The status of nurse practitioners in gastroenterology

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ABSTRACT – The role of the nurse practitioner in the UK is new. It extends the traditional role of the nurse and may help overcome some of the difficulties in communication that have bedevilled clinical practice in recent years. This paper reviews the emergence of nurse practitioners in the USA and considers their status in the UK. The philosophical basis for clinical interventions by nurses is assessed and the training needs and legal consequences explored. The future role of nurses in prescribing drugs is uncertain, but likely to be significant.

KEY WORDS: nurses, practitioners, interventions, philosophy, prescribing, training

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The emergence of nurse practitioners during the last five years will have a radical effect on the future delivery of healthcare in the UK. The recognition of nurse specialists and nurse consultants will influence training of both doctors and nurses and the way in which the general public views them. As the need for expansion in the number of those who provide healthcare becomes ever more pressing, the blurring of the therapeutic boundaries which have traditionally divided doctors from nurses, will be inevitable. Patients will seek good quality care and will be more concerned that it is timely than about its source. Indeed, patients have traditionally sought advice from nurses rather than doctors. Doctors, particularly specialists, have often been seen as remote and unapproachable. In many ways, the movement towards a more scientific and evidence-based delivery of healthcare has emphasised the remoteness of many members of the medical profession. This isolation of doctors from their patients has been the basis of many complaints and has characterised investigations such as the Bristol Enquiry.

Against this background, the opportunity to develop new models of healthcare led to the emergence of nurse endoscopists and inflammatory bowel disease nurses, alongside the more traditional role of the stoma therapist. The purpose of this review is to investigate the future status of nurse practitioners within the field of gastroenterology. The very choice of the two words, 'nurse' and 'practitioner', to describe these developments would appear to emphasise a dual role. However, the combination of care, investigation, treatment and prevention is at the core of any holistic approach to health delivery and fits well within the role of the nurse. Having said this, many of the activities of nurse practitioners go well beyond the traditional role of nurses. The background, training and the legal consequences of these new developments will be explored below.

The background

During the 1960s, Lorretta Ford and Henry Silver became concerned about the health of children living in rural areas of the USA where there were few doctors. They developed a multidisciplinary approach to this problem which led to the concept of the nurse practitioner. It clearly met a need and as a result spread rapidly across the USA. From its inception, the role was characterised by three key principles:

- It is primarily for the benefit of the patient.
- Inter-professional collaboration between medicine and nursing is essential.
- The nurse practitioner should have university-based graduate clinical training as basic preparation.

The purpose of nurse practitioners is not and should not become:

- to relieve doctors of some of their workload
- to save money through lower wages.

Equally their development is not just a fashionable exercise, but one with real purpose – the improvement of patient care and the widening of patient choice. The driving factor behind the work of Ford and Silver was the need to provide good quality care to children in rural areas lacking enough doctors. A similar need to widen the provision of good quality care exists in most specialties in the UK at present. The expansion of the traditional role of the nurse can overcome some of these deficits. However, it also encourages the view that nurse practitioners are 'doctors on the cheap'. The original American programme was very careful to ensure that this was not the case, and that nurse practitioners had their own independent professional status. This means that the distinction of nurse practitioners from specialist nurses is probably more than simple semantics. Within some countries, such as the USA, specialist

Key Points

Nurse practitioners will work alongside doctors

Nurse practitioners will be autonomous

Nurse practitioners will be legally responsible

Nurse practitioners will make clinical decisions, investigate and treat patients independently

nurses tend to provide specific nursing care and leadership rather than an extended diagnostic and therapeutic role. Within the UK, specialist nurse practice was recognised in some areas by the UKCC while nurse practitioner status remained ambiguous. However, for the purposes of this review, the term 'nurse practitioner' will be used as it encompasses a broader development of the role of nurses and includes within it those new concepts of generic training for healthcare professionals at both undergraduate and postgraduate level. It also addresses the question of how future care will be organised. There is a movement towards a patient-based service which responds to patient need rather than one which respects the tribal boundaries that separate doctors from nurses and nurses from pharmacists.

Within the USA, nurse practitioners soon found a role within the emergency departments of many hospitals, where through triage they were able to fast-track patients and prioritise care. The success of this approach depended on an early acceptance that such nurses could order X-rays and prescribe treatment. Such developments were radical changes and could only occur in an environment of mutual trust and respect between professional groups. Much can be attributed to the fact that within the USA nurse specialists already existed and nurse practitioners were simply people taking on an even more extended role and delivering more complete care to their patients.

During the 1980s, nurse practitioners began to appear in primary care in the UK. However, traditional boundaries between doctors, pharmacists and nurses have meant that developments have been much slower. The early failure to establish a central register of nurse practitioners and to define common standards of training and practice has contributed to this delay. The BSc Nurse Practitioner courses may provide a way of dealing with these difficulties.

The philosophy

Although the UKCC did not formally support these developments, they were only possible because of its recognition that such roles were within the professional scope of nursing. In 1992, *The scope of professional practice* recognised:

> *that practice remains dynamic and is able readily and appropriately to adjust to meet changing care needs. The reality is that the practice of nursing and education for that practice will continue to be shaped by developments in care and treatment, and by other events which influence it.*[1]

This document advocated that nurses should acknowledge the limits of their abilities in an open way:

> *Acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner.*

The limits on practice can therefore be imposed by individual nurses and, provided they have received adequate training, there would appear to be no limit as to the level at which they should be able to practise. It removed the concept of task-limited nurses and replaced it with the possibility of an autonomous and accountable practitioner. However, in practice limits can be placed by others and these include employers and other professional colleagues. Nurse practitioners in gastroenterology may encounter difficulties with radiologists if they request X-rays or with anaesthetists if they give intravenous sedation during endoscopic procedures. Such difficulties are linked to the need for autonomous and accountable practitioners to have diagnostic and therapeutic skills and for this to be recognised within clinical protocols. This will require the involvement of other specialists in training nurse practitioners, and here the jealous guarding of traditional roles can prevent this happening. A refusal to grant authority to nurse practitioners is a refusal to share power and is linked to the old paternalistic beneficent view of medicine in which 'doctor knows best' – except that she or he may not.

The wider introduction of nurse practitioners within gastroenterology will require recognition that such an advanced nursing role demands that:

- It is done primarily for the benefit of patients
- Other aspects of patient care do not suffer
- There is appropriate education for this role
- The role is holistic and integrated with all other aspects of patient care
- The nurse is allowed the level of autonomy that is consistent with full accountability.

In 1997, Bliss and Cohen defined the nurse practitioner as a nurse who can assess the healthcare needs of the patient, carry out the whole range of healthcare interventions needed to meet those needs (including counselling) and collaborate with other healthcare agencies.[2] In the case of a gastroenterology nurse practitioner, this means that she or he should be able to:

- Take a clinical history
- Perform a physical examination – in particular of the gastrointestinal system
- Perform appropriate investigations including endoscopy
- Prescribe treatment following agreed protocols based on evidence or consensus
- Give advice and counselling on prognosis and management.

How is this different to the activity of a doctor who is a gastroenterologist? In reality it may be little different, particularly as clinical training in medicine has moved towards the concept of focused histories and examinations. However, nurses and doc-

tors approach gastroenterology from a different philosophical base and bring all of the benefits and limitations of those bases to the discipline. The situation is akin to that now seen amongst barristers and solicitors, where solicitors can act as advocates in court and barristers will soon accept direct approaches from clients. In other words, traditional borders are being blurred. This is a concept which already exists in midwifery and obstetrics. The Royal College of Nursing Council in 1996 recognised the following roles of the nurse practitioner:

- To be the first point of contact for patients with undifferentiated and undiagnosed problems
- To make a health assessment using extra skills not normally taught in nursing education to date
- To make professionally autonomous decisions for which they have sole responsibility
- To develop a plan of nursing care to promote health
- To provide counselling for health and education for patients
- To screen patients for early signs of illness and risk factors
- To have the authority to refer patients to other health professionals or to admit/discharge if necessary.

Some of the proposed developments in the generic undergraduate training of all healthcare professionals – nurses, doctors, physiotherapists, dietitians, social workers etc – means that many of these skills will become common to many practitioners and that the boundaries will not have been created in the first instance.

In 2002, a statutory instrument created the Nursing and Midwifery Council. Its main objective is to safeguard the health and well-being of persons using or needing the services of registrants. It will have a significant role in the regulation of the work of nurse practitioners.

The practice

A study by Coopers and Lybrand[3] of the input of ten different nurse practitioners, including four who were hospital based, showed:

- considerable improvement in access to services
- favourable comments by patients on the ease with which they understood information and advice given by nurse practitioners, especially when compared with doctors
- reduced workloads for other health professionals
- better quality output at reduced cost
- a more holistic approach to care with better teamwork
- greater nurse satisfaction.

However, as Reveley *et al* have written:

> *Nurse practitioner role development is therefore a continually evolving product of negotiation with the medical profession, based upon demonstrated competence.*[4]

If coexistence can be achieved, then rather than detracting from medical expertise it will be possible in gastroenterology and other disciplines to add to it nursing expertise and so provide more comprehensive and better care. Although many doctors may consider these developments radical, they are not so different to the acceptance of barber surgeons and apothecaries by the fellows of the Royal College of Physicians in earlier centuries. The current status enjoyed by surgeons will be shared with nurse practitioners in the future!

Legal status

In accepting such a new and expanded role, nurses will need to be clear about accountability and responsibility and to ensure that their skills are both relevant and up-to-date. *The scope of professional practice* places this burden clearly on the shoulders of practitioners.[1] Nurses' duty of care to patients means they must give safe, high-quality care and this should only occur after the patient has been given information which they understand. Such care must be accepted freely and without coercion. Comparisons will be made with other competent practitioners in the field. The *Bolam* Principle states that:

> *A doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion.*

However, more recently in *Bolitho* it was decided that:

> *Ultimately the judge must decide whether a particular clinical practice, even one endorsed by a body of doctors, puts the patient unnecessarily at risk. Thus, while compliance with approved practice may make it unlikely that a doctor is guilty of negligence, it does not settle the matter.*

The situation with regard to specialist practitioners may be more complex. In *Wilsher* v *Essex Area Health Authority*, Mustill LJ stated:

> *the standard is not just that of the average competent and well-informed junior houseman (or whatever the position of the doctor) but of such a person who fills a post in a unit offering a highly specialised service.*

Glidewell LJ supported this view:

> *The law requires the trainee or learner to be judged by the same standard as his more experienced colleague. If it did not, inexperience would frequently be urged as a defence to an action for professional negligence.*

The status of nurse practitioners has yet to be explored in any detail in the courts. However, it is likely that nurse practitioners will be judged by the same standards as their medical colleagues.

Training needs

Before nurses and doctors become equal in status, their range of training will need to be considered and interim programmes developed. In the foreseeable future, combined training at both undergraduate and postgraduate level will ensure considerable overlap in the training of both professional groups.

Clearly the questions that will need to be addressed include whether nurses can:

- offer a diagnostic service
- request investigations
- perform invasive procedures
- prescribe medication.

Linked with these questions are issues of:

- professional status
- training
- terms of employment, including limiting guidelines
- accountability and vicarious accountability.

Do nurses have the professional status to be accepted as nurse practitioners offering a comprehensive diagnostic and therapeutic service? Will they be accepted by their colleagues and also by doctors and pharmacists in this role? The extended range of nurse practice accepted within *The scope of professional practice* suggests that the governing body of the profession accepts that there will be individual nurses who wish to provide an holistic approach to care, which will include all these elements. However, will doctors accept that nurses can attain equivalent specialist expertise, but from a different philosophical and academic background? Clearly many already do, and a more open-minded approach to healthcare in which traditional boundaries are being removed will actively encourage such developments. The nurse practitioner presents a much less radical challenge to conventional medical practice than did the apothecaries or barber surgeons in earlier centuries. The idea that there may be a range of backgrounds and a range of methods of training by which individuals can become specialists and provide service to a client group has been accepted throughout the academic and professional world during the last decade. Clinical care should be no exception.

However, in order to ensure comparability in skills it will be essential that the training of nurse practitioners meets common standards for all professional groups offering a specialist service. In fact, nurse training has often been more rigorous than that of junior doctors: it is usually better defined, better monitored and subsequent practice more frequently audited. The belief that this is a form of generic training offered to nurses as well as doctors misses the point that in the future there will be a range of professional groups who will deliver healthcare of equal quality.

The need for high standards of training will be particularly important as we move towards regular public statements of mortality rates experienced by individual clinicians. Patients will expect similar data for nurse practitioners. As part of these expectations, patients will want to know the background of the person caring for them – in particular whether they are a nurse practitioner or doctor. It will be important that there is no confusion. It will be incumbent on the carer to identify him or herself. When consent to examination, procedures and treatment is sought, patients will need to know whether the practitioner is a nurse or a doctor. There must be no suggestion of fraud. The way nurse practitioners and doctors will 'hold themselves out' to patients must be clear – and this could include aspects of language and dress. However, in the future it is likely that patients' main concerns will not be about who delivers care, but how good that care is. Indeed, some recent unpublished research on patients' views about endoscopists has suggested that the majority fall into one of two groups:

- patients who do not care who does the procedure as long as it is done rapidly
- patients who do not care how long they have to wait provided the procedure is done by a doctor.

Consent is now a question of making an informed choice. Nurses are much better information givers and so are more likely to obtain true agreement to invasive tests or forms of therapy.

Nurses who are allowed to prescribe are restricted by the Medicinal Products: Prescription by Nurses Act 1992 to:

- those registered in Parts 1 or 12 of the Nursing and Midwifery Council (NMC) Register as a registered general nurse (RGN) who holds a current district nurse qualification and is a district nurse
- registered in Part 10 of the NMC Register (a midwife)
- registered in Part 11 of the NMC Register (a health visitor).

In addition they must have received training from a national board to NMC standards. However, the types of medication they can prescribe are limited to the Nurse Prescribers' Formulary (NPF). This list consists mainly of laxatives, skin treatments and dressings. However, two interesting exceptions are the treatments for threadworm, roundworm and hookworm – mebendazole and piperazine. These drugs are associated with significant side effects. Nurses who worked in a hospital were excluded by this Act, but the Review of Prescribing, Supply and Administration of Medicines Report published by the Department of Health in 1999 and accepted by the government in March 2000 recognised the need to extend rights of prescribing to other healthcare professionals. Nurses with this right will be:

> *responsible in law for ensuring that the prescription is used in accordance with their instruction.* (ENB, 1998:2.2)

In practice, many hospitals have bypassed these restrictions, and nurses are able to prescribe sedation and other drugs through protocols that have been developed within the unit. In the case of gastroenterology, there are a number of products which can be purchased over the counter. They include:

- antacids
- antispasmodics – alverine, mebeverine and peppermint oil as well as hyoscine, dicyclamine and atropine
- H2 receptor antagonists – ranitidine, cimetidine, nizatidine and low-dose famotidine (20 mg daily)
- anti-diarrhoeals, eg loperamide
- laxatives.

In other words, with the exception of proton pump inhibitors, 5 ASA compounds, steroids, ursodeoxycholic acid and pancreatic supplements, most of the gastrointestinal pharmacopoeia can be bought by the general public. Indeed, even digestive enzyme supplements, which can be effective in the treatment of

pancreatic insufficiency, can be bought over the counter in many herbal stores. Nurses could advise patients to purchase these preparations without writing a prescription and so it would seem sensible to extend the prescribing rights of nurse practitioners in gastroenterology. This would need support through adequate training and in the first instance this would need to come from medical mentors. If nurses recommended patients to buy such products across the counter they would be accountable for the advice and therefore formalising their training would reduce clinical risk.

Such a future role for nurse specialists and nurse practitioners is very much within the plans of the Chief Nursing Officer. She has identified ten key roles which include:

- ordering diagnostic investigations
- making and receiving referrals direct
- admitting and discharging patients with specified conditions and with agreed protocols
- managing patients for specific conditions and with agreed protocols
- running clinics
- prescribing medicines and treatment
- performing minor surgery.

She has called for the breaking down of tribal boundaries within healthcare and has identified the need for 'clinical leaders who set high standards of care, who are skilled and knowledgeable'.

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Instruments

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