

Abstract and Summary of the Monograph ~

APRNVoices: Holes in the Historical Fabric of American Nursing

An Oral History by Martha M. Libster, PhD, MSN, APRN-CNS, APHN-BC

©2014 Golden Apple Publications

Free Download of Complete Monograph 48 pages – Available Upon Request

Abstract:

Purpose: While the Affordable Care Act in the United States has introduced significant change in American health care policy, the nursing profession has undertaken its own substantial attempt at national reform of the licensure, accreditation, certification, and education (LACE) of Advanced Practice Registered Nurses through what is known as the Consensus Model (CM). The purpose of this paper is to present some of the current concerns with the CM and its implementation through LACE as themes identified from an oral history study of the “voices” of APRNs, particularly those who have worked for decades as Clinical Nurse Specialists. **Methods:** The methods used in the study include oral history following the research guidelines of the Oral History Association and narrative inquiry. **Setting/Sample/Design:** The “voices” of 130 APRN participants were collected via an anonymous online survey format. Seven themes observed in the APRNVoices stories are analyzed in juxtaposition with seven themes derived from review of the minutes from the National Council of State Boards of Nursing “State of Consensus” meeting in April 2014. **Results:** The results of this APRNVoices study suggest that seeking “consensus” through state-to-state uniformity challenges state authority to construct statute and leads to an unraveling of the historical fabric supporting the identity of the Clinical Nurse Specialist and its holistic paradigm of professional nursing practiced by many in America. **Implications:** A discussion of the analysis of themes, solutions through storytelling, and the purpose of including dissensus in policy making and statute construction ensues.

Keywords: *Consensus Model; Advanced Practice Nursing; Oral History; Narrative Inquiry; LACE*



Summary:

The APRN Consensus Model (CM) is a regulatory model in nursing designed to align licensure, accreditation, certification, and education (LACE) of advanced practice nurses. It is believed that the model will provide a “more uniform system of new opportunities through the possibility of ease of mobility across state lines” and is designed to “elevate the role of APRN’s and increase job satisfaction through opportunities to practice more independently.” (ANCC FAQ, 2012) Representatives from more than 40 nursing organizations have participated in the development of the APRN Consensus Model and now the implementation of LACE. There are many APRN’s and APRN educators who are satisfied with this historic change and have experienced the transition with ease. Current leaders implementing the CM/LACE argue that it is time to “move forward,” because they have fulfilled their obligation for listening to public (i.e. the larger body of practicing APRN’s) comment years ago; however, a new dimension of concern has begun to surface as LACE moves forward. The study described here suggests evidence for an emerging story of dissensus. There are practitioners, nurse leaders, and educators with significant concerns. These concerns range in intensity from the stressors imposed on family and practice, to prohibitive costs of compliance, to perceived evidence for restraint of trade. Two of the most prevalent concerns are the ability to become compliant with frequently changing regulations and the seeming inability for some experienced APRN’s to continue to practice at the level of their education and experience. This is particularly disturbing given this time of shortages of experienced health care providers.

The methods used in the study include oral history following the research guidelines of the Oral History Association and narrative inquiry. The “voices” of 130 APRN participants were collected via an anonymous online survey format. While some in this study, like their colleagues working on the implementation of LACE, may have agreed initially to the implementation of the CM with the hope of resolving some issues in APRN practice such as inconsistency between states about licensure requirements, the CM/LACE activity stressing one level of entry is clearly having significant negative effects on the professional experiences of APRNs, most notably in the experienced psychiatric nursing CNSs in the field, who were more than the majority of respondents in this study. Some clinicians are losing their livelihood when they have served their communities well, harmed no one, committed no crime, and in some cases trained those Nurse Practitioners who are now taking their places. The way that the issue of grandfathering is being handled is perhaps the most disturbing for many of the APRNVoices cited in the monograph. It is one thing for a profession to devise a new educational preparation program and tie it to licensure. It is another to require professionals who have had honorable careers for decades to return to college or university for more education and fulfill new requirements for practice.

Those who are satisfied with the changes represented by the current Consensus Model and LACE guidelines as well as with the emerging consensus forming around philosophical underpinnings of those adopted guidelines are given forum for expression,

such as in the media campaigns promoting the support of the Consensus Model in all 50 states. There are other dissenting "voices" of APRNs, which are not given a forum for expression during this important historic transition. This study was an attempt to provide a place for concerned participants to relay their stories.

While many acknowledge that some of the issues the CM has sought to address have been a challenge for the profession for some time, the concerns voiced in this study as repeating themes deal with the way practicing APRNs, specifically psychiatric CNSs, are being treated as a result of the significant policy changes in APRN education and licensure. Seven themes observed in the recordings of the APRNVoices stories were analyzed in juxtaposition with seven themes derived from review of the minutes from the National Council of State Boards of Nursing “State of Consensus” meeting in April 2014. They are:

- | | | |
|----|-------------|--|
| 1. | APRNVoices: | “I’m not good enough...no matter what I do...” |
| | CM: | Competencies Not Hours |
| 2. | APRNVoices: | “I Can’t Move...” |
| | CM: | Moving Forward |
| 3. | APRNVoices: | “I am being discarded and deceived...” |
| | CM: | Working Toward the Future |
| 4. | APRNVoices: | “I am being forced...” |
| | CM: | One Level of Entry |
| 5. | APRNVoices: | “Patients matter...so do I” |
| | CM: | Safety |
| 6. | APRNVoices: | Excessive Value Placed on Prescriptive Authority and Medicalization of Advanced Practice Nursing |
| | CM: | Standardization Not Disenfranchisement |
| 7. | APRNVoices: | Although it was not a major theme, there were some participants who have not experienced change. |
| | CM: | Change |

One of the major overarching themes is that the CNS role is being dismantled and replaced by the NP title and role even though the profession recognizes the differences in the roles. In 2006, the NCSBN’s draft “Vision Paper: The Future Regulation of Advanced Practice Nursing” states that in seeking uniformity under a CM, Clinical Nurse Specialists will be “grandfathered and called nurse practitioners.” The CNS is, in fact, being required to succumb to absorption into an NP paradigm. For some CNS specialties, there may be little shift in ideology. Others, however, risk losing their identity all together as some of the APRNVoices have said repeatedly in the study.

It is a historic period for APRNs not only because of this significant shift in APRN ideology and statute represented by the CM. The social problems related to the extent of states’ and professions’ regulatory authority and boundaries are being sorted out at the federal level as well. Questions about restraint of trade/anticompetitive practice are being raised in many professional arenas, particularly by the health professions. In October 2014, the U.S. Supreme Court heard case number 13-534 “The North Carolina State

Board of Dental Examiners v. Federal Trade Commission” on antitrust issues. All four American APRN professional associations joined together as *amici curiae* expressing concern that any ruling by the Supreme Court in this case would not in any way negatively “impact the ability of nursing professionals to practice to the fullest extent of their professional training and education” thereby potentially “limiting patient access to quality care” (Amici Curiae Nursing, 2014). The ruling in this case will be in June 2015. There is hope that it will provide further insight from the level of the Supreme Court about the reach of professional regulatory authority and its effects on practicing clinicians, such as those represented in this APRNVoices study. Some participants in our study raised the question as to whether NP model dominance and subsequent suppression of the CNS might be construed as “restraint of trade.”

While some CM leaders have framed concern and dissent to the CM/LACE as a lack of cooperation and compliance, the APRNVoices and their representatives in organizations have requested additional dialogue in an attempt to retain experienced, quality APRNs whose jobs and livelihood are in jeopardy. It is quite apparent from minutes and reports, such as the presentation on the state of the CM after five years at a 2014 NCSBN meeting, that achieving consensus about the CM has been fraught with controversy. Those involved have been committed and worked very hard at a project they believed in. None would argue. However, dialogue with clinicians in the field appears now to be non-existent. CM and LACE meeting minutes demonstrate that organizational leaders attend meetings by invitation only. This is quite different from the typical practice of State Boards of Nursing that invite the public to comment and attend meetings regularly when policies are being discussed. The frustration that results from exclusion is demonstrated by the deep emotion expressed in the APRNVoices stories. While ambiguity about APRN practice state-to-state may cause anxiety and concern related to potential lack of control, the alternative of creating uniformity in consensus might ultimately be counterproductive in the implementation of the policy changes. The very nature of the drive to seek and achieve consensus diverts discussion to the back room. This study, however, suggests that there are important matters of concern to APRN-CNSs in particular that still need to be addressed if they too are to be able to move forward.

Many of the public documents that detail the evolution of the CM and LACE are referenced here. They suggest that there is a form of control if not censorship occurring in the establishment of the CM by LACE and the NCSBN with the stated intent of safeguarding the public, but, as those who oppose the CM in California point out, without evidence for error, malpractice, harm, or public complaint. History is a record of human events over time. Often the history that is written is a record of the "Voices" of those with power. This study has given opportunity for those without social power to voice their stories. Evidence from American nursing history is included in the monograph that describes an example of identity censorship within the discipline during the 19th century importation of the Nightingale (British) Model of Secular Education for the establishment of the "Trained Nurse." This resulted in the exclusion of a large segment of professional nurses' contributions from our history. The APRNVoices in this study strongly represent a death in terms of their perceived loss of professional vision and

identity. A new identity is being birthed and many hope that there will be “consensus” across all 50 states as to what that identity will be and not be.

Is social reform possible without the acceptance of multiple views? Pluralism rather than consensus/uniformity guides the building of caring peaceful community. Valuing pluralism and realizing the potential benefits of dissensus promotes community building and peace. One way to start dialogue when attempting to solve tough problems is to tell stories. That is the simple approach to opening dialog attempted here. Creativity flows when there is open dialogue. Dialogue opens the door for the possibility of the emergence of new solutions. Caring communities such as advanced practice nursing have the potential to meet great ideas in the air, catch them as story and generate new solutions in health care. But in a culture that values consensus as uniformity, the stories of dissensus must be caught too. Those who listen carefully to the dissensus stories actually benefit from the process. Within the dissensus stories lies evidence for the gaps or holes in the fabric of transition. There are always holes in policy; we know, because some person somewhere will find that hole and walk through it or fill it. Holes are part of nature. They are part of the nature of being human.

LACE is an interesting choice of acronym for this controversial policy in the history of American advanced practice nursing. Lace, a fabric, is actually a very fitting metaphor for the current state of the APRN CM in the US. There are holes in consensus and dissensus. There are holes in the CM too. The most striking feature of lace is that its delicate beauty is as a result of holes in the fabric. Traditionally, though the holes are formed as the lace is made—they are not cut out afterwards. According to the Lace Guild (www.laceguild.org) established in 1976, despite the effect of the industrial revolution and the emergence of bobbins and machine copies of handmade laces, the craft of handmade lace making still exists today. It takes time to make and may be more costly, but some still prefer traditional handmade lace.

It may take more time and it may be costly, but this study suggests that there must be a kind and generous solution that would allow the valuable caring tradition represented in the stories of the APRNVoices to be preserved within the emerging CM. It is perhaps the good people represented by the APRNVoices who may be just the right size and shaped “holes” of dissensus that will beautify the LACE.