

Nurse practitioners in the ED: a rebuttal

To the Editor: In a prior issue of the journal, Drummond and Bingley published a discussion paper questioning the potential value of nurse practitioners (NPs) in the emergency department (ED).¹ This work reminds us that no single change can be a panacea for the Canadian health care system, but several of the arguments presented are problematic.

First, the authors correctly point out that there is national variability in the education and use of the title "Nurse Practitioner;" however, the Canadian Nurses Association (CNA) is leading a national initiative to achieve uniformity. The Canadian Nurse Practitioner Initiative (CNPI) is supported by a federal grant of more than \$8 million dollars and this group is in a position to promote consensus about education, titling and a variety of other issue related to the NP role.

Second, the authors argue that there are no data to support the effectiveness of NPs in the ED, and that the paucity of emergency NPs supports this position. In fact, there are several studies confirming that the effectiveness of NPs is equivalent to physician care in both EDs and primary health care settings.²⁻¹⁰ Spisso and cohorts¹¹ showed that NPs provided and increased quality of care and documentation in a trauma program. Powers and colleagues¹² reported that, while there was no difference in patient satisfaction between the NP group and the physician group, the patients cared for by NPs had improved comprehension of the diagnostics and therapeutic interventions. These studies suggest the care provided by NPs was comparable or superior to care provided by ED physicians.* Drummond and Bingley also suggest that the paucity of ED NPs reflects their lack of

effectiveness, but the authors fail to acknowledge that, in the USA, where the NP role has been in existence for more than 30 years, there are more than 65 000 NPs and 1950 work in EDs.¹³ It is also important to point out that the primary reason for the scarcity of ED NPs is not ineffectiveness — but rather the shortage of NPs in general. Curry reported that there was a single NP available for every 7 vacant positions.¹⁴

The authors also argue that NPs may overload ED nurses by generating too many orders. This implies that EDs should base physician staffing levels on nursing workloads rather than patient needs — clearly a non-tenable position. In fact, the limiting factor in the assessment and treatment of ED patients is often the heavy workloads of ED physicians. We believe that an increased NP presence is more likely to enhance rather than impair rapid patient treatment.

Drummond and Bingley also argue that NPs see only 1 to 2 patients per hour.^{2,15} While we do not refute this figure, it does not contrast unfavourably with the 2.5 patients per hour that is used as the benchmark for ED physicians.¹⁶ Moreover, the authors fail to point out that the NP role in the ED is clearly different. NPs may be used to expedite care for minor complaints or, in some settings, they are preferentially asked to see patients presenting with multi-system complaints. In fact, the authors acknowledge that one strength of NPs may be to manage complexity and chronic illness in an ED, thereby

*We feel that the strong tendency in the literature, a tendency to compare NP and physician practice, is on the whole unfortunate. Although this type of comparison is easy for health professionals and the public to comprehend, in the end such comparisons set up an adversarial relationship between NPs and physicians. We feel that the value of the NP role lays not so much in the role functions that overlap, as in the role functions that are unique.

allowing for increased physician time to deal with patients and procedures beyond the NP scope of practice.¹¹

We recognize that, just as is the case between Registered Nurses and Licensed Practical Nurses when the latter sought to expand their role, there is a similar tension around the issues of prescription and diagnosis between physicians and NPs. The roles of various health care providers within our system have been somewhat static for decades. However, we are currently facing many challenges to a viable health care system, including inadequate funding, a shortage of physicians and nurses, and an aging population experiencing multiple, comorbid acute and chronic conditions. This situation is the impetus for re-examining traditional roles.

Increasing volume and acuity has affected all of our practices. Canadian EDs are overcrowded. Drummond and Bingley argue that NPs will not solve this problem. And we agree! Overcrowding is a symptom of a sick health care system. It has not been solved by emergency physicians and it is unlikely to be solved by NPs. But this is not a shortcoming of the NP role.

The NP complements the members of the existing ED health care team. At minimum, NPs are well qualified to manage the one-half to one-third of non-urgent ED patients for primary health care concerns due to a shortage of primary health care providers.^{3,17} Although these ED visits are arguably inappropriate, they continue to grow in numbers. These patients require care with a holistic focus rather than a narrower, problem-based focus that is our tradition in ED settings.

New roles within the Canadian health care system must be examined critically for value. NPs do not seek to replace physicians; instead, they add particular expertise and skills to the team. In the context of an aging popu-

lation with multiple co-morbidities and a shortage of primary health care providers, we are convinced the NP role will prove to be synergistic with ED physicians. This value is some years away from being realized, however. As we prepare for that time, continued thoughtful dialogue and debate will be invaluable.

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[The authors respond:]

We read with interest the comments about our article on NPs in the ED.¹

The correspondents' contention is that we have argued against a role for NPs in the ED. This Quixotic charge notwithstanding, our article was an attempt to review the historical and international experience of NPs in the ED

and to outline both the pitfalls and benefits to their eventual introduction in a Canadian context.

In fact we have no doubt that NPs will have a role and an opportunity to improve the quality of care provided for Canadian emergency patients. The question is not whether they can provide primary care in the ED but whether they should. Our belief is that they have more important contributions to make.

Despite government's fixation with non-urgent patients, there is little evidence supporting the premise that these patients pose a significant problem for EDs. And if they are not the problem, does the average Canadian ED need a solution in the form of another level of primary care provider in the ED?

There are, however, clear gaps in emergency care delivery — particularly in the areas of preventive health care and education, chronic disease management and assistance for our patients in negotiating the increasingly complex journey through the health care system. NPs should be encouraged to fill these voids and, in so doing, provide value added to the services already available in the ED.

The role of the NP in the ED is, as yet, undefined and still in evolution. It will certainly differ in different departments. Ultimately, the contribution of NPs to emergency health care will be judged by their ability to enhance quality of care and improve patient outcomes.

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