

Advanced Practice in Nursing and the Allied Health Professions

Third Edition

Edited by

Paula McGee

 **WILEY-BLACKWELL**

A John Wiley & Sons, Ltd., Publication

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This edition first published 2009
© 2009 by Blackwell Publishing Ltd

Blackwell Publishing was acquired by John Wiley & Sons in February 2007. Blackwell's publishing program has been merged with Wiley's global Scientific, Technical, and Medical business to form Wiley-Blackwell.

Registered office

John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ,
United Kingdom

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9600 Garsington Road, Oxford, OX4 2DQ, United Kingdom
2121 State Avenue, Ames, Iowa 50014-8300, USA

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Library of Congress Cataloging-in-Publication Data

Advanced practice in nursing and the allied health professions / edited by Paula McGee.—3rd ed.
p. ; cm.

Rev. ed. of: *Advanced nursing practice* / edited by Paula McGee and George Castledine. 2nd ed. 2003.
Includes bibliographical references and index.

ISBN 978-1-4051-6239-5 (pbk. : alk. paper) 1. Nurse practitioners—Great Britain. 2. Nursing—Great Britain. I. McGee, Paula. II. *Advanced nursing practice*.

[DNLM: 1. Nurse Clinicians—trends—Great Britain. 2. Allied Health Personnel—trends—Great Britain. 3. Nurse Practitioners—trends—Great Britain. WY 128 A2435 2009]

RT82.8.A365 2009
610.73'60941—dc22

2009008239

A catalogue record for this book is available from the British Library.

Set in 10/12.5 pt Palatino by Laserwords Pvt Ltd, Chennai, India
Printed in Malaysia

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Introduction

Advanced practice is an approach to health care that enables practitioners to meet the everyday needs of their patients in whatever setting these arise. Advanced practitioners may be found in any health profession. Their enhanced knowledge and skills complement those of medicine and, therefore, increase both access to and the availability of health care. Advanced practice represents a reconceptualisation of professional roles in health care: a move away from the traditional approach, in which medicine was pre-eminent, towards a more collegiate model in which the strengths of each profession can be fully utilised. This reconceptualisation requires health professions, societies and governments to recognise the increased complexities of modern health care and to find the best ways of addressing these. In other words, modern health care leads people to ask what sort of a health-care practitioner will best meet their needs, what type of doctor, nurse or physiotherapist is needed and what they should be able to do.

Nursing provides an example of this reconceptualisation. In countries as diverse as Botswana and the United Kingdom, nurses make up by far the largest part of the health-care workforce. They are, therefore, an important resource through which health care is delivered, especially to vulnerable and socially marginalised populations (World Health Organisation 2000). It is appropriate that governments should attempt to make good and better use of this resource. One example can be seen in the United Kingdom. The NHS Plan introduced a wide-ranging reform of the health service that had implications for all health professions including nursing. New roles would allow nurse-led services to be developed. These would enable nurses to admit and discharge certain patients, manage caseloads, prescribe and treat patients. They would also be trained to perform certain types of surgery, triage patients and carry out resuscitation procedures (DH 2000). These plans facilitated the development of advanced nursing practice, allowing it the freedom to develop new approaches to care and treatment. They also provided a basis from which advanced nurses could function as clinical and professional leaders (DH 2000).

Advanced nursing practice now has many different forms, both in the United Kingdom and worldwide. In remote areas and developing countries, primary care providers and advanced nurse practitioners are well placed to promote health, assess, diagnose and treat common ailments. In secondary care, they are able to extend their role, taking responsibility for aspects of patient care that might previously have required medical attention, for example, the management of patients with long-term conditions. In all settings, advanced practitioners are able to apply their knowledge and skills to the development of innovative approaches to care that meet the health needs of local people (Schober and Affara 2006).

Alongside this development is a trend towards comparable changes in allied health professions. In the United Kingdom, for example, the NHS Plan introduced new roles for pharmacists in managing repeat prescribing and other aspects of care, especially for patients with long-term conditions. Other allied health professionals were also given the opportunity to develop their roles and pioneer new ways of working. Physiotherapists, occupational therapists, speech therapists and many other professionals could become consultant practitioners working closely 'with senior hospital doctors, nurses and midwives in drawing up local clinical and referral protocols alongside primary care colleagues' (DH 2000, p. 86). Medical practice was also to be reconfigured to ease pressure on general practitioner (GP) services and allow hospital consultants to develop new ways of working (DH 2000).

Inherent in these developments is a huge cultural shift away from traditional modes of operation towards a patient-centred system of health care. This cultural shift has required changes in the initial preparation of practitioners, equipping them to work more in partnership with patients and reduce health inequalities by ensuring that everyone can access and use services. Post-registration education has also changed to enable practitioners to further enhance their professional knowledge and skills and take the lead in working with certain patient groups. Advanced practitioners are, therefore, prepared as versatile professionals, able to provide both direct care to patients and leadership to colleagues.

This climate of professional and organisational change has provided many opportunities for advanced practitioners to combine their traditional expertise with new health knowledge and technologies. Such combinations exemplify the growing confidence of practitioners in testing out and adopting new roles, even if these mean taking on work previously the preserve of other professionals. This does not mean that advanced practitioners are becoming doctors. Their roles are meant to complement, rather than replace medical practice, leaving doctors free to develop their own work in new ways that better meet the needs of patients. Nevertheless, there is a risk that advanced practitioners may leave too much of their traditional work to assistant practitioners in order to take on tasks that they regard as more exciting or prestigious. It is a matter of balance. Patients still need to be washed, fed and made comfortable; they still need help with mobility problems, speech and mental health difficulties. However, they also need expert care from practitioners who are able to draw on the latest authoritative evidence and competently implement new health technologies.

The aim of this book

This new edition is based on the view that, in health professions, there is a form of practice, which exceeds that achieved by initial registration and which is distinguishable by definable characteristics. This is referred to, throughout this book, as *advanced practice*. This book aims to clarify these characteristics across different professional fields with the intention of

- presenting an account of developments in different professions with a view to the possible future establishment of parity between advanced practitioners, regardless of their particular origins;
- examining the ways in which advanced practice is conceptualised both theoretically and in response to health policies;
- demonstrating the actual and potential contributions of advanced practice to direct patient care;
- examining the influence of advanced practitioners as professional and clinical leaders;
- reflecting on the preparation required for advanced practice and the ways in which practitioners are currently developing their careers;
- developing an agenda for future research and development in advanced practice.

Key features of this new edition

This third edition has been substantially revised to include both nursing and allied health professions. As in previous editions the key questions are presented at the end of each chapter. It is hoped that these will help readers to continue to debate the many issues raised in this book and contribute towards the further development of advanced practice in health professions.

The book begins with an overview of the development of advanced nursing practice in the United Kingdom. This allows continuity with previous editions, which, together with this chapter, form what is probably the only account of how advanced nursing practice developed. The chapter highlights several issues that are further discussed as the book unfolds: the influence of health policy, the role of professional bodies and the interface with medicine. The chapter shows that advanced nursing practice has not developed in an orderly or predictable fashion. Rather, development seems to be a piecemeal affair with many disparate elements that do not necessarily fit neatly together partly because so many different factors and factions have been involved and also because no one thought to maintain a running record of events; the result is an incomplete account of developments.

In Chapter 2, Alistair Hewison takes up and expands upon the issue of health policies in the United Kingdom. As he points out, this is no easy task given that the NHS seems to be in a constant process of reform and change. This chapter presents an accessible explanation of these reforms and their implications for advanced nursing practice as a new role through which the changing health-care needs of the population can be accommodated. As this chapter points out, one of the main problems with advanced nursing practice is that, in the United Kingdom at least, the profession seems unable to make up its mind about what it should be. Consequently, advanced or higher-level nursing is not clearly defined.

Nursing and health policy provide a basis for introducing advanced practice in allied health professions. Chapter 3 begins by examining the implications of health

policy and reforms in terms of the introduction of consultant practitioners and the subsequent pathways taken by professional bodies. This is followed by an overview of developments in physiotherapy, a profession that has, so far, relied heavily on nursing research, particularly that of Benner (1984). Benner (1984) proposed that nurses developed through several stages, beginning as novices and gradually progressing to become experts. Occupational therapy has also drawn on Benner's (1984) work in developing post-registration roles and levels of practice. The one allied health profession that appears to be out of step with this reliance is radiography. In this instance, health policy and the example of nursing do not seem to have been driving forces. Instead, as David Cole explains, advanced roles in radiography have developed in response to direct pressure, on NHS trusts, to improve pay and careers. This pressure came directly from practitioners and this chapter presents the first published account of their efforts that appear to have resulted in a sonography role that is very similar to advanced roles in other professions.

Changes in health policy, new developments in treatment and care and the rise of advanced practice in allied health professions necessitated a reappraisal of the conceptualisation of advanced practice put forward in the last edition (McGee and Castledine 2003). Chapter 4 presents an updated view of the three elements first described in the previous edition: *professional maturity*, *challenging professional boundaries* and *pioneering new practice*. These elements are discussed in a broader way that explains their applicability to allied health professions and the ways in which emergent advanced roles may interface with medicine. This discussion puts forward the view that direct practice and engagement with patients, together with interpersonal skills, form the core of advanced practice irrespective of the professional discipline involved. To be considered advanced, the practitioner must spend a significant amount of time in practice; without this, individuals cannot be considered to be advanced, no matter how competent they are in other ways. The next two chapters expand on the key activities of assessment, diagnosis, treatment and care within advanced roles. Chapter 5 presents a discussion of the different types of assessment that an advanced practitioner may employ. In Chapter 6, Sue Shortland and Katharine Hardware present an overview of the regulations and governance issues concerning the prescription of medication.

Chapters 7 to 10 present, for the first time, views of advanced practice from differing professional perspectives. In Chapter 7, Linda Hindle describes her work in dietetics and, in particular, in helping obese people to manage their weight more effectively. In Chapter 8, Lynne Frith and Janette Walsh discuss specialist and consultant roles in occupational therapy. These have been slow to develop but it is anticipated that further developments will take place as the profession develops a clearer career structure. Chapters 9 and 10 see a return to nursing. In Chapter 9, Mark Radford discusses his views as an advanced nurse practitioner. This is followed by Kate Gee's account of her work in cardiology, based on a model devised by Zubialde *et al.* (2005).

The next three chapters address other aspects of advanced practice. These may be part of direct interaction with patients but can also apply in working with colleagues and other staff. Chapter 11 examines the importance of cultural competence. As senior members of their professions, advanced practitioners should be skilled in working

with patients and colleagues from diverse backgrounds. Moreover, they should be able to promote cultural competence within the organisation as a whole ensuring an ethical environment in which patients and staff are treated equitably. In Chapter 12, Sally Shaw addresses the role of the advanced practitioner as a professional and clinical leader. The indicators of successful leadership are deliberately set out as checklists to provide a tool to help practitioners and their managers to determine progress. The topic of management is taken up by Paula McGee and Mark Radford in Chapter 13. This chapter sets out the key points that concern managers, including strategic planning in the light of current health service priorities, and examines the implications of these for the advanced practitioner as both a clinical expert and a manager. The chapter also addresses issues in managing advanced practice posts and the need to evaluate their impact.

Chapters 14 and 15 address the preparation and careers of advanced practitioners. Chapter 14 examines the issue of competence and the types of expertise required by advanced practitioners. These competences fall into two groups: generic and specialist. The chapter proposes that generic competences could be common to all advanced roles; specialist competencies could be generated by the individual practitioner's specific field and profession. Chapter 15 focuses on career development and presents, for the first time, the outcomes of a survey, by Chris Inman and Paula McGee, of graduates from an MSc advanced nursing practice course. This survey reinforces earlier statements about the piecemeal development of advanced nursing practice in the United Kingdom and the need for progress on matters relating to employment, work activities and long-term career prospects.

The final two chapters present two different aspects of advanced practice. In Chapter 16, Madrean Schober discusses the factors that have contributed to the international development of advanced nursing practice and highlights the different approaches adopted by various countries. It is hoped that, in future, this chapter may be complemented by a similar account of developments in allied health professions. However, there is still much to be done before this can happen. Chapter 17 draws the book to a close by setting out an agenda for further work based around direct practice, collaboration with service users, inclusivity, professional regulation and control, education and assessment. These ideas take account of the recommendations set out in the most recent health service review that provide many exciting opportunities for advanced practitioners in nursing and allied health professions (DH 2008).

Paula McGee

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Chapter 1

The Development of Advanced Nursing Practice in the United Kingdom

Paula McGee

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Introduction

The United Kingdom Central Council (UKCC) defined advanced practice as 'adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs and with advancing clinical practice, research and education enrich professional practice as a whole' (UKCC 1994:20). To a certain extent, this definition can be taken to represent the culmination of years of work and debate in which individual nurses explored and experimented with new ideas and roles that might enable them to provide both better patient care and meaningful professional activity. In this context, the Council can be seen as trying to bring some sort of order to the patchwork of established and emerging roles beyond registration by issuing a statement about the form these roles should take. Alternatively, the definition can be regarded as the beginning of a thorough examination of the nature of post-qualifying nursing practice, about what patients, the profession and society as a whole want from nursing and the impact this might have on other health professions, especially medicine.

One of the difficulties in both analyses is that the Council never quite made clear how the definition of advanced practice would apply to the realities of daily life in practice. Consequently, there was a great deal of confusion among nurses, managers, employers and other health professionals as to what the Council intended. This confusion created a fertile ground for debate, both useful and acrimonious, as nurses and other health professionals tried to determine the most appropriate way forward; there was quite a lot of research, some of which helped illuminate the path. In practice, there was a proliferation of posts and roles that were labelled as *advanced* but that were never formally scrutinised to ascertain whether they conformed to the Council's ideas (RCN 2008).

In spite of, or maybe because of, the fluidity of this situation, some consensus has emerged in which there appears to be an agreement that advanced practice should contain a clinical component, set the pace for changing practice and be underpinned by formal preparation that is beyond the level of initial registration. There is also an acceptance that practice is not static and that nursing must continue to move forward. However, there is far less agreement about the nature of this clinical practice, how that move forward should be made or even the direction it should take.

This chapter presents an examination of the main issues and influences that have contributed to the current state of advanced practice in the United Kingdom and the further developments anticipated. The chapter closes with some key questions to prompt further discussion.

Health policies and reforms

The health policies and reforms instigated by the Labour government during the late 1990s and early 2000s have had a marked effect on the development of advanced practice by creating opportunities for innovation both in the development of nursing roles and in clinical practice. The reforms were intended to improve the quality of health services by ensuring that they were tailored to meet local needs and reduce health inequalities (Box 1.1). The reforms were also aimed at valuing staff and developing a more transparent approach to both the management of information and the decision-making process (DH 1997, 2000, 2001a). The strategy for nursing that accompanied the introduction of these policies and reforms made clear that the profession had an essential role to play because nurses were seen as ideally placed to promote health, particularly in community settings such as schools and places of work (Box 1.2). Their skills and expertise could be directed towards early identification and treatment of health problems and the provision of support for those with long-term conditions, especially during periods of crisis. Such nurse-led activity could offset the need for more expensive services including admission to hospital. Where such admission was necessary, nurses could use their skills to develop care pathways, promote continuity of care and address specific problems such as infection control (DH 1999).

Box 1.1 Core principles of health policy reforms

- Provision of a health service that covers all clinical needs is available to everyone and is free at the point of delivery
- Development of individual packages of care and services that are accessible by, and which meet the needs of, local populations instead of a *one-size-fits-all* approach
- Improvements in the quality of care and greater transparency about what is happening in health-care organisations, both locally and nationally
- Creation of a better working environment for staff
- Patient and public involvement in service design and delivery
- New ways of working, better interprofessional and multi-agency working
- Promotion of health and the reduction of health inequalities

Source: Adapted from Department of Health (2000) *The NHS Plan. A Plan for Investment. A Plan for Reform*. Wetherby, DH.

Box 1.2 The role of nursing in health policy reforms

- Promoting health in ways that meet local needs
- Reducing health inequalities, especially among members of marginalised groups
- Instigating nurse-led initiatives to provide faster access to services and treatment
- Expanding roles in primary care settings to reduce hospital admissions and enable people with long-term conditions to remain at home
- Independently prescribing medicines
- Expanding roles in secondary care and collaborating with other professionals to provide specialist care, develop care pathways and promote evidence-based practice
- Providing intermediate care and promoting independence for those with complex needs
- Tackling specific problems such as infection control
- Promoting seamless care and inter-agency working

Sources: Summarised from Department of Health (2005) *Supporting People with Long Term Conditions: Liberating the Talents of Nurses Who Care for People with Long Term Conditions*. London, DH.

Department of Health (1999) *Making a Difference. Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare*. London, DH.

The UKCC and *higher-level practice*

The Council recognised the growing concern about the lack of understanding and agreement regarding forms of practice beyond registration, both within the profession and among employers. There was a lack of clarity about the terms *advanced*, *specialist*, *specialism* and *speciality* as used within the Council's statements about practice after registration, and practitioners had difficulty in distinguishing between them, especially with regard to the differences between working in a *speciality* and being a *specialist*. Similarly, distinctions between the roles, responsibilities and preparation of both *advanced* and *specialist* nurses were unclear. This lack of clarity had the potential to erode public confidence in nursing (Waller 1998).

In response to these concerns, the Council entered into consultation with the nursing, midwifery and health visiting professions, including practitioners, stakeholders and professional organisations, about forms of practice beyond registration; after much deliberation, the Council accepted that these forms were actually levels of practice but carefully avoided associating these with the term *advanced* (UKCC 1999). From this consultation emerged the concept of *higher-level practice*, which the Council explained as applying to those nurses who were clinical experts and were able to apply their extensive knowledge, skills and expertise to develop practice and improve patient care (UKCC 1999). Following this consultation, the Council pressed forward with plans to develop *higher-level practice*, further assisted by 700 volunteer nurses, midwives and health visitors, from across all four countries of the United Kingdom. The result was a standard for *higher-level practice*, incorporating seven domains that were later taken up by employers to facilitate the development of nurse consultant posts. The final report from the Council's working group made 15 recommendations that were then referred to the then newly constituted Nursing and Midwifery Council (NMC) in 2002 (UKCC 2002, Castledine 2003).

One of the many problems with the concept of *higher-level practice* was the inexact use of terminology; words such as *expert* require some clarification. There are varying opinions on what it takes to be an *expert*, none of which seems to provide a completely satisfactory explanation (Table 1.1). The Council itself did not venture to explain what it regarded as an *expert*, and gradually *higher-level practice*, *expert* and *advanced practice* were used interchangeably. The Council's decision to award all the volunteers who met the higher-level standard the status of advanced practitioners compounded the situation and subsequently there has been no serious consideration of what these terms mean for advanced nursing.

The interface with medicine

The introduction of the New Deal and the Working Time (Statutory Instrument 2002) Regulations 2002 created opportunities for advanced nursing by altering the working lives of doctors through reducing their contracted hours and improving their training (NHSE 1991). In August 2007 the junior doctors' contracts stipulated a maximum working week of 56 hours. This will be reduced to 48 hours by August 2009

Table 1.1 Perspectives on expert practice.

Author	Definitions	Comments
Benner (1984)	An <i>expert</i> is one who is able to intuit the essence of a situation and to focus accurately on a clinical problem; is not distracted by irrelevancies	Benner's work focuses on clinical practice. The <i>higher-level practice</i> standard incorporates domains that are not necessarily associated with direct practice. It is not clear whether her views of an expert performance would apply
Hamric (2005)	Clinical practice is the focus of <i>advanced practice</i> but there are other competencies which are also essential. These include acting as a consultant for others. The advanced practitioner is described as an <i>expert</i>	The term <i>expert</i> is not examined in depth but <i>expert</i> clinical practice is only a part of advanced practice. Thus a nurse may be highly proficient in one sphere but not <i>advanced</i>
Jasper (1994)	The <i>expert</i> must possess a specialised body of knowledge, extensive experience, be able to generate new knowledge and be recognised as an <i>expert</i>	Jasper does not elaborate on how nurses acquire such knowledge the nature of that knowledge, and whether or how <i>expert</i> knowledge differs from that of others. The deeper knowledge of the <i>higher-level</i> practitioner must be recognised by others
Zukav (1979, pp. 34–5)	The <i>expert</i> is someone who 'started before you did' and 'always begins at the centre, at the heart of the matter' with the enthusiasm of acting for the first time	Zukav's <i>expert</i> has a store of knowledge on which to draw and thus may be said to be dealing with what is known. In pioneering new roles the <i>advanced</i> practitioner is entering into the unknown

Sources: Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, California, Addison Wesley.

Hamric, A., Spross, J. and Hanson, C. (eds) (2005) *Advanced Nursing Practice. An Integrative Approach*, 3rd edn. St Louis, Elsevier Saunders.

Jasper, M. (1994) Expert: a discussion of the implications of the concept as used in nursing. *Journal of Advanced Nursing*.

Zukav, G. (1991) *The Dancing Wu Li Masters*. London, Rider.

(DH 2007). Alongside these contractual changes is a move away from the traditional apprenticeship system for training junior doctors towards a new, competency-based scheme. All junior doctors now enter a 2-year foundation programme that equips them with '*basic practical skills and competencies in medicine and will include: clinical skills; effective relationships with patients; high standards in clinical governance and safety; the use of evidence and data; communication, team working, multiprofessional practice, time management and decision-making and an effective understanding of the different settings*

in which medicine is practised' (DH 2004a, p. 8). Those who successfully complete the foundation programme may enter a further programme to become either a general practitioner (GP) or a hospital specialist. Inevitably, implementing these programmes has affected the amount of day-to-day work that junior doctors are able to do, a situation that has been complicated by the number of senior practitioners who are approaching retirement. A flexible retirement scheme was introduced to encourage hospital consultants to continue in post beyond the age of 65 and financial incentives were offered to GPs for each additional year that they deferred retirement (The Lords Hansard 2002).

The implications of the reduction in the availability of doctors were not lost on the British Medical Association (BMA), which proposed that, in primary care, nurse practitioners (NPs) could act as the first point of contact for most patients and refer them on to doctors or other health professionals if necessary. Similarly, in hospitals, specialist nurses could act as care coordinators (BMA 2002a, b). Even prescribing by nurses and pharmacists was accepted provided that it was 'limited and in line with the individual's training and experience' (BMA 2006). The BMA was thus supportive of new roles in nursing to the extent that its members expressed frustration at, as they saw it, the failure of both employers and the NMC to bring about a change, which resulted in 'the undermining and de-valuing of nurses with extended roles' (BMA 2004).

This justifiable criticism is not new. The history of advanced practice shows that some doctors have been very influential in spearheading new developments, often providing a vision of what could be achieved. For example, in 1957, in North Carolina, Dr Eugene Stead envisaged an NP's role that was between nursing and medicine and found a nurse to share this vision but was opposed by both the senior nurses in the local university and the National League for Nursing, which refused to accredit the necessary postgraduate training course because doctors would have had to teach much of the content. As a result of this failure, the university instituted a physicians' assistant (PA) course. In another example, Loretta Ford, one of the most well-known NPs, worked with Dr Silver setting up a postgraduate course in paediatric care for poor rural children in Colorado but the American Nurses Association would not support this, preferring to concentrate on preparing nurses for teaching or management. In both examples, the doctor provided or helped to provide a significant vision through which particular health needs might be met; it was nursing's professional bodies that appeared to have difficulties. Unsurprisingly, the doctors concerned lost interest and moved on (Dunphy *et al.* 2004).

Nursing theorists are keen to point out that advanced practice is about developing nursing and not about taking over medical work, but the interface between the two professions is not clear cut. Advanced NPs diagnose and treat illness – activities that are perceived by patients to be part of the doctor's repertoire of skills. There is certainly an area of overlap between the two roles. For example, the advanced NP and the doctor may diagnose repeated and severe tonsillitis but it is the doctor who will have the skills required to perform a tonsillectomy and the nurse who will be best equipped to manage the post-operative period. Both will draw on the same research and use the same decision-making and problem management skills but in different ways (Hunsberger *et al.* 1992) (Figure 1.1). Thus the two roles are complementary

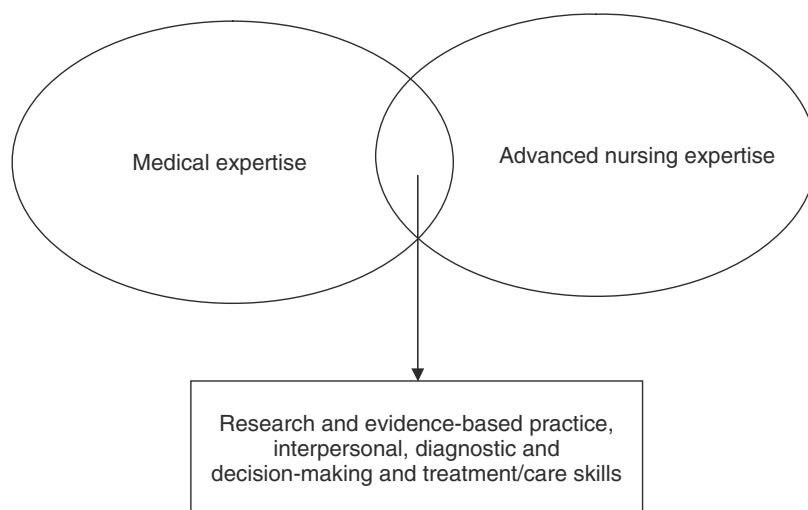


Fig. 1.1 The interface between advanced nursing and medicine (based on Hunsberger *et al.* 1992).

rather than competitive, allowing both to concentrate their efforts where they are most needed. Moreover, the holistic orientation of the advanced NP allows for greater consideration of factors that may impinge on the patient's recovery, for example, social circumstances or psychological problems. Patients often do not like to, as they see it, *bother the doctor with such details* but are likely to reveal them to an advanced nurse.

This notion of complementarity leads naturally to the idea that the two roles of advanced nurse and doctor meet as equals in the practice setting. While individual practitioners in both camps may agree with this, as a body, doctors clearly disagree. The BMA's support for advanced nursing roles was qualified by their capacity 'to improve the working lives of doctors' (BMA 2004). Nurses might extend their roles but only within 'a defined field answerable to a medically qualified doctor' (BMA 2005). The subordination of nursing to medical expertise was, therefore, to continue and there was strident protest when nurses attained positions in which this balance of power was overturned. Thus the BMA found it 'outrageous and totally unacceptable that a nurse consultant has been appointed as the lead clinician in occupational health and that she, with the assistant director of human resources, will perform the annual appraisal of the occupational health consultant' (BMA 2005).

It would seem, therefore, that the interface between advanced nursing and medicine is highly ambivalent. Individual practitioners may develop pioneering partnerships based on mutual regard for each other's expertise but formal relations between the two professions still require considerable effort on both sides. In practice, it is usually the advanced nurse who must make the first move, involving medical staff from the start of any initiative so that they understand what is happening and the reasons for it and can begin to see the potential that advanced nursing practice can bring to their own sphere of work.

The introduction of new roles

Modern matrons

The managerial roles of matrons were introduced in hospitals as part of a range of initiatives to improve the quality of service. Other initiatives included tackling standards of cleanliness, improving the quality of hospital food, the introduction of the Patient Advisory Liaison Service and benchmarking. The title of *matron* emerged following public consultation that revealed a preference for the presence of a clearly identified and authoritative presence, in each setting, to whom patients and relatives could turn for help, advice and to complain. Matrons were to take charge of a group of wards and resources to ensure that patients received the best possible care and that support services fulfilled their responsibilities to the highest standard and to provide leadership (NHSE 1999, DH 2001b).

More recently, matrons' roles have been exported to primary care settings as part of the strategy for supporting patients with long-term conditions (DH 2005). The intention is to enable patients to receive the help they need from primary care services and, therefore, reduce the number of admissions to hospital. Community matrons were intended to use case management strategies to identify patients' needs and formulate care plans based on multi-professional working to enable patients to become as independent as possible (DH 2005).

The managerial orientation of matrons' roles tends to place them outside the advanced nursing sphere. Advanced nurses are primarily practitioners engaged in direct patient care; their roles do not include responsibility for managerial issues such as staffing, budgeting or resources. Matrons, on the other hand, are concerned with precisely these factors as a means of creating environments in which patients can be given the best possible care. It is possible that there may be some areas of overlap between the two roles and research is needed to examine this unexplored territory. What is certain is that, to be effective, the advanced nurse, like the matron, must have the status, power and authority to act and to direct others when necessary. Consequently, the advanced practitioner must ensure that these issues are clearly addressed in the development of any new post.

Nurse consultants

The idea of nurse consultants is not new. In the 1970s, it was envisaged that the development of a consultant's role would provide clinical leadership but would be free from the demands of managerial responsibilities (Ashworth 1975). The health service reforms introduced in the late 1990s facilitated the introduction of nurse consultant posts (DH 1999, 2000, 2001c, NHSE 1999). Consultants were expected to be clinical experts who spent at least half their working time in practice, working directly with patients and acting as focal points for professional advice, education and research, activities similar to those required by advanced practitioners. Many of the attributes of advanced nursing practice can be found within the consultant's role and a number of advanced practitioners have gravitated towards nurse consultant posts.