Nurse Practitioners: The Early Years (1965-1974)

Just as the health care system is currently experiencing upheaval and redefinition, so it was in the era in which nurse practitioners first came to be. In the mid-1960s, the concern over those with inadequate access to health care was great. President Johnson's Great Society moved towards improving health care coverage by providing Medicare and Medicaid. The neighborhood health center idea was resurrected as part of the war on poverty (1). Tumult continued through the early 1970s as President Nixon imposed a wage and price freeze, fostered enabling legislation for HMOs, and moved unsuccessfully to reintroduce health reform measures.

No book exists to chronicle the development of nurse practitioners, so information is gathered from a variety of written sources, including interviews, graduation addresses, research studies, and letters to editors. Those interested in the evolving health care issues of today will benefit from being familiar with the roots of nonphysician providers and how health professionals responded to them.

The first nurse practitioner program, developed by a nurse educator and a physician, appeared at the University of Colorado in 1965 (2). Focusing on pediatrics, it was an idea whose time had come. Within 9 years, there were 65 programs established in pediatrics alone, while additional programs focused on women's health or on the entire family (3). Over 1000 nurses had become practitioners, of which over 13% were in private independent practices (4). Nurses moved into other "advanced practice" roles as well, becoming nurse midwives and nurse anesthetists.

What factors caused this to be "the right time" for nurse practitioners to appear? On a national level, there was a health care manpower shortage of which the Vietnam war was a component. The maldistribution of primary care doctors exacerbated the problem, and consumers were demanding improved access and quality (5, 6). Leaders in government and health care were striving to address the needs of the underserved, particularly children (7). Medical costs were rising, and some foresaw an increased demand for care due to the passage of Medicare and Medicaid (8). There was concern about the adequacy of the training of foreign medical graduates (5). The civil rights movement and women's movement sought equality of opportunity.

Within nursing, poor salaries, benefits, and working conditions caused thousands of nurses to become inactive (9, 10). Women with a commitment to patient care felt blocked in career advancement, since the career ladder led into academia or administration and away from the care of patients. Interestingly, many of the early NP programs were not begun by nurses, but initiated by physicians and social scientists to draw upon experienced but inactive nurses addressing the health care needs of the nation (11).

Physician Assistants

As the Colorado program was beginning, physicians at Duke University were independently creating an alternative solution to the health manpower shortage (12). Their approach was to create physician's assistants, whose role was to carry out delegated tasks. The program was specifically targeted to men, "since the long-range goals of most females remove them from continued and full-time employment..."(p. 182). Great pains were taken not to have the physician's assistant seen as a male nurse. Medics returning from Vietnam found in physician's assistant programs a role with which they were familiar and negated the need to consider nursing as a career choice. Stead (12) also made clear that the focus of this role was on assisting the physician and working under supervision. Although developing at the same time as nurse practitioners, the PA programs had an orientation which was initially physician centered.

Nurse practitioners who brought with them experience in providing nursing care, including teaching and support, were to be more focused on clients. This was in contrast to the initial focus of the PA, and also differed from traditional nursing, which was more focused on services within an institution (13,14). However, it was not long before health professionals professed that the two roles were indistinguishable (15).

Education of NPs

Nurse practitioners appeared on the scene before nursing had developed uniformity in educational preparation for nursing. In the early 1960s, the majority of nurses were from 3-year, hospital based programs, 8% were entering associate degree programs, and 20% were entering baccalaureate programs. Only 2% of nurses had a graduate degree. Nursing leaders were striving to make the baccalaureate degree required for entry into "professional" nursing (16). In contrast, recognizing a shortage of health care personnel, a national task force called for expanding the training of health workers at the community college level (17).

In 1965 the American Nurse Association published a position paper supporting baccalaureate education as the basic educational background of the "professional" nurse. Against the background of this multipathway approach to nursing education, which was highly valued by some, rose the question of what constituted adequate preparation for the nurse practitioner (13, 18). While some programs involved several weeks or months of training leading to a certificate, other educators encouraged nurse practitioner programs to be nested within baccalaureate programs, and a few education institutions created master's level programs (19).

During the early years, few nursing educators possessed the knowledge or skill to teach students the medical components of the new role. Physicians and physician support were therefore essential to the development and success of the nurse practitioner role (7). Gradually, nursing faculty could draw from a pool of experienced practitioners. In some ways, however, this later served as a detriment since nursing and medicine returned to their more isolated modes of learning (3, 19). Several authors encouraged joint medical and nursing education in areas where practice overlapped (9, 11, 20, 21). This would

contribute towards more collegial working relationships, maximize the contributions of each discipline with patients ultimately benefiting, and result in fewer turf wars.

Licensing and Certification

In the early 1970s, the Department of Health, Education, and Welfare recommended that states reexamine licensing laws, building in flexibility so as to enable health personnel to practice in expanded roles (3, 22). Nursing faculty also called for standardization of educational preparation so that nurse practitioners could achieve some sort of certification (19). McAtee and Silver (23) noted that accreditation and certification "will lead to an improved role-identity for the nurse and greater acceptance of the expanded role by other health professionals and the public" (p.578).

Reimbursement and Funding

Another area of concern was ongoing funding. Due to the health manpower shortage, the new health providers were generally accepted, or at least tolerated, by the medical establishment. Federal funding and private foundations contributed to pilot and demonstration projects, leading to the rapid increase in the number of nurse practitioner programs. Ultimately, stable sources would be needed (23).

Interestingly, it was physicians who encouraged nursing to work towards third party reimbursement, since the lack of appropriate reimbursement hindered nursing's capability in addressing the crisis of health care access (5, 24). Public health professionals writing in The Lancet pointed out that reimbursement practices must change if the new providers were to conserve health care dollars (15). The fee-for-service approach tended to force the midlevel providers into the roles of technicians, since the more they did and the more patients they saw, the more the physician could bill. The physician, as employer, could bill the regular rate for care provided, pay the lower salaries of the employees, and pocket the difference. The reimbursement mechanisms thus worked against fleshing out the hope that the new providers would bring a broader approach to health with an appreciation for psychosocial issues within the family and community.

Responses from Medical and Nursing Communities

How did nurses respond to the programs which followed in Colorado's footsteps: The early years were marked by a lack of uniformity in program structure and educational length, in purpose, and even in having a common name for the new role (18, 19). Whereas some saw the role as a return to nursing's roots, particularly to the independent and family oriented public health nurse of the early 1900s, others saw the Colorado program as a new type of nurse (18). It was implied that the success of PA programs was a reflection of nursing's failure to respond quickly and innovatively to the changing health care scene (22). Others, noting that physicians were often prominently involved in the development or running of NP programs, saw this as an effort by medicine to control nursing, particularly when the AMA published a plan to turn 100,000 nurses into physician's assistants (24).

The literature on NP's which began to appear in medical journals during the early years was very favorable towards NPs. The programs were new and the need was great. Self-

selection may have played a part in these early enthusiastic reports, since the physicians, the nurses, the institutions, and, in many instances, the patients, could choose to participate in "the NP experience" (11, 25).

The reports reflect a great deal of variability in NP training and how the NPs were utilized. Some viewed the nurse as a health screener, almost in a health triage sort of role, and functioning under the direct supervision of a physician (26, 27). Others focused on the benefit the NP brought to the physicians. The presence of a nurse who could focus on health maintenance issues was seen as being of great assistance (28). Delegating routine health problems to the nurse practitioner for assessment and management freed physicians to focus on patients with more complex or serious health problems (25).

Many authors suggested that the nurse could work with a great deal of autonomy in patient care, developing a collaborative relationship with physicians, rather than being merely technical assistants (6, 7, 15, 22, 30-33). This was illustrated in one study in which nurses worked in an ambulatory clinic for those with chronic illness. Using individualized care plans with medical and nursing objectives and standing orders, they could handle 95% of patient visits (31). In reviewing the few studies available about family nurse practitioners, Pickard, Jr. (6) reported that "nurse practitioners were able to manage between 67% and 76.9% of patients without consulting with the physician" (p. 267). That nurse practitioners could provide quality care was documented repeatedly (11, 30-32).

Reflecting the idealism of the era, there was a great deal of encouragement for nursing to nurture the talents and strength of nurses, but augment those with skills learned from medical colleagues. The NP and MD roles were seen as functioning in complementary ways by many. Nursing was encouraged to recognize that "health care is a broader concept than either medical or traditional nursing" (34, p. 94), to "not get lost in the dominant medical culture" (24, p.688) and to "integrate some medical functions with improved nursing skills in the interest of the patient" (3, p.631). Those writing at the time felt that "the special talents of nurse practitioners and physicians (could) be used in complementary instead of competing roles" (28, p.269).

Towards the end of the early era of nurse practitioners, Watergate had pushed aside talk of changes in health care. Nurse practitioners, having received the support of nursing, medicine, public health, consumers, and having filled a need in the health care system, had survived and flourished in their first decade.

The early years from 1965 to 1974 saw the development and evaluation of types of educational programs and health care providers. Studies published in medical journals supported the quality and cost-effective care provided by nurse practitioners. The 1960s, like the 1990s, was an era of change in health care. Like then, there is still a shortage of, and maldistribution of, primary care providers. There is an oversupply of physician specialists, and there is discussion of "retrofitting" them into primary care. This means increased competition for patients--and the shrinking health care dollars they represent--by a variety of health care professionals. The early years of nurse practitioners were

characterized by conflict over the role. Yet creative physicians and nurses worked together to create nurse practitioners as a means of maximizing the contribution of each discipline to America's health, an effort which must continue.

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