed Nurse Practitioners and we have another 30-40 candidates in preparation to become Nurse Practitioners in various specialities. We have Nurse Practitioners in renal dialysis, palliative care, while other areas including psychiatry are being developed.

BW: What sort of differences (personal, professional, clinical, research and/or education) has the NP degree made to you and your practice?

CH: *Certainly the transition from expert nurse to Nurse Practitioner is a long road and personally has been a tremendous learning experience for me. I have acquired many advanced clinical skills and I have interacted with many colleagues of various disciplines over these last three years. There was considerable academic preparation (a Masters degree and one of the recognised pharmacology courses), which I had already completed before I started formally as a candidate which I found challenging and which provided me with a much more thorough appreciation of the politics of health as well as the clinical components of my work. A Nurse Practitioner not only has to have a Masters in nursing but also has to have a professional qualification in pharmacology recognised by the Nurses' Board of Victoria, and that for me was a fantastic learning experience.*

I think one of the most interesting areas that expert nurses find as they move to the Nurse Practitioner role, is that of clinical decision-maker. Speaking with many of my colleagues, the move from the collegial team approach where one often relies upon colleagues, usually, medicine to make definitive decisions and then acting upon those, to the Nurse Practitioner making definitive management is one of the greatest transitions. While the role remains essentially highly collegial Some of my colleagues have found this to be one of the most challenging aspects of the role, whereas one may have presumed that it would have been the academic content or the rigour that one has to demonstrate in the acquisition of clinical skills.

BW: How has this role been accepted within the Nursing professions?

CH: *I think it's fair to say that nurses are excited and stimulated by the role and clearly it is an area of interest to me and my junior colleagues where I work. I believe that nurses are looking for Nurse Practitioners to be role models of expertise and to advocate for nursing, not necessarily just advanced nursing, but all aspects of what nursing really is. Undoubtedly, there are some of my colleagues who are finding this threatening; there is a large informal knowledge base in nursing and Nurse Practitioners have taken on the challenge to formalise what is "need to know" for advanced practice. For some colleagues that has been a challenge for them to come to terms with, and I think we're moving through that now and on the whole nursing as a profession is also. Certainly the nurses I meet on a day-to-day basis find this exciting and invigorating for the nursing profession.*

BW: How have other disciplines accepted this new role?

CH: *I think it is no secret that whilst many of my colleagues I interact with on a daily basis are extremely supportive of what I do, some areas of medicine have been very*

reluctant and that can be seen in concerns of the Australian Medical Association in papers they have published and on their past position statements, although they appear to have started to move towards a greater acceptance of Nurse Practitioners. I think that overall, people I meet are highly supportive; the reality is that health care is getting busier, our patients are quite reasonably making increased demands of us, and we need to be able to make the most of our highly skilled, and in many aspects, under-utilised workforce, that is nursing.

So, the initial reluctance of some areas of medicine and also of allied health care professionals is starting to melt away. I think those concerns have stemmed from a lack of awareness of what we do and what we don't do, as well as a growing recognition that nursing will be doing this with others not instead of them. There is some fear amongst the Australian Medical Association I believe that the introduction of Nurse Practitioners will result in a loss of income and influence. Overseas Nurse Practitioners have moved largely into primary health care and that clearly I think that will ultimately happen in Australia as well. I don't feel that will cause any threat to general practitioners, I think it will only offer our patients that we both see, a greater access to health care. Nurse Practitioners and general practitioners bring different perspectives to the care we offer our patients.

BW: What was the driving force for the NP to be developed? Has the role made any impact to patient care?

CH: *Nurse Practitioners started in America in the mid-1960s. This was really to address the appalling delivery of health care to disadvantaged populations because of the large degree of privatisation in the US health care system, but also with the burgeoning group of veterans returning from Vietnam. Rapidly, Nurse Practitioners established themselves in the emergency care, but also in other acute care areas, for example intensive care, where they used to have a large amount of influence, and then rapidly established themselves as being able to address a patient cohort that was ill-served by what health care was able to offer at that time.*

In the early 1980s, Nurse Practitioners started in London, essentially starting to provide service for homeless men living in central London who were unable to gain adequate access to health care in National Health Service. The Nurse Practitioners in the United Kingdom have grown from that to be well established in many aspects of health care.

In Australia we have been fortunate never to have suffered the severe problems of health care delivery that North America and the United Kingdom have, but certainly we have areas that we could certainly improve for our patients. To that end, several States, initially NSW, introduced Nurse Practitioners. In NSW the role was clearly to address the inadequate provision of health care in rural areas of Western NSW, and that has been addressed to a degree. Other States subsequently introduced Nurse Practitioners and now we have Nurse Practitioners, as I said before, in most States. The role therefore in Australia is a balance between improvement in health care delivery, but also improvement in career structure and professionalisation for nursing. So, in some ways,

the quality of our ongoing health care delivery that we're fortunate to have in Australia, enables us to be more cautious and possibly better prepared in the development of our Nurse Practitioners.

BW: Can you see this type of professional extension being offered in other health care settings?

CH: *The extension of role for other health care professionals working in emergency care is the areas that I'm most knowledgeable in. I am aware of the paramedic practitioner, which has been introduced in Victoria and is now well established in other parts of the world. The reality is that, as I understand it as a Nurse Practitioner in emergency care, much of the paramedic practitioner work is in the home and is not in the truest sense of the word, emergency. We have a burgeoning population of patients attending Emergency Departments to gain health care, as they see it, in a reasonable timeframe. In my limited experience of the paramedic practitioner role in the United Kingdom, those undertaking the role have extensive further skills so they can attend a person who falls at home, that person when treated by the paramedic practitioner doesn't need to wait 6-8 hours in Emergency Department, as the paramedic practitioner will evaluate the person, arrange for their x-rays, repair any wounds they may have, for example suturing their wounds, and would counsel them on what may have contributed to this, but also with their paramedic skills, have an expert knowledge of what could have possibly caused this person to fall. The paramedic practitioner could explore if the episode of collapse was secondary to an episode of angina, or palpitations, etc. So, I think there are many opportunities for role extension, after all, as health care providers we must openly come up with systems that better meet the needs of our patients. We live in an ageing population in Australia, and we have to recognise that we must make best use of the health dollar and best use of those personnel that we have available to our patient population.*

BW: What advice would you provide to other RN's considering application to NP?

CH: *On completion of a graduate nurse program the individual should choose an area of specialist study. This will need to be undertaken at graduate diploma level. Following this I would suggest the nurse wanting to become a Nurse Practitioner undertakes one of the specific Nurse Practitioner masters programs available. It is important to emphasise that not all of them offer units in pharmacology that are accepted by all state boards of nursing, so it is crucial to undertake a course that offers a pharmacology course that will be acceptable to the relevant board of nursing when the nurse applies for endorsement.*

While the nurse is undertaking a Master's degree, he/she needs to also secure a position as a Nurse Practitioner candidate. The process of candidacy is designed to provide the nurse with a period of mentorship so they acquire the advanced clinical skills required to function as a Nurse Practitioner. During all of this he/she will also need to actively pursue further clinical skills and professional involvement; by showing interest and commitment to the discipline they have chosen - for example, emergency care. To apply for

endorsement successfully, he/she needs to be seen as an expert by colleagues, professionally active, active within one's own hospital or health care organisation, to show that they are a well rounded expert, and for want of a better expression, has an executive approach to their clinical practice yet maintains an essentially strong and expert clinical nursing flavour.

Before endorsement, the candidate also needs to be able to acquire and prove a significant research portfolio, to show that their practice is based on evidence, and that they are contributing to the profession as a whole. This includes presenting and publishing. At the end of the Masters program, including pharmacology, with evidence of research activity and evidence of professional presence within their discipline, one can apply to be a Nurse Practitioner. Now, where one applies and at which point one applies, is different, some states require the candidate to be employed in an organisation that supports their practice, e.g. a hospital, whereas other states do not require this, and the Nurse Practitioner can apply for endorsement and then subsequently secure the position to practice as a Nurse Practitioner..

Those States which require the candidate to be supported by an organisation, e.g. Victoria, also require that the clinical practice guidelines, (which essentially will define in Nurse Practitioner area and extent of practice) are well established and accepted by various disciplines within the health care organisation. Whereas in those States that do not need this the Nurse Practitioner is able to write the clinical practice guidelines subsequent to their appointment.

End of interview.

Response by Dr. Julie Considine, RN, PhD. Clinical Nurse Educator, Emergency Department, The Northern Hospital, Melbourne, and Research Fellow, Deakin University, Melbourne.

This interview is timely as Emergency Nurse Practitioners (ENP) gain momentum in Australia. The ENP model of care is becoming established as effective method of emergency care delivery for particular patient groups. Projections for future increases in Emergency Department attendances and workforce projection data also suggest that ENP will be an important strategy for the sustainable management of increased service demands.

Given the recency of the ENP role in Victoria, and Australia it is important to define the scope of the ENP practice. There are many outcomes of ENP care that are still unknown, however, researchers must be cautious not reduce the ENP role to a series of tasks based on extensions to practice. Further studies are needed to accurately quantify the contribution that ENP make to emergency care and patient outcomes.

It is important that health professionals and patients understand the role of ENP so that debate and discussion is based on informed and considered information rather than assumptions and conjecture. A key example of the need for informed discourse is the

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debate about nurse prescribing and the opposition voiced by some professional groups about Nurse Practitioner prescribing. Until recently there has been little accurate data related to Nurse Practitioner prescribing to inform this debate. One recent study showed that only half the patients managed by Emergency Nurse Practitioners required medications and majority received simple oral analgesics, immunizations and oral antibiotics. It is interesting to note that the opponents of Nurse Practitioner prescribing do not include this type of information in their public statements.

One of the greatest advantages of establishment of Nurse Practitioner roles for nursing in Australia is that it has forced communities, nurses and health care professionals to become acquainted with what nurses do, the calibre of decisions that nurses make and the contribution of nurses to health care. Although Mr Hawkins describes clinical decisions made by Nurse Practitioners, it is important to recognise the importance of clinical decisions made by nurses at all levels. Although many nurses in acute care settings function as part of a health care team, nurses in all contexts of nursing make independent decisions that affect the health outcomes of patients every day. It should also be acknowledged that many health care providers, including Nurse Practitioners base their decisions on information provided by nurses. Quantifying and developing the decisions made by nurses at all levels can only further advance nursing and advanced specialist roles such as Nurse Practitioner.

Response by [Prof. Malcolm Woollard](#), Consultant Paramedic and Registered Nurse, UK.

The situation regarding nurse and allied health practitioners in the UK has some important differences. Firstly, the academic level that an individual calling themselves a 'practitioner' has not yet been standardised, and as such there is no protection of this title. This has resulted in it having little credibility in the UK: its use simply implies some extended level of practice that may be supported by anything from a few days training to the possession of a Masters degree. This is beginning to change, however, and discussions are underway to standardise the minimum level of qualification for nurses using the title of practitioner. Further, the emerging profession of 'emergency care practitioners' (ECPs) – made up largely of paramedics and some nurses with additional primary and urgent care skills – is also developing a minimum standardised qualification, although this looks as if it will be a Bachelors degree. There are, however, already opportunities for ECPs to expand their education to Masters level. As a separate issue, any registered nurse in the UK who has the support of their employer can undertake a module at BSc level which subsequently permits them to prescribe any medication, other than some controlled drugs, provided this is within their sphere of practice and with the approval of their employer.

Perhaps a more analogous UK role to the Australian Nurse Practitioner would be the Consultant Nurse. This has a standard job description, requiring the post-holder to spend 50% of their time in autonomous advanced clinical practice, with the remaining time

spent on research, teaching at university level (post holders must have a joint health service and university appointment), and professional leadership. The minimum qualification is a relevant Masters degree and it is preferred that candidates have or are working towards a PhD. All posts and appointments have to be approved by government health authorities and interview panels must include a representative from such an organisation, and the relevant professional body. Identical posts are available at Consultant level for allied health professionals, including paramedics. There are consultant nurses in a wide range of specialities, including emergency medicine, renal medicine, cardiology, and forensic psychiatry. The role of 'consultant' sits at the top of a career framework that is standard for all national health service clinical professions, and includes, rather confusingly, 'practitioners' (first level qualified professionals such as nurses), specialist practitioners (such as emergency nurses with an additional sub-degree level qualification), advanced practitioners (Masters-qualified with some degree of autonomy), and consultant. It is apparent from this that there is even some confusion and disagreement on titles between professions and the major health employer in the UK.

The drive to extend the role of nurses and allied health professionals in the UK has arisen from rapidly increasing demands on health services, including emergency and unscheduled care. There has been a stated desire to support higher standards of patient care by encouraging good clinicians to stay in a patient care role, rather than being forced to seek career progression by moving into management. However, one suspects that there may also be a political component – an attempt to break the power base of the medical profession, perhaps? In reality, whilst a small number of our medical colleagues have resisted this change, most have been very supportive, expressing concerns only when these were justified by attempts to cut corners and costs in training programmes. Indeed without medical input, most of the opportunities available for career enhancement would not have been realised. A number of pilot extended practitioner roles have been trialled in the last few years by the English Department of Health, including anaesthetic, surgical, neonatal transfer, critical care transfer, and medical (primary care) practitioners. The trial is now over, and central funding has been withdrawn, so it is now for local health service commissioners to determine if these roles have a future.

Response from Chris Hawkins to Dr. Considine and Professor Woollard

Thank you for the opportunity to respond to Dr Considine's and Professor Woollard's comments.

Dr. Considine further highlights the increasing demand on health care resources and emphasises the capacity of Nurse Practitioners to become a significant component in addressing the increased strain on these limited resources. Of particular interest are Dr. Considine's comments regarding the need for research on the role of Nurse Practitioners, I would go further to say that as the role of Nurse Practitioners varies widely around the

world; this research should be local to ensure that it assists us all in developing a Nurse Practitioner role that best meets the needs of the patients we serve.

Professor Woollard has reinforced the importance of ensuring that the qualification we wish to require of Nurse Practitioners in Australia is both appropriate for the role and clearly defined. Only by ensuring this will we maintain the trust of our patients and continue to achieve the confidence of our colleagues in other disciplines. We are fortunate that our leaders have had the foresight to ensure that Masters preparation is the requirement for Nurse Practitioner endorsement throughout Australia.

As a point of clarification, it is worth noting that in Australia the Nurse Consultant role is seen as a Registered Nurse position, requiring no further endorsement and not permitting areas of practice not usually undertaken by Registered Nurses. Whereas, the Nurse Practitioner role is both legally defined and offers the capacity for the Nurse Practitioner to undertake advanced areas of practice not available to Registered Nurses.

Whilst Dr. Considine highlights the low rate of Nurse Practitioner prescribing, Prof Woollard raises the extent of the formulary available to specifically prepared Registered Nurses in the UK. This is currently an area of considerable debate in Nurse Practitioner circles around Australia. Personally, I believe that to best care for our patients Nurse Practitioners should also have access to the whole formulary available on the Pharmaceutical Benefits Scheme. With appropriate training this would permit Nurse Practitioners to wholly care for their patients without having to delay treatment whilst they seek co-prescribing by medical practitioners. In my opinion such delays can only lead to reduced equity of access to timely health care and unnecessary delays in treatment.

The Author would like to thank Chris Hawkins, Dr. Considine and Professor Malcolm Woollard for contributing to this interview.

Other interviews by the Author:

- [**Removal of Invasive Devices from Deceased Persons: Forensic implications for Paramedics - A Victorian Perspective. Interview with Professor Stephen Cordner on 11th May 2005, followed by responses from Dr. Hugh Grantham and Dr. Garry Wilkes.**](#)
- [**Developmental Disability Medicine: Is it time for its inclusion into the paramedic curriculum? Interview with Dr Jane Tracy on 27th April 2006, followed by responses from Andrew McDonell and Melinda Service.**](#)