What are the differences in nurse practitioner training and scope of practice in the US and UK?

Lessons learnt in preparation and practice in the US could be used to develop the nurse practitioner role in the UK, maximising the potential of the profession.

INTRODUCTION

Being a nurse practitioner was one of the 10 best jobs of 2009 – if you worked in the US. According to Money, a US personal finance magazine, and the CNN television news channel, NPs had the fourth best job in the country based on pay, career opportunities, personal satisfaction and job security (CNNMoney.com, 2009).

The article cited only one major drawback to the role: the frustrations caused by dealing with insurance companies. Since this is a task that few nurses in the UK will have to deal with, why is the NP role not similarly recognised as an attractive career path on this side of the Atlantic?

It would be easy to cite lower pay and fewer opportunities as the primary reasons why being an NP in the UK is not as popular a job choice as it is in the US. In 2007, average NP pay in the US was $81,400 (about £51,000) (Rollett and Lebo, 2008) while the maximum NP pay in the UK was £43,335 (Royal College of Nursing, 2007). These disparities could be attributed to the fact that NPs are a newer phenomenon in the UK and simply need time to catch up. However, there are also several fundamental organisational principles supporting NPs in the US that are absent here.

This article examines the differences in NP training, licensing and practice between the US and the UK; recommendations are made for using the lessons learnt in the US to help promote the development of NPs in the UK.

HISTORY

The first training programme for NPs was established at the University of Colorado in 1965 to prepare experienced nurses to provide primary care for medically underserved populations in rural areas (O’Brien, 2003). The first few cohorts of NPs fought hard to demonstrate that they were successfully filling the gap created by a shortage of GPs.

However, it was not until NPs were "professionalised" that they were fully integrated into the US healthcare system (Center for Health Workforce Studies, 2004). The process of professionalisation included three steps, which were described by Hodson and Sullivan (2001):

- A separate registry administered by the Nursing and Midwifery Council and a recordable qualification for nurse practitioners;
- Clear definition of the role, including scope of practice, that differentiates nurse practitioners from other nurses;
- The setting of educational standards that are linked to nurse practitioners’ scope of practice, with competencies for each major specialty.

The history of NPs in the UK has followed a different path. New roles were created mainly in two places: primary care surgeries, where NPs eased the workload of GPs; and acute care settings, where the role evolved to fill specific niches. The latter included emergency NPs who dealt with minor illnesses and injuries that flooded accident and emergency departments, and endoscopy NPs who were trained to carry out particular procedures. This is where NPs continue to work today, with 47% working in GP surgeries and 49% in either NHS acute or primary care trusts (Ball, 2006).

ROLE IN HEALTHCARE

There is great potential to expand and promote the role of the NP in the UK. Lancaster (2000) suggested these practitioners provide cost savings for the
TABLE 1. SAMPLE CURRICULUM FOR NURSE PRACTITIONER PROGRAMMES IN THE US AND UK

<table>
<thead>
<tr>
<th>Courses required for MSc as a nurse practitioner</th>
<th>US</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vernacular</td>
<td>Philosophical, theoretical and ethical basis for nursing</td>
<td>Principal methods for healthcare research</td>
</tr>
<tr>
<td>Vernacular</td>
<td>Intermediate biostatistics</td>
<td>Evidence based decision making in healthcare</td>
</tr>
<tr>
<td>Vernacular</td>
<td>Application of research to practice</td>
<td>Dissertation</td>
</tr>
<tr>
<td>Vernacular</td>
<td>Context of healthcare for advanced practice nursing</td>
<td>Independent prescribing</td>
</tr>
<tr>
<td>Vernacular</td>
<td>Physiology/orthopedics</td>
<td>Advanced practice in a specialty such as cardiac care</td>
</tr>
<tr>
<td>Vernacular</td>
<td>Clinical pharmacology</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Advanced health assessment and measurement (two terms)</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Health promotion and disease prevention</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Diagnosis, symptom and illness management (two terms)</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Advanced practice in primary care (two terms)</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Advanced practice nursing: clinical topics and professional issues</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Human development across the lifespan</td>
<td></td>
</tr>
<tr>
<td>Vernacular</td>
<td>Dissertation</td>
<td></td>
</tr>
</tbody>
</table>

US courses are for the Adult Nurse Practitioner (Primary Care) Programme offered by the Johns Hopkins University School of Nursing (2008). UK courses are those required for the Advanced Practice Nurse Practitioner Programme at the Florence Nightingale School of Nursing and Midwifery at King’s College London (2009).

higher compliance may be attributable to simple communication: NPs are usually shown to have better communication with their patients than doctors (American Association of Colleges of Nursing, 1995; Fitzgerald et al, 1995). The more patients understand about their treatment regimen and its importance, the more likely they are to follow it.

Studies from the US show that NPs provide the same quality of care as GPs, with comparable patient outcomes (Spitzer et al, 1974). In the current economic climate in the UK, with the NHS using smaller budgets to deliver the same or preferably better care, the expanded use of NPs seems like the perfect solution. However, there is a problem: NPs in the UK do not always have easily recognisable, standardised roles. The RCN (2008) noted that there was a “lack of an explicit description of advanced nurse practitioner practice” and that this often denies NPs the rights that other healthcare professionals enjoy.

An example of this is the finding that 44% of NPs in the UK have had an X-ray request refused (Ball, 2006). It is interesting to note that the RCN survey only addressed X-ray requests: NPs in the US routinely request CT scans, ultrasounds, endoscopic procedures or any other diagnostic test required for patient care.

Research also suggests that GPs are hesitant to embrace the NP role because they are not convinced that the training is always adequate (Wilson et al, 2002).

Should the UK move closer to the US model for the role of NP? Would such a move benefit patients or NPs? Possibly, but first it is necessary to explore the underlying differences between the role and how it is understood in the two countries.

NP TRAINING

The minimum education required to become an NP in the US is a graduate degree (American Academy of Nurse Practitioners, 2007a). In contrast, there is no minimum educational requirement for NPs in the UK. The RCN (2008) recommended that nurses working in NP roles should have at least an honours level degree, but the Nursing and Midwifery Council lists no educational requirements for NPs. This may change, however, as the recent report from the Prime Minister’s Commission on the Future of Nursing and Midwifery (2010) recommended that the NMC “must regulate advanced nursing practice, ensuring that advanced practitioners are recorded as such on the register and have the required competencies”.

Universities in the UK have worked hard to provide advanced practice nursing education but, without any official guidelines to follow, the programmes they offer to aspiring NPs vary a great deal. At one university alone, students learning to be NPs could study for a BSc, a postgraduate diploma or an MSc (University of Cumbria, 2009a; 2009b; 2009c).

NP programmes can be accredited through the RCN, but such accreditation is voluntary and requires the university to pay hefty fees (RCN, 2009). If a school of nursing chooses to become accredited, this means only that its curriculum meets the RCN’s criteria but not that any specific level of qualification is attained by the students. As all preregistration nursing programmes in the UK must lead to a degree by 2013 (NMC, 2009), it seems appropriate that NPs should have further education beyond that.

It is worth considering that patients have confidence in doctors because they know every doctor has completed rigorous training and in nurses because they know that all of us have graduated from official nursing programmes. Similarly, patients might appreciate knowing that all NPs have demonstrated graduate level thinking and reasoning skills in a university setting and have been awarded an MSc.

The curriculum

There are vast differences between the curricula of NP programmes between the two countries (Table 1).

US NP programmes are rigid – within their broad specialties (adult acute care, paediatric primary care or women’s health, for example), all students take the same classes, regardless of previous experience or what type of work they plan to do after graduation. To cater for such a diverse group of students, US programmes necessarily contain many modules, all required by the Advanced Practice Registered Nurses Joint Dialogue Group, a consortium of professional nursing organisations, state

| Education and salary costs – this is particularly relevant in the UK where the government pays much of the cost of both nursing and medical education; and second, patients who see NPs have higher compliance rates with recommended treatments such as antibiotic therapy than those who see doctors, which means that NPs’ patients recover more quickly from illnesses and need fewer interventions (Caine et al, 2002).

Higher compliance may be attributable to simple communication: NPs are usually shown to have better communication with their patients than doctors (American Association of Colleges of Nursing, 1995; Fitzgerald et al, 1995). The more patients understand about their treatment regimen and its importance, the more likely they are to follow it.

Studies from the US show that NPs provide the same quality of care as GPs, with comparable patient outcomes (Spitzer et al, 1974). In the current economic climate in the UK, with the NHS using smaller budgets to deliver the same or preferably better care, the expanded use of NPs seems like the perfect solution. However, there is a problem: NPs in the UK do not always have easily recognisable, standardised roles. The RCN (2008) noted that there was a “lack of an explicit description of advanced nurse practitioner practice” and that this often denies NPs the rights that other healthcare professionals enjoy.

An example of this is the finding that 44% of NPs in the UK have had an X-ray request refused (Ball, 2006). It is interesting to note that the RCN survey only addressed X-ray requests: NPs in the US routinely request CT scans, ultrasounds, endoscopic procedures or any other diagnostic test required for patient care.

Research also suggests that GPs are hesitant to embrace the NP role because they are not convinced that the training is always adequate (Wilson et al, 2002).

Should the UK move closer to the US model for the role of NP? Would such a move benefit patients or NPs? Possibly, but first it is necessary to explore the underlying differences between the role and how it is understood in the two countries.

NP TRAINING

The minimum education required to become an NP in the US is a graduate degree (American Academy of Nurse Practitioners, 2007a). In contrast, there is no minimum educational requirement for NPs in the UK. The RCN (2008) recommended that nurses working in NP roles should have at least an honours level degree, but the Nursing and Midwifery Council lists no educational requirements for NPs. This may change, however, as the recent report from the Prime Minister’s Commission on the Future of Nursing and Midwifery (2010) recommended that the NMC “must regulate advanced nursing practice, ensuring that advanced practitioners are recorded as such on the register and have the required competencies”.

Universities in the UK have worked hard to provide advanced practice nursing education but, without any official guidelines to follow, the programmes they offer to aspiring NPs vary a great deal. At one university alone, students learning to be NPs could study for a BSc, a postgraduate diploma or an MSc (University of Cumbria, 2009a; 2009b; 2009c).

NP programmes can be accredited through the RCN, but such accreditation is voluntary and requires the university to pay hefty fees (RCN, 2009). If a school of nursing chooses to become accredited, this means only that its curriculum meets the RCN’s criteria but not that any specific level of qualification is attained by the students. As all preregistration nursing programmes in the UK must lead to a degree by 2013 (NMC, 2009), it seems appropriate that NPs should have further education beyond that.

It is worth considering that patients have confidence in doctors because they know every doctor has completed rigorous training and in nurses because they know that all of us have graduated from official nursing programmes. Similarly, patients might appreciate knowing that all NPs have demonstrated graduate level thinking and reasoning skills in a university setting and have been awarded an MSc.

The curriculum

There are vast differences between the curricula of NP programmes between the two countries (Table 1).

US NP programmes are rigid – within their broad specialties (adult acute care, paediatric primary care or women’s health, for example), all students take the same classes, regardless of previous experience or what type of work they plan to do after graduation. To cater for such a diverse group of students, US programmes necessarily contain many modules, all required by the Advanced Practice Registered Nurses Joint Dialogue Group, a consortium of professional nursing organisations, state...
boards of nursing, the US Department of Health and Human Services and universities (APRN JDG, 2008). These modules include:

- Advanced physiology;
- Advanced health assessment;
- Pharmacology.

The pharmacology component includes the pharmacodynamics, pharmacokinetics and pharmacotherapy of all broad categories of drugs (APRN JDG, 2008). This rigorous study of pharmacology is required because prescribing is not an optional part of NP practice in the US – it is an expected competency and students must have the depth of knowledge to be able to prescribe safely and appropriately for the full range of conditions that they will encounter during the course of their career.

The other competencies students must master include: management of patient health/illness status; NP/patient relationship; the teaching/coaching/feedback; professional role; managing and negotiating healthcare delivery systems; monitoring and ensuring the quality of healthcare practices; and cultural competence (AANP, 2007a). Most importantly, students must complete at least 500 hours of clinical experience, done one to one with experienced mentors, in a variety of clinical settings (Bray and Olson, 2009).

NP programmes in the UK are broadly designed to take nurses who already have experience in their specialty and give them specific tools to progress further in that area. Therefore, modules in the UK are usually focused in scope, covering distinct systems or conditions such as cardiology or diabetes, and the practical learning is often conducted in specialist settings similar to where nurses hope to practise once they have completed their training.

Most programmes also allow students to use past experience to make an accreditation of prior (experiential) learning claim, which exempts them from some of the modules. Given there are already disparities in the level of education offered on NP programmes, this exemption means that even students in the same MSc programme, for example, might be completing modules that are significantly different and gaining practical experience with different patient populations.

While this might allow for highly specialised NPs, it does lead to one problem identified in a recent Cochrane report: there is an inconsistent level of qualification required to use the title “nurse practitioner” (Laurant et al, 2010). Can a group of nurses – one of whom has completed a BSc level NP programme, another who has postgraduate certification as an NP and the third who is an MSc trained NP – all provide the same level of care?

**Examination and licensing**

After completing their MSc, NP students in the US must pass the licensing exam in their specialty before they can begin to practise (APRN JDG, 2008). The exams are written by experienced NPs and aim to reflect real life issues that might appear in practice. As the questions are realistic, universities must spend time giving students a solid foundation in the art and science of advanced practice nursing so they can deduce and reason to the answer to questions, much like one would in actual practice.

There is no way to “teach to the exam”, because the only way to pass it is to have learnt the material and know how to apply it. The exam is challenging and the public can be confident that students who pass it have demonstrated a standard level of knowledge and reasoning skills, regardless of which university they trained at.

After passing the exam, individuals are licensed as advanced practice registered nurses and can legally use the “nurse practitioner” title. Falsely identifying oneself as an NP in the US is a criminal act and carries penalties that can include fines or a jail term (Board of Registered Nursing, 2009). The protected name is the final step in ensuring public confidence. Much like the British public knows that anyone who calls themselves a GP must have fulfilled all the educational and training requirements to register with the General Medical Council (2009), the US public can be sure that any NP they visit is equally well prepared for their job.

In the UK, where NPs are neither licensed nor have their own registration with the NMC, there is not even agreement on what the name of the role should be. A quick search on the website www.jobs.nhs.uk on 5 January 2010 found the following positions listed:

- NP;
- Registered NP;
- Clinical NP;
- Senior NP;
- Advanced NP;
- Associate NP.

These posts ranged from band 5 to band 8A on the Agenda for Change pay scale and the job descriptions were sufficiently varied that it was difficult to tell what specific part of each of the roles justified the use of the term “NP” in the title. It is impossible to expect other professions, the general public and patients to understand what NPs do if the term is used so flexibly.

**SERVICES PROVIDED**

What services do NPs in the UK provide? What services should they provide? Part of the reason that the training and use of the title is so variable here is that these questions have not been answered.

In the US, NPs “assess, diagnose, treat and manage patients’ health problems and needs” and the services they provide include but are not limited to, ordering, conducting, supervising and interpreting diagnostic and lab tests and prescription of pharmacologic agents and nonpharmacologic therapies” (AANP, 2007b).

This short statement covers every service provided in primary care. The job description might seem incredibly broad, but consider this: by providing rigid education and certification standards, the profession produces NPs with skills that can be applied to a wide range of settings and allows for vast work opportunities.

As already explained, NP roles in the UK tend to fill particular service needs and the education of NPs has developed to support this specialisation. This continuing cycle means that NP opportunities are now defined by job descriptions that are specific to each post. Mantzoukas and Watkinson (2006) suggested that identifying common core characteristics of practice, such as those used in the US definition, strengthens the NP role. Without an NMC qualification, the only means by which UK nurses can define NP practice is the broad competencies suggested by the RCN (2008).

The Department of Health recently commissioned advice from the Council for Healthcare Regulatory Excellence on the state of “advanced practice” in the UK. The final report, delivered in July 2009, found significant differences in the ways in which the term “advanced practice” was used (CHRE, 2009). Furthermore, it recommended that areas of developing practice that are significantly different from existing practice and the use of new skills and proficiencies should be recognised by regulatory bodies.

Essentially, its findings mirrored those of the Prime Minister’s Commission: if NPs assess, diagnose and manage patient care, they are using a more advanced skill set than those nurses who care for patients under the direction of a doctor or surgeon and should be recognised as distinct by the NMC.
CONCLUSION
The role of the NP has evolved differently in the US and the UK. In the US, it was created to deliver primary care in areas of GP shortage and the training is designed to give students knowledge and skills necessary to do that. The UK enjoys a robust system of primary care so, to date, NPs have been used to provide much more specific services and the training is focused on a narrower set of skills, unique to each student. However, the variability in training, role definition and responsibilities in the UK, along with the lack of formal recognition by the NMC, has hindered the advancement of this important segment of the nursing profession.

Although the culture of nursing and healthcare is different in the US, there are nevertheless strategies that UK NPs could adopt from the US – backed by both research and governmental recommendations – that would support further development of the role:
● NPs need a separate registry administered by the NMC or, at the very least, they must have a recordable qualification, similar to that for independent prescribing;
● The title “nurse practitioner” must be clearly defined, to include a scope of practice that describes what NPs do that is unique and distinct from the work of other nurses. This title should be legally protected;
● There should be educational standards set for nurse practitioners that are linked to their scope of practice, with competencies for each major specialty.

This represents only a starting point in the discussion about the role of NPs in the UK now and what should be done in the future. There is no doubt that NPs provide an important service and that the sooner their unique contribution is widely recognised and supported, the better it will be for our patients and our profession.

REFERENCES
King’s College London (2009) Advanced Practice/Nurse Practitioner/Community Matron/Case Manager/MSc/PG Dip/PG Cert/Part Time. London: King’s College London.
Nursing and Midwifery Council (2009) Confirmed Principles to Support a New Framework for Pre-Registration Nursing Education. London: NMC.
University of Cumbria (2009a) BSc (Hons): Advanced Nurse Practitioner. tiniyurl.com/BSc-advanced

INCREASE YOUR KNOWLEDGE
Nursing Times Learning is a new, cost effective way to update your knowledge and skills. Our online units are written by experts and use case scenarios to relate your learning to practice. Our expanding range of units includes:

● Giving appraisals and being appraised: www.nursingtimes.net/appraisal
● Resolving conflicts: www.nursingtimes.net/conflict
● Equality and diversity at work: www.nursingtimes.net/equality