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*Holes in the  
Historical Fabric of*  
**AMERICAN  
NURSING**



**GOLDEN APPLE**  

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**PUBLICATIONS**

## Abstract and Summary of the Monograph

### APRNVoices: Holes in the Historical Fabric of American Nursing

An Oral History by Martha M. Libster, PhD, MSN, APRN-CNS, APHN-BC

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#### Abstract:

**Purpose:** While the Affordable Care Act in the United States has introduced significant change in American health care policy, the nursing profession has undertaken its own substantial attempt at national reform of the licensure, accreditation, certification, and education (LACE) of Advanced Practice Registered Nurses through what is known as the Consensus Model (CM). The purpose of this paper is to present some of the current concerns with the CM and its implementation through LACE as themes identified from an oral history study of the “voices” of APRNs, particularly those who have worked for decades as Clinical Nurse Specialists. **Methods:** The methods used in the study include oral history following the research guidelines of the Oral History Association and narrative inquiry. **Setting/Sample/Design:** The “voices” of 130 APRN participants were collected via an anonymous online survey format. Seven themes observed in the APRNVoices stories are analyzed in juxtaposition with seven themes derived from review of the minutes from the National Council of State Boards of Nursing “State of Consensus” meeting in April 2014. **Results:** The results of this APRNVoices study suggest that seeking “consensus” through state-to-state uniformity challenges state authority to construct statute and leads to an unraveling of the historical fabric supporting the identity of the Clinical Nurse Specialist and its holistic paradigm of professional nursing practiced by many in America. **Implications:** A discussion of the analysis of themes, solutions through storytelling, and the purpose of including dissensus in policy making and statute construction ensues.

**Keywords:** *Consensus Model; Advanced Practice Nursing; Oral History; Narrative Inquiry; LACE*

## Summary:

The APRN Consensus Model (CM) is a regulatory model in nursing designed to align licensure, accreditation, certification, and education (LACE) of advanced practice nurses. It is believed that the model will provide a “more uniform system of new opportunities through the possibility of ease of mobility across state lines” and is designed to “elevate the role of APRN’s and increase job satisfaction through opportunities to practice more independently.” (ANCC FAQ, 2012) Representatives from more than 40 nursing organizations have participated in the development of the APRN Consensus Model and now the implementation of LACE. There are many APRN’s and APRN educators who are satisfied with this historic change and have experienced the transition with ease. Current leaders implementing the CM/LACE argue that it is time to “move forward,” because they have fulfilled their obligation for listening to public (i.e. the larger body of practicing APRN’s) comment years ago; however, a new dimension of concern has begun to surface as LACE moves forward. The study described here suggests evidence for an emerging story of dissensus. There are practitioners, nurse leaders, and educators with significant concerns. These concerns range in intensity from the stressors imposed on family and practice, to prohibitive costs of compliance, to perceived evidence for restraint of trade. Two of the most prevalent concerns are the ability to become compliant with frequently changing regulations and the seeming inability for some experienced APRN’s to continue to practice at the level of their education and experience. This is particularly disturbing given this time of shortages of experienced health care providers.

The methods used in the study include oral history following the research guidelines of the Oral History Association and narrative inquiry. The “voices” of 130 APRN participants were collected via an anonymous online survey format. While some in this study, like their colleagues working on the implementation of LACE, may have agreed initially to the implementation of the CM with the hope of resolving some issues in APRN practice such as inconsistency between states about licensure requirements, the CM/LACE activity stressing one level of entry is clearly having significant negative effects on the professional experiences of APRNs, most notably in the experienced psychiatric nursing CNSs in the field, who were more than the majority of respondents in this study. Some clinicians are losing their livelihood when they have served their communities well, harmed no one, committed no crime, and in some cases trained those Nurse Practitioners who are now taking their places. The way that the issue of grandfathering is being handled is perhaps the most disturbing for many of the APRNVoices cited in the monograph. It is one thing for a profession to devise a new educational preparation program and tie it to licensure. It is another to require professionals who have had honorable careers for decades to return to college or university for more education and fulfill new requirements for practice.

Those who are satisfied with the changes represented by the current Consensus Model and LACE guidelines as well as with the emerging consensus forming around philosophical underpinnings of those adopted guidelines are given forum for expression, such as in the media campaigns promoting the support of the Consensus Model in all 50 states. There are other dissenting "voices" of APRNs, which are not given a forum for expression during this important historic transition. This study was an

attempt to provide a place for concerned participants to relay their stories.

While many acknowledge that some of the issues the CM has sought to address have been a challenge for the profession for some time, the concerns voiced in this study as repeating themes deal with the way practicing APRNs, specifically psychiatric CNSs, are being treated as a result of the significant policy changes in APRN education and licensure. Seven themes observed in the recordings of the APRNVoices stories were analyzed in juxtaposition with seven themes derived from review of the minutes from the National Council of State Boards of Nursing “State of Consensus” meeting in April 2014. They are:

1. APRNVoices: “I’m not good enough...no matter what I do...”  
CM: • Competencies Not Hours
2. APRNVoices: “I Can’t Move...”  
CM: • Moving Forward
3. APRNVoices: “I am being discarded and deceived...”  
CM: • Working Toward the Future
4. APRNVoices: “I am being forced...”  
CM: • One Level of Entry
5. APRNVoices: “Patients matter...so do I”  
CM: • Safety
6. APRNVoices: Excessive Value Placed on Prescriptive Authority  
and Medicalization of Advanced Practice Nursing  
CM: • Standardization Not Disenfranchisement
7. APRNVoices: Although it was not a major theme, there were some  
participants who have not experienced change.  
CM: • Change

One of the major overarching themes is that the CNS role is being dismantled and replaced by the NP title and role even though the profession recognizes the differences in the roles. In 2006, the NCSBN’s draft “Vision Paper: The Future Regulation of Advanced Practice Nursing” states that in seeking uniformity under a CM, Clinical Nurse Specialists will be “grandfathered and called nurse practitioners.” The CNS is, in fact, being required to succumb to absorption into an NP paradigm. For some CNS specialties, there may be little shift in ideology. Others, however, risk losing their identity all together as some of the APRNVoices have said repeatedly in the study.

It is a historic period for APRNs not only because of this significant shift in APRN ideology and statute represented by the CM. The social problems related to the extent of states’ and professions’ regulatory authority and boundaries are being sorted out at the federal level as well. Questions about restraint of trade/anticompetitive practice are being raised in many professional arenas, particularly by the health professions. In October 2014, the U.S. Supreme Court heard case number 13-534 “The North Carolina State Board of Dental Examiners v. Federal Trade Commission” on antitrust issues. All four American APRN professional associations joined together as *amici curiae* expressing concern that any ruling by the Supreme Court in this case would not in any way negatively “impact the ability of nursing professionals to practice to the fullest extent of their professional training and

education” thereby potentially “limiting patient access to quality care” (Amici Curiae Nursing, 2014). The ruling in this case will be in June 2015. There is hope that it will provide further insight from the level of the Supreme Court about the reach of professional regulatory authority and its effects on practicing clinicians, such as those represented in this APRNVoices study. Some participants in our study raised the question as to whether NP model dominance and subsequent suppression of the CNS might be construed as “restraint of trade.”

While some CM leaders have framed concern and dissent to the CM/LACE as a lack of cooperation and compliance, the APRNVoices and their representatives in organizations have requested additional dialogue in an attempt to retain experienced, quality APRNs whose jobs and livelihood are in jeopardy. It is quite apparent from minutes and reports, such as the presentation on the state of the CM after five years at a 2014 NCSBN meeting, that achieving consensus about the CM has been fraught with controversy. Those involved have been committed and worked very hard at a project they believed in. None would argue. However, dialogue with clinicians in the field appears now to be non-existent. CM and LACE meeting minutes demonstrate that organizational leaders attend meetings by invitation only. This is quite different from the typical practice of State Boards of Nursing that invite the public to comment and attend meetings regularly when policies are being discussed. The frustration that results from exclusion is demonstrated by the deep emotion expressed in the APRNVoices stories. While ambiguity about APRN practice state-to-state may cause anxiety and concern related to potential lack of control, the alternative of creating uniformity in consensus might ultimately be counterproductive in the implementation of the policy changes. The very nature of the drive to seek and achieve consensus diverts discussion to the back room. This study, however, suggests that there are important matters of concern to APRN-CNSs in particular that still need to be addressed if they too are to be able to move forward.

Many of the public documents that detail the evolution of the CM and LACE are referenced here. They suggest that there is a form of control if not censorship occurring in the establishment of the CM by LACE and the NCSBN with the stated intent of safeguarding the public, but, as those who oppose the CM in California point out, without evidence for error, malpractice, harm, or public complaint. History is a record of human events over time. Often the history that is written is a record of the "Voices" of those with power. This study has given opportunity for those without social power to voice their stories. Evidence from American nursing history is included in the monograph that describes an example of identity censorship within the discipline during the 19th century importation of the Nightingale (British) Model of Secular Education for the establishment of the "Trained Nurse." This resulted in the exclusion of a large segment of professional nurses' contributions from our history. The APRNVoices in this study strongly represent a death in terms of their perceived loss of professional vision and identity. A new identity is being birthed and many hope that there will be “consensus” across all 50 states as to what that identity will be and not be.

Is social reform possible without the acceptance of multiple views? Pluralism rather than consensus/uniformity guides the building of caring peaceful community. Valuing pluralism

and realizing the potential benefits of dissensus promotes community building and peace. One way to start dialogue when attempting to solve tough problems is to tell stories. That is the simple approach to opening dialog attempted here. Creativity flows when there is open dialogue. Dialogue opens the door for the possibility of the emergence of new solutions. Caring communities such as advanced practice nursing have the potential to meet great ideas in the air, catch them as story and generate new solutions in health care. But in a culture that values consensus as uniformity, the stories of dissensus must be caught too. Those who listen carefully to the dissensus stories actually benefit from the process. Within the dissensus stories lies evidence for the gaps or holes in the fabric of transition. There are always holes in policy; we know, because some person somewhere will find that hole and walk through it or fill it. Holes are part of nature. They are part of the nature of being human.

LACE is an interesting choice of acronym for this controversial policy in the history of American advanced practice nursing. Lace, a fabric, is actually a very fitting metaphor for the current state of the APRN CM in the US. There are holes in consensus and dissensus. There are holes in the CM too. The most striking feature of lace is that its delicate beauty is as a result of holes in the fabric. Traditionally, though the holes are formed as the lace is made—they are not cut out afterwards. According to the Lace Guild ([www.laceguild.org](http://www.laceguild.org)) established in 1976, despite the effect of the industrial revolution and the emergence of bobbins and machine copies of handmade laces, the craft of handmade lace making still exists today. It takes time to make and may be more costly, but some still prefer traditional handmade lace.

It may take more time and it may be costly, but this study suggests that there must be a kind and generous solution that would allow the valuable caring tradition represented in the stories of the APRNVoices to be preserved within the emerging CM. It is perhaps the good people represented by the APRNVoices who may be just the right size and shaped “holes” of dissensus that will beautify the LACE.

# **APRNvoices:**

## **Holes in the Historical Fabric of American Nursing**

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Thank you to all readers who participated in the analysis of the study and all reviewers whose valuable input provided greater clarity in so many ways. While many have helped in the process, the content of this monograph is my responsibility and any errors my own.

## Abstract

**Purpose:** While the Affordable Care Act in the United States has introduced significant change in American health care policy, the nursing profession has undertaken its own substantial attempt at national reform of the licensure, accreditation, certification, and education (LACE) of Advanced Practice Registered Nurses through what is known as the Consensus Model (CM). The purpose of this paper is to present some of the current concerns with the CM and its implementation through LACE as themes identified from an oral history study of the “voices” of APRNs, particularly those who have worked for decades as Clinical Nurse Specialists. **Methods:** The methods used in the study include oral history following the research guidelines of the Oral History Association and narrative inquiry. **Setting/Sample/Design:** The “voices” of 130 APRN participants were collected via an anonymous online survey format. Seven themes observed in the APRNVoces stories are analyzed in juxtaposition with seven themes derived from review of the minutes from the National Council of State Boards of Nursing “State of Consensus” meeting in April 2014. **Results:** The results of this APRNVoces study suggest that seeking “consensus” through state-to-state uniformity challenges state authority to construct statute and leads to an unraveling of the historical fabric supporting the identity of the Clinical Nurse Specialist and its holistic paradigm of professional nursing practiced by many in America. **Implications:** A discussion of the analysis of themes, solutions through storytelling, and the purpose of including dissensus in policy making and statute construction ensues.

Keywords:

Consensus Model; Advanced Practice Nursing; Oral History; Narrative Inquiry; LACE



One of the most pressing social issues in the United States (US) today is the call for health care “reform.” The word reform has become so common in the media when referring to new legislation, such as the Affordable Care Act (ACA), that one could easily make an assumption that reform is inevitable simply because a change in policy has been adopted. But reform is a complex creative process, the outcome of which is determined over time. Reform is a historical distinction. If reform occurs, there is change. Whether or not health care or any social system or structure is actually reformed or changed is determined over time by making comparison between what life was like before and after a change occurred. Change occurs when that which is perceived as new is adopted. Transition is the process of adapting to the change that people navigate with the intent to create sociocultural reform. While the ACA has introduced significant change in American health care policy, the nursing profession has undertaken its own substantial attempt at national reform of the licensure, accreditation, certification, and education (LACE) of Advanced Practice Registered Nurses (APRNs) through what is known as the Consensus Model (CM). The webpage for the CM on the National Council for State Boards of Nursing (NCBSN) website, <https://www.ncsbn.org/736.htm> delineates the purpose of the CM as the “uniformity” of state laws in the regulation of APRNs.

While many are hopeful about the success of APRN policy change and subsequent reform of American nursing, there are, as with any attempt to reform a contingent of people, those who have concerns about the ramifications of policy shift. Often the people most opposed to any particular social change are those who are disenfranchised by it in some way. The purpose of this paper is to present some of the current concerns with the CM and its implementation through LACE as themes identified from an oral history study of the “voices” of APRNs. The methods used in the APRNVoices study include oral history following the research guidelines of the Oral History Association and narrative inquiry. The nature of this type of study is known to be highly subjective in that it honors and follows the participants’ voices. Because nursing is a science as well as an art and spiritual practice, we realize that honoring subjectivity may pose a challenge to those readers who value objectivity; however, in this case, we have sought to further explore and understand some of the stories of APRNs we had been hearing for some time. Those stories are a specific sketch of the deep concerns that senior APRNs, particularly psychiatric mental health Clinical Nurse Specialists and NPs following a holistic paradigm, have with the CM and LACE.

History affords us the opportunity to understand past human endeavor and in that quest we are able to learn from success and mistake alike. However, one is most often unable to definitively discern the intimate views of the people involved in that historical moment in time when reading a public record, journal, and sometimes even a diary. The choice to conduct this study of current concerns with the CM/LACE according to the chosen methods of oral history and narrative inquiry were deemed the most appropriate for capturing the real-time thoughts, feelings, beliefs, and perceptions of those currently experiencing the CM as proposed social reform.

In the APRNVoices study, we have sought to capture the stories of those with a specific response to the CM/LACE that challenges the status quo. Only those with an actual concern

about the CM were included in the APRNVoices oral history study. For the views of those who have no concerns about the CM, the reader can view the website of the NCSBN as well as the websites of any national nursing organization or accrediting body representing APRNs. We find that the tenor of such websites and their references to the CM frames the adoption of the CM as a *fait accompli*, although its implementation is still in progress and many states and individuals find LACE confusing. What is currently under way is reform through LACE – and that reform is perceived as a matter of working out the details of acceptance, adoption, and administration state by state.

APRN licensure is conducted by each state and therein lies the greatest challenge to “consensus.” Consensus, according to the Merriam-Webster dictionary (Merriam-Webster, 1999), means “general agreement.” It is also “judgment arrived at by most of those concerned.” The campaign for APRN consensus is spearheaded by the NCSBN. The results of this APRNVoices study and its historical context presented here suggest that seeking “consensus” through state-to-state uniformity challenges state authority to construct statute and unravels the historical fabric supporting the identity and role of the Clinical Nurse Specialist in particular.

## **A Model for Consensus?**

The NCSBN reports that there are more than 267,000 APRNs in the US. Currently, there are four different professional roles in which the APRN can achieve LACE: Clinical Nurse Specialist (CNS), Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), and Certified Nurse Midwife (CNMW). “LACE stands for licensure, accreditation, certification and education. The LACE Network is an electronic platform designed to provide a mechanism for transparent and ongoing communication among organizations tasked with implementing the APRN CM and to disseminate current information to the nursing community regarding the implementation.” (AACN, March 2013, Update on the LACE Network and Implementation of the APRN Consensus Model) The LACE Network meets monthly to work toward the deadline of full implementation by January 2015. Topics discussed are: Delineation of Acute and Primary Care NP Roles, Grandfathering, Clarifying the CNS Role from Wellness through Acute Care, Other CNS Issues Related to the Implementation of the CM (lack of certification exams and integrating specialty preparation into CNS Curriculum), and Accreditation of Post-Graduate Certificate APRN programs.

The most-cited document representing the formation of the CM and LACE is the 2008 publication of the NCSBN ([https://www.ncsbn.org/Consensus\\_Model\\_Report.pdf](https://www.ncsbn.org/Consensus_Model_Report.pdf)). The rationale cited for the development of the CM is the “lack of common definitions regarding the APRN roles, increasing numbers of nursing specializations, debates on appropriate credentials and scope of practice, and a lack of uniformity in educational and state regulations limiting the ability of patients to access APRN care” (NCSBN, [https://www.ncsbn.org/APRN\\_Consensus\\_Model\\_FAQs\\_August\\_19\\_2010.pdf](https://www.ncsbn.org/APRN_Consensus_Model_FAQs_August_19_2010.pdf)).

The CNS role has posed major challenges to consensus as defined by LACE because of its historical focus on specialty rather than population. The paradigm for the CNS role is also quite different from the other three APRN roles. Role or identity confusion can emerge in

a social group, such as a profession, when members of that group hold different worldviews about purpose, values, and behavior or practice.

One of the most often-stated values of those who support the CM/LACE is that of national examination, i.e., board certification, as “protection” for the public and a “career milestone” for the nurse. Certification, credentialing, and accreditation are fully equated with safety in the CM. As a result of successful examination, certifying bodies promise professional “recognition and accomplishment,” “credibility,” and “achievement” as the “improvement in ability to care” for patients and participation in “raising the stature of nursing” (<https://www.nccwebsite.org/justask.aspx>). Who could possibly argue against certification as national policy, that is, requirement for licensure? The California Nurses Association (CNA), for one.

On March 6, 2014, the CNA submitted a letter to the Board of Registered Nursing for the state of California titled “Draft Revisions to California Code of Regulations, Article 8, Sections 1480-1484 – OPPOSE.” In the letter, CNA members questioned the authority of their State Board of Nursing (BRN) to require national certification. They requested clarity on a number of other major issues in the proposed changes to state statute related to licensure of APRNs based upon the CM. Their points of opposition include but are not limited to the following quoted excerpts from their letter:

- By requiring national certification as a condition of BRN certification as an NP, it appears that the BRN is proposing language that “supersedes the requirements of Business and Professions Code 2835.5 and thus may violate Government Code 11349(d) which requires regulations be consistent with existing statute.” They requested clarification on the authority upon which the BRN proposes to require national certification with an enabling statute.
- “We oppose efforts to compel RNs and APRNs to obtain and maintain national certification as there is no evidence that national certification improves patient outcomes. Additionally, these examinations are quite costly and there is little to no oversight of their content or validity.
- According to the NCSBN's Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements, “A Board using professional certification as a qualification for licensure/authority to practice should establish criteria for accepting the certification and retains control of the licensure/authority to practice.” In essence, then, the certification exam becomes the equivalent of the state board exam. Unfortunately, the BRN does not have control over the contents of the exam, exam security, or validity to current clinical practice; therefore, we must recommend the Workgroup eliminate this language. There is no requirement that organizations that provide national certification, such as the American Nurses Credentialing Center or National Certification Corporation, notify the BRN when test content changes... The Board, then, would cede its statutory authority to set requirements for certification in that the test may or may not reflect validated

current practice and may or may not change over time – which would be completely out of the control of the Board...in essence allowing national certification corporations to dictate APRN certification requirements to California. This presents a serious legal concern. The legal authority associated with accreditation is fundamentally linked to the legal authority to pursue enforcement. A non-governmental credentialing body cannot protect health care consumers...we strongly object to the language that NPs would be required to pay additional money to a private enterprise...

- Lack of Clarity – such as that the new language required “certification” while a subsection of the statute defines authority to practice as an APRN as “**Licensure.**”
- Change to limit NP to practice in 4 population areas. No problems in current regulation with more areas of focus. Lack of supporting information for change.
- Lack of information on grandfathering those already licensed. Cost of requiring APRNs to comply with new regulation.

(CA BRN Nursing Practice Committee Minutes March 6, 2014

**[http://www.rn.ca.gov/pdfs/meetings/np/np\\_materials\\_mar14.pdf](http://www.rn.ca.gov/pdfs/meetings/np/np_materials_mar14.pdf)**)

The National Association of Clinical Nurse Specialists (NACNS) echoes similar concerns for Clinical Nurse Specialists, who have historically been educated and licensed according to specialty rather than “population.” In their position paper on the implementation of the CM, NACNS (**<http://www.nacns.org/docs/NACNSConsensusModel.pdf>**) also voices concerns that the administrators of the exams leading to state licensure under the CM are proprietary organizations and that one of the intended outcomes for the implementation of the CM – state-to-state transfer – has yet to be worked out. The NCSBN is looking to create a licensure compact much the same as what is done in some states for RNs. But consensus requires states to agree and many are not close to consensus on that issue. One proprietary certification organization, the American Holistic Nurses Credentialing Corporation (AHNCC) also levies its concerns with the CM/LACE on the premise of philosophical differences, stating that the disease-based practice model inherent in the construction of the CM is incongruent with the model of care utilized by the AHNCC’s certified APRNs. CM and LACE meeting minutes dating back to 2006 demonstrate support for the AHNCC’s claim that the organization has been excluded from meetings because it has voiced opposition to the narrowing of APRN practice to a biomedical philosophy of care. As will be shown, these and other concerns are echoed by the APRNVoices in this study.

### **APRNVoices Study**

The study surveyed 130 health practitioners from across the US. At the time of the study, 96 percent specialized in psychiatric mental health nursing, 8 percent were in holistic care, and 10 percent in other specialties such as oncology and family nurse practitioner. Ninety percent worked with adults, 13 percent with families and 12 percent across the lifespan. Eighty-three percent were CNSs, 32 percent were NPs, and some were both. One was a

nurse midwife. Fifty-two percent hold prescriptive authority and 33 percent do not. Five people, who had no concerns about the CM, were excluded from the study. Eighty-one percent are female and 11 percent are male. Fifty-two percent are age 40 – 59 and 35 percent are in the 60 – 79 age group. Forty-three percent of the group have been practicing for more than 20 years. Fifty-four percent were employed full or part-time as an APRN. Nine percent were educators with faculty practice and another 7 percent were educators without faculty practice. Five percent were students. Thirty-seven percent were self-employed in private practice or consulting. Forty-two percent of the participants described their annual income as greater than \$90,000. Another 22 percent earned between \$60,000 and \$89,999.

## **Procedure**

The purpose of the APRNVoices oral history project was to collect some of the stories of APRNs around the country who have been experiencing concerns about the transition to the national CM and application of LACE guidelines. The guiding research question was, “What are the concerns of those APRNs who are facing the professional and personal challenges of this transition in national policy?” Upon receipt of approval through the Internal Review Board at Governors State University in Chicago, the stories (“voices” of the APRNs) were collected anonymously in an online survey format via the platform Constant Contact. Each participant entered the study through the website [www.APRNVoices.com](http://www.APRNVoices.com), where they were able to read background information on the project and were given the opportunity to participate in the study. Recruitment was conducted by a committee of five national nurse leaders who announced the website at national meetings attended by APRNs in 2013. All participation was confidential, anonymous, and voluntary. The online survey was open until December 2013.

Because no website or survey vendor is 100 percent immune from hacking, there was a potential risk that the data collected could be hacked on the vendor’s server. Therefore, no personal data was collected, except the state in which the APRN was licensed. Inclusion criteria were that the person held a master’s-level degree in nursing and was an APRN. Exclusion criteria for this oral history were that the participant had to have a personal/professional story of concern about the Consensus Model or LACE. All those who had no concerns with the implementation of the Consensus Model have other venues for telling their stories. The survey platform was used to implement the exclusion criteria, allowing for the focus of the study on a specific population of APRNs.

The study began with a greeting, which served as the consent, followed by a 17-item survey, and a closing “thank you” page. The first item in the survey verified consent agreement. The next 14 items collected demographic data but nothing of a personal nature save the identification of the state in which the APRN participant is licensed. (See survey attached). The final two questions provided space (1,000 characters each) for the participant to voice their story. The principle investigator (PI - Libster) for the study monitored the website bi-weekly. All demographic quantitative data were managed with SPSS software. The PI and three readers (Shields, Evers and Anonymous) conducted a thematic analysis of the qualitative data (the voices or histories) collected by reading and reviewing the stories.

The initial reading was by the PI, who is a historian, and the first reader, who is a narrative researcher and storyteller, to capture an overall impression of the “voices” collected during the web survey. The impressions were then discussed followed by a second reading to begin noticing repeated ideas. A third reading was conducted to identify emergent themes and capture the narrative within the theme to be able to tell the story. Two additional readers, both APRNs, were asked to read the “voices” (without any other data access). They were asked to give their impressions of the voices and summaries of the repeating themes they observed. Data saturation, (no new information emerged), was reached early in the reading, yet all narratives were read and included in the reporting.

In general, the most striking theme was the participants’ belief that the CM and LACE had in fact been fully implemented and their concerns that centered around the seriousness of the loss associated with the changes resulting from the implementation of the CM. Reading and then reflecting on the stories shared by these participants revealed their truths and experiences of living with the day-to-day reality of the effects of the ongoing process of implementation of the CM through LACE. The stories reveal an emotional transition of sadness, fear, anger, distrust, disbelief, and acknowledgment of having to give up a treasured part of their personal identity and nursing history. We were struck at the tenor of the stories and how very different they are from what are reading on websites and hearing in professional meetings about LACE.

Therefore we thought it significant to present the themes that emerged in the participants’ stories (data) here with verbatim excerpts of the actual voices. The excerpts are organized thematically for purposes of analysis and publication. There is a perceptible deviation from the status quo represented in these stories. In light of this, we decided to present the APRNVoces and themes in juxtaposition to themes representing the status quo for which we selected those derived from an analysis of the minutes of the NCSBN “State of Consensus” meeting held on April 23, 2014, in Chicago, Illinois (<https://www.ncsbn.org/4621.htm>). Seven APRNVoces themes and their juxtaposing NCSBN themes are presented here.

#### Themes

APRNVoces: “I’m not good enough...no matter what I do...”

CM: Competencies Not Hours

Voices: (Excerpts from stories that exemplify the theme.)

- I resent the fact that changes to practice/educational requirements are continually being made by those who lack the same degree of clinical expertise.
- I did everything that I was supposed to (master's, doctorate, publications, CEs, etc.). I will never tell anyone to go into nursing. It has been oppressive to me and I don't think that people in this profession will ever stop hurting each other or deciding that we are not good enough. Physicians and lawyers treat one another with respect but nurses just keep each other down. I can't afford to get another degree!
- Well, for one I no longer meet the qualifications for my present job and CNS is not recognized.

- I am an award-winning and record-setting graduate of one of the very top graduate programs in 1990, with many academic honors and a number of peer-reviewed publications who put my career first and am now facing the end of my career although I am only in my early 50's.
- Having earned two Master's degrees from \_\_\_\_\_, I thought I would be forever ready to participate in the health care workforce. Maintaining my licensure and credentials was daunting but kept me abreast of the state of the science... I spoke with a rep at ANCC who informed me that I would need a post-master's certificate as either a PsychNP or Family PsychNP to apply to sit for the boards to be most current.
- I need 500 hours of supervised practice. So while I have had prescriptive privileges for years, I will need to spend thousands and go back to school to be credentialed to do what I already do.
- Might as well be an MD. AND I DON'T WANT TO BE AN M.D., NEVER HAVE. It is bad enough that nurses no longer know how to care for patients, and the ones who skipped elementary nursing are not practicing and acting like M.D.s, as are PAs.
- I have practiced through my entire career. I felt I had to return to school to get an NP after ANCC retired exams because I don't want to be in the position where an illness or move to a place where it is difficult to find a collaborator jeopardizes my career.
- Trying to become a nurse practitioner. I am currently a CNS. The state university in the state in which I live will not accept my MSN credits from the state university where I obtained my CNS MSN. I have been told I must return to the state where I originally graduated so my courses can apply towards a nurse practitioner degree. I am now faced with out-of-state tuition in order to take courses to complete my nurse practitioner degree. Out-of-state tuition is three times what it would cost me compared to my in-state university. I also have a 200-mile commute from each state to state to attend these classes. This is a hardship on me and I believe this doesn't make any sense.
- I decided to return to school. At the University from which I graduated, I was told by the assigned academic adviser, "I am sure you are a very good therapist, but a psychiatric nurse practitioner is a totally different specialty." I have had to repeat over 12 credits that I took in my original program and in the end will have had to take 27 credits to get a post master's certificate. The cost is unbelievable. Over \$12,000 this semester alone for repeating.
- So here I am, many tears later as CNS with prescriptive authority and battling getting on insurance panels since I am not a NP.
- I worry that CNSs will eventually lose their prescriptive authority and will not be viewed as favorably as NPs... am concerned that insurance companies will stop covering CNS care, particularly my certification since the test was phased out.
- As it is turning out we are being viewed more as a poor man's primary care provider than a specialist and master of an area.
- I know I can continue to keep my certification – which I plan to do – but I fear the day when my supervisor (a PhD in Psych who seems not to appreciate Psych ARNPs) tells me I need to get my Nurse Practitioner training in order to continue

the work I've been doing here for 13 years. What other profession makes changes decades later without grandfathering in the earlier group?

- There is no interest in the CNS designation – in fact, many people STILL do not know what a CNS is...and this will only get worse... later stages of professional life in an unfortunate position, jump through one more hoop so I can practice in any state I want and have freedom to move if I so choose? LACE ensures that will be necessary.
- The consensus model is absurd, and to my mind feeds into what I call the profession's "inferiority complex." Sad to say that.
- I find it absurd that I can supervise & percept both adult and child & adolescent NP students but I don't have enough hours to sit for the exam.

Analysis: Numerous participants shared their repeated attempts to meet the requirements that seemed to be changing continuously and inconsistently, e.g., education, employment, board certification, and state licensure. The narratives demonstrate deep frustration and, in some cases, resignation that no matter what they did, they would “never be good enough.”

1. APRNVoices: “I Can’t Move...”  
CM: Moving Forward

Voices:

- It would prevent me from relocating to another state to practice, have had a hard time in NY State getting employed in a private practice b/c they all tell me that I cannot get insurance reimbursement, so they don't even give me a chance.
- This will limit my opportunities in the future to return to APRN/CNS practice should I decide to do. I will be unable to do so because my CNS certification will only continue to be honored in this state.
- I do believe that consistency with the same criteria for each certification state to state is and should be one of the goals of the consensus model. ANCC is saying I can continue to practice as a CNS with board certification & I can continue to practice and maintain that certification as long as I do not let it expire. So if some reason or another my certification expires, I will be out of luck. I will not be able to take the certification test again, since they will retire such certification test at the end of this year.
- Uncertainty of how I will be able to practice and where in the future.
- However, I have great concerns for the near future when my specialty ANCC certification as an Adult Psychiatric Mental Health NP will be no more but be replaced with the Family version that I will be unable to find work elsewhere.
- Have concerns about moving out of state as a CNS at this point as the Boards of Nursing vary from state to state with regards to being able to prescribe.
- It will negatively affect me if I ever want to transfer to another state.
- Would be concerned if considering move.
- Since the licensure for psychiatric CNS and NP is being withdrawn, I have concerns re: moving to another state.
- All states' licensure requirements are not the same. It is difficult to accept forcing



- people to return to school or get additional certifications. Granted, I am for CE as a requirement to a degree. My future mobility across states may be significantly impacted.
- Need all these changes to be recognized by the health care industry and to receive adequate reimbursements.
  - Concerns about moving to another state and what the implications would be in terms of reciprocity.
  - This will absolutely diminish my employment option.
  - I am limited to what states I can practice in which means I cannot move to any state I want.
  - The adoption of the Consensus Model has become a major barrier to my ability to continue to practice as an experienced Psych APRN and have the mobility to move east to care for my aging parent.
  - PMHNP may not be recognized in other states in the future. I don't anticipate an issue at my age.

Analysis: Participants shared the concern that they were being put in a position that diminished their ability to move, whether within the profession or between states. Many discussed the inconsistency between states and how they could not physically move without being affected by recognized regulations during the transition.

## 2. APRNVoices: “I am being discarded and deceived...”

CM: Working Toward the Future

Voices:

- My experience has been that the nursing profession, rather than supporting their ranks and building on the successes of their early APRN pioneers, is working to undermine itself.
- I feel as if CNSs, especially Psych CNSs like myself, are being discarded.
- Onset was that the Consensus Model/LACE would move our practice away from nursing and psychotherapy to a role as physician extender with emphasis on diagnosis and prescription.
- We are deceiving ourselves and selling out to market forces rather than advocate for increased standards. I fear changes directly and indirectly related to LACE are destroying my career.
- I feel no one cares or appreciates the CNS and everything we have contributed.
- One of my main concerns is the risk of irrevocably losing my certification in the context of the retiring of the psych CNS exam and the increased difficulty finding a CNS position.
- What a loss! I was miserable, left job of 25+ yrs and moved to PT consulting in community where I now provide Med Mgmt in isolation.
- I no longer teach, no longer mentor, no longer respect APNA.
- But I have totally lost my professional identity. If I were 20 years younger, I would probably pursue other graduate education, and change careers entirely.
- I still grieve. My CNS training/expertise is far more valuable & rewarding than Rx skills. LACE was meant to elevate the APN role but the opposite happened.

- Worker is NOT valued and they can just train others to take your place. Nursing used to be a lot of fun.
- My organization is only hiring Nurse Practitioners at this point in psych-mental health. The priority is to prescribe and see as many people as possible.
- I am very saddened that the CNS title will likely not be around much longer. I am okay with being an APRN but I am NOT an NP. My scope of practice and training is greater.
- I graduated with my Master's and the following year, my certification was "retired"... I do not know the impact of these new decisions. I guess I am relying on faith that this will all work out.
- By eliminating the specialty age groups, we are/have watered down and diluted the nursing profession to be nothing more than generalists. This of course is exactly the overall arching plan though with regard to the dismantling of the profession from within.
- Now when new RNs call me a NP I don't even bother to try and teach them the difference. I figure they will be right in a few years. Everyone in my position will be a NP.
- It makes me angry to be in a profession where after thirty years of practice, I would have to return to school because the rules changed. It makes me feel marginalized that my 30 years of practice, continuing education, and contributions to the field are not valued enough to make the powers that be see me as someone who is as competent as a newly graduated APN.
- What I can say is the following: It was very difficult to speak with anyone at ANCC by phone or email and when I was able to reach the designated staff was told to contact Schools of Nursing to determine the requirement for a post master's which would be needed to sit for the exam.
- Each job I have had there have been great obstacles to overcome in regard to physician resistance to accepting NPs as part of the care team. I have experienced quite a bit of incivility in the workplace from physicians and, believe it or not, RNs who are not NPs. This is somewhat disheartening
- When CCNE did our visit for accreditation in 2010, we were "cited" bc I was the director of a program and was a psych CNS, not an NP according to the Essentials document used at that time! I had been on a work group and knew this was likely to change bc it was an issue across the country. However, in our administrators' response to CCNE, they said I would be going back to school to get my psych NP (I had no intention of doing this and apparently someone failed to mention this to me!) Notably, I have owned a very successful private practice since 1992 and started prescribing many years ago (as soon as our state allowed)... The only reason to do this was to meet an absurd "rule" that if you were director of any NP program, you had to be an NP. Felt dismissive, devaluing, and was a burden.
- What distresses me is that the nursing profession continues to avoid making a decision about baccalaureate education as entry level to practice yet a DNP will soon be required for my old psych liaison position.
- I must also mention that I am in private practice part time and am most distressed that my professional liability insurance is now \$1200 + a year because of the Consensus Model and I pay the same amount as a NP who is prescribing

medications! How about those apples! An example, once again, of the nursing profession selling out its own members.

- ...CNS colleagues will feel disenfranchised and leave the profession, however I am also concerned they are putting pride before parity.
- I do wish the ANCC had been more astute and offered either a bridge exam or proof of competency through continuing education as a means for experienced CNSs to attain the NP – universities are providing tailored programs to meet the need so there is little reason the ANCC could not have made an effort.
- Nurses "eat" other nurses in ways that are not mimicked.
- What other discipline or profession requires one to continually prove their knowledge and provide proof that they are not obsolete? How many hoops do we have to jump through?
- I feared repercussions of LACE on CNS - returned @ 52 to get FNP (tuition costs low as Univ employee, but added stress on top of a 50-hr work week) w/ remarkably little knowledge acquisition. Yet another senseless Nursing "hoop."
- Why do nurses have to do this?
- I am extremely concerned that the CNS is now not the certification....nursing continues to "divide" more roles.
- With the new model coming I will be in an even worse position, since the only advanced practice nurse that is recognized is the NP. Nursing organizations have not been promoting the CNS, and will definitely not promote it after.
- And once the certification is gone, there will be no market/jobs for those who have it. I am not recognized as an APRN and am not licensed to work at the level of my education, experience or expertise.
- I have concerns about what will happen to the role of CNS.
- Am concerned about some of the things that I hear about LACE...that perhaps I will not be able to receive third-party reimbursement, that my board-certified CNS will be seen as a thing of the past & will not be an asset in terms of job searching, that clients will not know what this means anymore. I am afraid that because I am in this transition, I have transitioned myself out of a nursing position.
- Per ANCC regulations, I was barred from taking this test, as I did not have 500 hours of supervised clinical practice, within my Master's program. I was told that I need to return to University setting to complete 200 additional hours of clinical practice. This is an affront to me, as I had been functioning at CNS level for several years.
- Employment, but how I was totally sold out by my own discipline. Hospital administrators and doctors have not been so cruel. The Grand Dames of ANCC changed my life forever, and not in a good way. ANCC has no integrity, function as a giant guerrilla group.
- I face not being able to continue to be certified in the future. The test to recertify will no longer be an option... Therefore, I bit the bullet and am now back in school to become a psych NP. I am spending a great deal of time.
- They didn't even ask whether you are a CNS. Even though I could answer "yes," it made me mad that CNSs would obviously not be considered. It was probably out of ignorance, but the results excluded the CNS. And the irony is that the position

was for a psych consultation position, one of the roles of the traditional CNS.

Analysis: Participants revealed their deep concern with the way their own nursing colleagues have treated them in the process of making change.

3. APRNVoices: “I am being forced...”  
CM: One Level of Entry

Voices:

- The CNSs have been marginalized by the profession in the LACE document and are not included. As a CNS originally, I did go back to school and took more courses about content I already knew so I could take the Adult PsychNP exam, which I did.
- As I stated above, I felt thwarted when attempting to get my ANCC board certification by the numerous barriers that were imposed. Each time I applied to sit for the exam and was then told I needed even more class work (with no recognition of experience). The ANCC also kept a large part of the admission fee. I 'lost' \$400 being denied.
- One amendment in the bill will force APRNs to be ineligible for licensure if they own or possess shares in PCs or PLLCs! This is incredibly WRONG! The amendment to the bill is theoretically supposed to prevent APRNs from establishing their own practices and that not only discriminates against us as small-business owners, but more importantly, it will block any improved access for our Michigan residents to primary health care.
- Psychiatric CNSs were the first APNs. Now, there is no longer Psychiatric CNS certification available and no psych CNS programs. Due to LACE, people assume I am an NP, which is a different protected title than my own. I am forced to offer long explanations of my professional credentials.
- LACE has just thrown aside independently practicing CNSs and confused the public further. The solution was divisive and back stabbing. All APRNs should have been included with an emphasis on the APN or APRN title. In my view this was simply a heavy-handed abuse of power by Nurse Practitioner advocates.
- I was precepting 2nd year NP students (OHSU in PDX) who could sit for the NP exam I couldn't take. REALLY?! NO ONE outside nursing could believe the DNP program I started was almost - politically brainwashing students to be systems/administrative/political activists.
- I am not interested in paying \$50,000 now to keep my career. I instead choice [sic] to start learning the accordion and travel...I have done over 100 hours of continuing education a year to stay up to date. I retook medical physiology for two semesters to revisit what was new. I took physical assessment at the graduate level while commuting from bush Alaska... Nursing is no longer working for me... Nursing used to be a lot of fun.
- Main concern is over the methodic dismantling of the CNS role. Most recent example is ANCC eliminating the psych CNS exam claiming "practice similarities" with psych NP role. This is hogwash.
- This restriction of trade has been and continues to be unacceptable.

- I was asked to review the newly emerging LACE taskforce work as they constructed the Consensus Model several years back. Aghast at what I was reading and anticipating many issues for those of us in practice, I expressed loud oppositional feedback in hopes of advocating for those of us in practice, with the knowledge that state-to-state regulatory individualities would also complicate the stated goals of the Consensus Model. I received a postcard from the ANCC years later, several years ago, welcoming me to understand the Model and its implications for my practice.
- And the issue is a monetary one. Stop hiding behind how we are elevating the practice. Nursing and educators want to continue to fill their pockets. Making everyone go to school two more years will do it.
- I do not want to be forced to go back to school to re-define the degree and specialty that I already have earned and excelled at. When I return to school, it will be for my PhD and I will sadly need to retire my CNS.
- I can afford to work where I want or retire, but the state is forcing me to choose the latter.
- No longer licensed as "advanced practice nurse," since I left the State of Georgia, and did not duplicate this license elsewhere. What I am SUPREMELY ANGRY ABOUT is how this entire process took place.
- The clinic was taken over by .....medical center. In preparation for this, they had a process of on-boarding that was practically abusive.
- If the consensus model had consolidated PMHCNS along with PMHNP, to make one category (APRN-PMH ) then we all would be better off. Role confusion exists with potential employers and others.

Analysis: Participants are angry about what they are being forced to do. Their voices are not heard.

4. APRNVoices: “Patients matter...so do I”  
CM: Safety

Voices:

- Suddenly the focus changed to be across the lifespan.
- That saddens me as there are so many differences between caring for a 25-year-old versus an 85-year-old and the model no longer distinguishes that as specialty practice.
- I am concerned that insurers will seize this opportunity to deny claims for patients. I have finally gotten insurance reimbursement for clients to practice "across the life span." It seems to "dumb down" the depth of knowledge that is needed to address issues of the various stages of life.
- I cannot possibly list my many concerns about LACE and its impact on expert practitioner and patient care.
- The consensus model thinks MH-APRNs should treat across the lifespan; while psychiatrists with more education have to specialize to be certified for adolescents and children. Seems backwards.

- This concept of practicing cradle to grave is absurd.
- Retiring the CNS designation creates confusion and a schism with Psychiatric NPs.
- There is such a shortage of advanced practice psych nurses in Florida that some physicians are giving adult NPs protocols to follow and letting them loose in LTC facilities to treat our most fragile, difficult patients.
- That means I am a psychiatric mental health child and adolescent CNS and I'm never going to be anything else.
- When I was first certified as a CNS in 1990, I was able to have an independent private psychotherapy practice. The requirement to collaborate with a psychiatrist has been both a blessing and a curse...we all know, there is a paucity of Psych NPs in psychiatry who might do therapy and medication management and even fewer psychiatrists who do both.... back in business but fully aware of how dependent I am upon another person to practice and provide for my patients.
- I am sad that APNs in the Psychiatric specialty will no longer be nurse psychotherapists and also nursing staff development experts.
- NPs are not system focused, psychotherapy focused or education focused. The consequence in society will be less expertise on patient outcomes, psycho-education and therapy. Nurses will not have staff development expert mentors in the future.
- I am truly distressed for the future of our profession.
- My main concerns with the consensus model for mental health are the de-emphasis of counseling/therapy skills that leave PMHNPs primarily functioning as physician extenders prescribing only; the lifespan certification that eliminates many existing practitioners.

Analysis: Participants were deeply saddened about the way the CM/LACE was affecting them and the impact this has on patient care. They expressed great concern over the lifespan requirement, loss of specialization (now all generalists), emphasis on medication, and de-emphasis on therapy (psych CNSs).

5. APRNVoices: Excessive Value Placed on Prescriptive Authority and Medicalization of Advanced Practice Nursing  
CM: Standardization Not Disenfranchisement

Voices:

- Elimination of this exam is really just the latest in an overall effort to medicalize the profession and move the paradigm towards a medical model of practice.
- Prescriptive authority is highly overvalued. Advanced practice seems to have become synonymous with prescriptive authority.
- I was valued only for my prescribing and not for my psychotherapy skills. I was best at helping people get off psychiatric meds!
- As a CNS-NP, both consumers and employers felt that what I primarily offered was the skill, tho less (and less expensive) than an MD, to prescribe. My well-honed psychotherapy skills were considered "extra" or "non-essential" to be offered whenever I could "fit it in." This was made clear by how patients were scheduled,

how I was introduced, and how salaries were paid... I now practice both as a staff nurse and as a CNS. I mentor PNP students.

- I am not so much bitter as sad about what is going on. I think we are really closing our eyes to the psychotherapy side of things in favor of the medical model approach.
- I have noticed that the NPs in my institution are becoming more focused on the medical model and with less focus on the patient as a whole. This is disturbing to me as I believe that the benefit to patients as having a nurse as a primary care provider is the holistic and relationship-based caring that nurses are prepared to practice.
- I figured out that in my 30 hours a week capacity, I was seeing more patients than the 2 full-time people.
- I am very disappointed that many states do not permit CNS with prescriptive authority to prescribe medication.
- CNS seems undervalued (within the nursing sector only). Advanced practice seems to have become synonymous with prescriptive authority.
- I feel no need to prescribe as I have plenty of trusted colleagues (both MDs and NPs) to refer to and I offer evidence-based psychotherapy from a mind-body perspective using my nursing education.
- My state requires a physician mentor for prescriptive authority.
- I am also very bothered by the emphasis on prescribing and reduced emphasis on therapy as a way to treat our clients. While it is true that some might benefit from medications, many others simply need therapy to address their issues. A pill does not “fix” some things, and abbreviated visits with a prescriber do not meet their needs.
- Keep in mind that in 1976 when I started grad school, there was no other way to specialize in Psy, except a CNS program... Here I am tears [sic] later as a CNS with prescriptive authority and battling getting on insurance panels since I am not an NP.
- I soon realized I did not want to have a prescribing practice...
- It is harder & harder to find a collaborator that agrees with my practice style. Frankly I am much more thorough than they are and I am uncomfortable with their level of care and/or the way they use higher doses of medication than I think is necessary.
- I am not interested in prescriptive authority. If I had been, I would have gone the NP route.
- I am VERY concerned! Also consensus model requires changes in curriculums that negatively affect education of CNSs who do not need or want prescriptive authority.
- I am very disappointed that many states do not permit CNS with prescriptive authority to prescribe medication. The requirement to have NP certification is extremely unfair and restricts the ability to practice.
- I have thought from the beginning of the LACE model that eventually, it will be realized that a huge mistake has been made – as the existence of the Speciality areas will be sorely missed and we will need to return to valuing the CNS expertise. Psych NPs do not get the same level of concentrated study as CNSs.

Analysis: Fifty-three percent of the participants hold prescriptive authority. Many spoke to the excessive value placed on the task.

6. APRNVoices: Although it was not a major theme, there were some participants who have not experienced change.  
CM: Change

Voices:

- The Consensus Model has affected my practice (and the practice of my colleagues) in that the administration in our company is paying more attention to reimbursement by insurance. We have had some companies that have refused payment due to CNS level of care and this has resulted in the administration having to get more pro-active.
- The gains we have made with public recognition have been remarkable. NP is a common term now. We need to find a way to blend the CNS and NP and respect each group as competent clinicians.
- At this point nothing has changed. I have read I have been grandfathered in with all my rights and privileges...this was in an initial letter I received from ANCC... I am reading the opposite elsewhere. I do believe that many nursing titles can and should be consolidated.
- I am concerned my CNS colleagues will feel disenfranchised and leave the profession, however I am also concerned they are putting pride before parity. Phasing out the CNS does not mean that we are eliminating the role, but rather adding and integrating skills into the NP designation for a more holistic provider and to decrease confusion in the marketplace.
- In California there is tremendous opposition to NPs practicing to the full extent of their education and experience. We recently had a senate bill that was defeated that would have expanded our ability to work without a collaborative agreement with physicians.

Analysis: Change is inevitable but the transition or adaptation to change is a creative process. How transition is conducted is a reflection of the values, beliefs, ethics, and knowledge of those in leadership and those who follow those leaders.

## **Synthesis of Analysis of Themes**

While many acknowledge that some of the issues the CM has sought to address have been a challenge for the profession for some time, the concerns voiced in this study as repeating themes deal with the way practicing APRNs, specifically psychiatric CNSs, are being treated as a result of the significant policy changes in APRN education and licensure. One of the major overarching themes is that the CNS role is being dismantled and replaced by the NP title and role even though the profession recognizes the differences in the roles. Education and “certification” of new Psychiatric Mental Health CNSs have already been dismantled. The APRNVoices demonstrate that this change to education and certification has had a negative impact on those CNSs continuing in their practices. In many cases, employers, third-party payers, and the public are working with Psychiatric NPs only. The CNSs are concerned that they may not be reimbursed where they had before, that



employers are hiring NPs, and that they are left with facing a campaign that has strategically supported the biomedical paradigm as *the* dominant and preferred APRN model of care. APRNVoices know that there are those who are “waiting for everyone to come into compliance” as was stated by the NONPF President at the NCSBN April 2014 meeting on CM. While some CM leaders have framed concern and dissent to the CM/LACE as a lack of cooperation and compliance, the APRNVoices and their representatives in organizations have requested additional dialogue in an attempt to retain experienced, quality APRNs whose jobs and livelihood are in jeopardy.

Analysis of the themes in the study seems to suggest that a new dimension of concern has begun to surface as LACE “moves forward.” It is normal to expect that this might occur. While some in this study, like their colleagues working on the implementation of LACE, may have agreed initially to the implementation of the CM with the hope of resolving some issues in APRN practice such as inconsistency between states about licensure requirements, the CM/LACE activity stressing one level of entry is clearly having significant negative effects on the professional experiences of APRNs, most notably in the experienced psychiatric nursing CNSs in the field. Some clinicians are losing their livelihood when they have served their communities well, harmed no one, committed no crime, and in some cases trained those who are now taking their places.

States that adopt CM language for their statutes and become part of an emerging compact of states seeking to dissolve licensure inconsistencies from state to state may face other problems, such as losing quality, experienced APRNs to other states or other professions. The concerns of the participants in this study are not minor. We provided a place through this study for people with concerns to tell their stories. Their stories are compelling perhaps mostly because those telling their stories are highly experienced experts. They were listened to thirty years ago when they were courageous enough to pioneer advanced practice licensure when it was unknown. They are courageous enough today to participate in this study and speak their truth. It seems prudent that their voices, if not their presence, would be invited as we move forward in CM implementation. These data suggest a need for seats at the table at LACE meetings for APRNs who may be unaffiliated with professional organizations, universities, and regulatory bodies.

## **Grandfathering**

The senior APRNs who tell their stories in this study about their decades of caring practice question the grounds upon which the states may, under the CM created with the intent of furthering public safety and quality APRN care, demand that they incur extensive expense to make significant changes to their practices. The biggest issue for senior clinicians is the required change of role from CNS to NP. The two roles are philosophically very different. Much of the concern and dialogue around LACE implementation has to do with inclusion and exclusion criteria related to grandfathering. Inclusion and exclusion for initial entry into advanced practice is not a concern for students because they are given the opportunity to make a choice as to whether they will spend the time and money to achieve education, certification, and licensure in an area of practice that has been established in congruence with LACE. But current recommendations do not call for unequivocal grandfathering of CNS clinicians licensed prior to LACE. The outcome of the state of LACE implementation

is the absorption of the CNS role into the NP.

The way that the issue of grandfathering is being handled is perhaps the most disturbing for many of the APRNVoces. It is one thing for a profession to devise a new educational preparation program and tie it to licensure. It is another for the people who do that to exercise their power to require professionals who have had honorable careers for decades to return to college or university for more education and fulfill new requirements for practice. This sends a clear signal that the practitioner has somewhere, somehow been deemed deficient; yet, without any evidence for that deficiency, is to be required to fulfill newly construed requirements for practice, licensure, and reimbursement. Many of the APRNVoces spoke of being the very ones who educated those who now occupy seats of regulatory and educational authority on advanced practice that is, in effect, extinguishing their role and livelihood. Others spoke of establishing policies decades ago that made it possible for the current APRN practice to exist at all. Yet the LACE meetings, are held by invitation only and meeting minutes are selectively posted to the LACE Network website. Specifically, minutes for meetings between 2008 when the CM document was published and 2012 are not available. Even more disturbing is the fact that minutes for meetings at which grandfathering issues were discussed are not available for public access.

Current leaders argue that it is time to “move forward,” because they have fulfilled their obligation for listening to public comment years ago. A state lobbyist representing organizations supporting the CM told one of the PI that “grandfathering occurred years ago,” suggesting that in some states grandfathering was conceived of as a one-time opportunity without thought for those who move to or are recruited to the state in the future. It is quite apparent from minutes and reports, such as the presentation on the state of the CM after five years at a 2014 NCSBN meeting, that achieving consensus about the CM has been fraught with controversy.

(See [Video](#) and [Transcript](#)  
**[https://www.ncsbn.org/transcript APRN 2014 KApple.pdf](https://www.ncsbn.org/transcript%20APRN%202014%20KApple.pdf)**)

Those involved have been committed and worked very hard at a project they believed in. None would argue. However, dialogue with clinicians in the field appears now to be non-existent. CM and LACE meeting minutes demonstrate that organizational leaders attend meetings by invitation only. This is quite different from the typical practice of State Boards of Nursing that invite the public to comment and attend meetings regularly when policies are being discussed. The frustration that results from exclusion is demonstrated by the deep emotion expressed in the APRNVoces stories. Some question if there might not be sufficient evidence to support an investigation by the Federal Trade Commission into the accusation of restraint of trade.

**[http://www.ftc.gov/system/files/documents/public\\_statements/568171/140716professionallicensurehouse.pdf](http://www.ftc.gov/system/files/documents/public_statements/568171/140716professionallicensurehouse.pdf)**.

These study participants are not the only people concerned. The APNA blog is replete with postings by CNSs who are “receiving no credit” for their decades of continuing education, good work, and service. The APRN CM is “designed to elevate the role of APRNs and increase job satisfaction through opportunities to practice more independently” (ANCC,

CM FAQ). Yet, the very ones who have been practicing independently for decades, the Psychiatric Mental Health CNSs, for example, rather than being a model for the policy shift have become victims of it. It was the senior APRN-CNSs who carved out the role and practice in the first place thirty years ago. While some Psychiatric CNSs did in fact support the changes that have occurred over the past few years, the participants in this study do not. Many of the public documents that detail the evolution of the CM and LACE are referenced here. They suggest that there is a form of control if not censorship occurring in the establishment of the CM by LACE and the NCSBN with the stated intent of safeguarding the public, but, as those who oppose the CM in California point out, without evidence for error, malpractice, harm, or public complaint. A censor is defined as “one who supervises conduct and morals; an official who examines materials for objectionable matter and a hypothetical psychic agency that represses unacceptable notions before they reach consciousness” (Merriam-Webster, 1999). What appears to be occurring is the suppression of any type of Advanced Practice that does not resonate with the ideology of the NP as represented by the guidelines and standards set forth by the National Organization of Nurse Practitioner Faculties (NONPF). None seem to argue the rights of nurse leaders, educators, and regulators to seek the evolution of education and practice standards or even in the paradigm in nursing. It is the encroachment on the livelihood of licensed-practicing APRNs and the protection of a legislative platform that supports the future growth of the profession that is troubling to the APRNVoices as CNSs and holistic nurses in particular.

At annual NCSBN meetings on the CM, the phrase used by those responsible for leading the process of working out the details is “coming into compliance.” In the midst of great confusion, APRNs are being asked to be compliant so that consensus can be achieved. The questions posed by the APRNVoices suggest that this compliance is being achieved through censorship of advanced practice nursing, particularly of the CNS role. This censorship represents significant reform to nursing policy and practice, and it also is a significant alteration to the history, that is the story of identity, of APRNs in the US.

#### Aligning APRN History in America with Reform

Identity censorship has happened before in American nursing history. It occurred during the antebellum period (the 19<sup>th</sup> century prior to the Civil War 1830-1860) that was one of significant social reforms in banking, industrialization, religion, and government. Some social activists of the period cited health care reform as the most critical of all social reforms upon which the others depended. Nursing history demonstrates that nurses provided leadership in their communities for much of the social change that the people cried out for. Many, if not most, of the professional nurses in the country practiced within the support structures of religious community (Libster, 2004). Although they relied strongly on each other and their communities for education, practice guidelines, and support, they practiced as autonomous decision makers, expert practitioners, and community confidants. Nurses often worked collaboratively with physicians and other community healers to promote individual, family and community wellness and quality health care by caregivers when needed in infirmaries, hospitals, asylums, and the home. Nurses of the period were empowered, entrepreneurial, and deeply respected in community. They did not have licensure, accreditation, or certification, but they did have education.

Nurses of the period were educated on the job according to tradition by trusted and experienced mentors. For example, the American Sisters of Charity, founded in 1809, were taught according to the *Common Rules* passed to them from their French counterparts, the Daughters of Charity, which had been in existence since 1633. It was these very same *Rules* that Florence Nightingale studied when she stayed with the Daughters in Paris during her own period of formation in the mid-19<sup>th</sup> century (Libster & McNeil, 2009). In the later part of the 19<sup>th</sup> century in America, however, nurses ceded their power base in community in the quest for secularization and separation from Catholic dominance of nursing work. “Modernization” of nursing in the US had become equated with secularization. Nursing history was censored and in essence re-written by Lavinia Dock (1858- 1956) and Isabel Stewart (1878-1963) in 1901 in support of the emerging Nightingale Model of “trained” secular (e.g., Protestant) nurses (Libster & McNeil, 2009, pp. 303-309). Despite the fact that Dock often cited a report by the American Medical Association that referenced a popular history of nursing by a Mrs. Jameson titled *Sisters of Charity*, Dock did not include the historic record of the Catholic Sisters’ significant accomplishments in the development of professional nursing in America in her books. Dock and Stewart did write a general statement in their 1925 book, *A Short History of Nursing*, that religious orders used “ancient ways” in caring for the sick and that they were “gradually altering” those ways by “attaching secular training schools to their hospitals” (Dock & Stewart, 1925, p. 147). Thus, the history of early American nursing has remained lost to many American nurses to the present day.

Graduates of secular training programs were given a specific title as “trained nurse.” There were still no licensing boards or national exams for nurses in the late 19<sup>th</sup> century, but programs that produced trained nurses typically provided their graduates with certificates of completion, which the nurse could then show as evidence for her qualifications. Whereas a Catholic nurse’s reputation was associated with her community’s history and experience, Protestant or lay nurses who entered the profession had no attachment to a record of public service. Instead, they depended upon the reputation of their training institutions that certified their safety and preparation.

Dock and Stewart concluded their historical assessment of nursing stating that when the Civil War broke out in 1861, there were “no trained nurses in the country” (Dock & Stewart, 1925, p. 148). If the authors were referring to *all* nurses when they made this statement, it would have been a “highly critical and perhaps slanderous statement against Catholic nurses, such as the Daughters of Charity in particular, who had been considered highly educated and referred to as ‘enlightened’ by medical professionals, the public, and other nurses for decades” (Libster & McNeil, 2009, p. 303). What Dock and Stewart were most likely referring to was the absence of secular or lay programs for “trained” nurses, a title describing a specific *brand* of lay nurse (i.e., non-Catholic) who was a graduate of a “training school” based upon the Florence Nightingale model of nursing education implemented in London.

Dock and Stewart made this statement about the lack of trained nurses prior to the Civil War in their book, which is considered a “classic in the nursing world” (MacDougall,

1932). Their words, echoed for more than eighty years in articles, textbooks, and histories, are most often taken out of context to mean that there were *no* professional nurses prior to the establishment of American nurse-training schools in the later part of the century. Because the history has been misinterpreted, the contributions of the Daughters of Charity and other Catholic communities are most often excluded from references to the early history of American nursing, even though the public, physicians, and nurses perceived their contributions as the professional ideal of the period.

Censorship of history leads to a revision of identity. In this example, early nursing identity was expunged from social memory. Nursing prior to training programs, such as the Nightingale program at Bellevue Hospital in 1873, has been characterized time and again as deficient in formal education. Nursing and historical texts and popular literature, too numerous to count, have perpetuated a myth implying that *all* nurses prior to the 1870s were drunkards, thieves, and whores. One scholar suggests that “reformers who wanted to redefine modern nursing also lumped all old nurses together into a homogenous mass, distinguished only by its variety of failings” (Poovey, 1988, p. 174).

This myth, a gross generalization significantly removed from historical context, not only has served to distance American nurses from a powerful part of their professional history, but is also a wound in the psyche of American nurses that affects professional identity. Most disturbing about the adoption of professional identity myth rather than historical evidence is that American nurses have allowed for the loss of an entire period of history of enlightened, powerful, entrepreneurial nursing that some American nurse leaders have equated with early *advanced practice* nursing (Libster & McNeil, 2009). Neither Dock and Stewart’s 1925 text nor Dock’s earlier *History of Nursing* that she wrote with Adelaide Nutting in 1907 state specifically that there were no professional nurses prior to 1873 (i.e., no “mass of failed old nurses”); however, these histories, deliberate or not, did provide the building blocks for the construction of the defamation myth (Libster & McNeil, 2009).

This phenomenon of censoring and revising history and repeating myths about identity in personal and professional life, which over time become regarded as the obvious and the true, has been described in a number of ways. In their 2004 article, nurse historian Sioban Nelson and co-author Suzanne Gordon referred to the disowning of nursing’s past as “the rhetoric of rupture” (Nelson & Gordon, 2004). Dr. Oliver Sacks, whose groundbreaking work on L-dopa was a result of being able to see beyond the obvious, has written on the scotoma or memory hole that can be created in the history of science (Oliver Sacks, “Scotoma: Forgetting and Neglect in Science,” in Silvers, 1995). Wolfgang Kohler, a pioneer in Gestalt psychology, wrote that “we are constantly putting aside, unused, a wealth of valuable material [which leads to] the blocking of scientific progress” (Silvers, 1995, p. 160). There is a rupture and scotoma in the history of American nursing pertaining to antebellum nursing and another is being established now in the gradual elimination of the Clinical Nurse Specialist role and its holistic nursing paradigm from American APRN practice.

This monopolistic approach has not gone unchallenged over the years. While we were conducting this oral history study, a number of former organizational leaders came forward

to state that they had tried to preserve the integrity of the four roles, particularly the CNS and the specialties represented as foundational to the CNS role. For example, a former Chair of the AHNCC Board of Directors attended a round table in 2006 in which she challenged leaders to consider that the evolving CM represented only one paradigm in nursing—that of the biomedical model that focuses on problems of disease management—when there are other models such as the holistic paradigm that focus on the human response to disease and the promotion of wellness. The chosen biomedical paradigm of the CM/LACE pioneers, which is embraced by all four roles but is foundational to the views of the NP community, has become the dominant culture and, in many cases, the only way to achieve APRN licensure in US states.

The systematic public promotion of the title of NP has been a historically powerful strategy for seeking to create cultural dominance in US APRN practice. In 2003, in an American Nurses Association testimony before the Federal Trade Commission and Department of Justice, Ms. Winifred Carson-Smith stated that since “most advanced practice nurses are identified as nurse practitioners in state licensure laws and through professional certification process, I will use the generic term ‘nurse practitioner’ (‘NP’) to discuss issues surrounding advanced practice nursing”

**([http://www.ftc.gov/sites/default/files/documents/public\\_events/health-care-competition-law-policy-hearings/030227trans.pdf](http://www.ftc.gov/sites/default/files/documents/public_events/health-care-competition-law-policy-hearings/030227trans.pdf)).**

The same public strategy was used by 19<sup>th</sup>-century “Regular” physicians who promoted their title and its purported representation of “safety” to the public to achieve sociocultural dominance (Libster, 2004) as had occurred in Britain. Ironically, it is physician sociocultural dominance that is the biggest impediment to the return of APRN independent practice today.

In 2006, the NCSBN’s draft “Vision Paper: The Future Regulation of Advanced Practice Nursing” states that in seeking uniformity under a CM, Clinical Nurse Specialists will be “grandfathered and called nurse practitioners.” The CNS is, in fact, being required to succumb to absorption into an NP paradigm. For some CNS specialties, there may be little shift in ideology. Others, however, risk losing their identity all together as some of the APRNVoices have said. It is a historic period for APRNs not only because of this significant shift in APRN ideology and statute represented by the CM. The social problems related to the extent of states’ and professions’ regulatory authority and boundaries are being sorted out at the federal level as well. Questions about restraint of trade/ anticompetitive practice are being raised in many professional arenas, particularly by the health professions. In October 2014, the U.S. Supreme Court heard case number 13-534 “The North Carolina State Board of Dental Examiners v. Federal Trade Commission” on antitrust issues. All four American APRN professional associations joined together as *amici curiae* expressing concern that any ruling by the Supreme Court in this case would not in any way negatively “impact the ability of nursing professionals to practice to the fullest extent of their professional training and education” thereby potentially “limiting patient access to quality care” (Amici Curiae Nursing, 2014). The ruling in this case will be in June 2015. There is hope that it will provide further insight from the level of the Supreme Court about the reach of professional regulatory authority and its effects on practicing clinicians, such as those represented in this APRNVoices study.

Some participants in the study raised the question as to whether NP model dominance and subsequent suppression of the CNS might be construed as “restraint of trade.” The Federal Trade Commission (FTC) has written letters of support to governors for certain states on behalf of NPs (and APRNs in general) in their battle for the right to practice despite physician opposition. Anticompetitive practices are defined on the FTC website <http://www.ftc.gov/enforcement/anticompetitive-practices>. The FTC is particularly helpful in challenging medical control of independent practice by APRNs. However, the concerns about possible restraint of trade within the APRN professional groups have not been addressed. Professional leaders are well within the law and their professional ethic to make changes to practice standards such as are represented in the CM and LACE; however, the questions raised by participants in this study have to do with the behavior of an existing group of APRNs (NPs) in a way that controls the marketplace so that another group of APRNs (CNSs) are denied their livelihood though they have neither committed a crime nor violated professional standards in existence when they were educated and licensed. Hence, the opportunity for ongoing open dialogue about concerns such as grandfathering becomes the crux of the matter for practicing clinicians when nursing leaders implement (LACE) widespread statute change such as is required in the CM.

The CM document defines grandfathering as “licensing based on current requirements rather than new regulations.” Unfortunately, the new regulations are, in fact, being applied to those in practice. State-by-state variability has not been allowed for in grandfathering as senior CNSs relocate. Variability is foundational to government in the US. The US is a republic in which states retain the authority to govern. Each state has the right and responsibility under the Constitution to construct regulations for its citizens. While a profession can and must evolve its professional policies, it cannot usurp the role of the states. The biggest challenge faced by the CM/LACE in this regard is the requirement of a state to cede its authority to a national proprietary organization for the certification *required* for state licensure of APRNs.

This tension between state-to-state variability in government and the identified need by some APRN leaders for professional consensus in regulations that cross state boundaries seems to be the core of the problem. Symptoms of the problem eventually surface during transitional periods and can result in stories from US citizens, such as are documented in this oral history and in the letter by the CA Nurses association referenced previously. At this particular time in history, the regulatory boundaries exemplified in such decisions as grandfathering of those already licensed are in question.

A NCSBN Guideline on Grandfathering has been published for state BRN use. It, in fact, adds to the suppression of the CNS role. The competence of previously licensed APRNs is tied to whether or not they hold national board certification even if they have a graduate degree from an accredited program in nursing. Current recommendations seem to contradict state policy in that they include allowance for endorsement of those *without*

graduate degrees as long as they have “advanced certification” (i.e., have passed an exam written by a proprietary organization), even though 48 states require a graduate degree as a prerequisite for APRN practice. They also recommend “Do Not Endorse” for those who hold graduate degrees as APRNs but whose certification examination was in a specialty area, such as oncology ([https://www.ncsbn.org/2014APRN\\_MAlexander.pdf](https://www.ncsbn.org/2014APRN_MAlexander.pdf)). This type of action against established practitioners is congruent with what is at the core of the concern of the APRNVoces. The current NCSBN Guidelines on Grandfathering disenfranchises senior members of the profession.

Neither grandfathering and professional policy nor reform needs be conducted in a way that creates division between APRNs and their profession, their colleagues, and ultimately their patients and communities. The American Medical Association realized these very pitfalls of a CM for physicians and in 2012 documented a guideline that countered many of the very issues raised by the APRNVoces as to the choices being made to alter the history and identity of APRN practice today. The AMA addressed concerns about the adoption of a CM approach in the AMA House of Delegates Proceedings, Annual Meeting June 2012 section H-275.978 on Medical Licensure. The topics and outcomes are included in Appendix B.

APRNVoces, the majority of which are psychiatric mental health CNSs, agree that access to quality care is essential and that state-to-state variability in licensure requirements has been a challenge. They disagree, however, that their decades of work, which is being marginalized as deficient, has not supported public health and safety. Psychiatric Mental Health CNSs have provided the safety net in numerous local and national crises, such as the support for community healing in the aftermath of the Columbine High School shooting in 1999 and Hurricane Katrina in 2005. The American Psychiatric Nurses Association considers the conflicting voice that is represented now in the APRNVoces study a “risk” associated with implementing the CM. “Access to quality care for all people with mental health needs is the underlying principle behind the implementation of the Consensus Model. Although the Consensus Model presents PMH nursing with a great opportunity to envision the future of PMH advanced practice, moving the profession from the present to the future presents some challenges that are unique to PMH nursing and will need to be addressed as part of the process of implementation of the Model... A major risk is that recommendations within and outside PMH nursing will be inconsistent. *Another risk is that there will be conflicting voices within PMH nursing*” (Emphasis added) (APNA Project Plan Revised – page 4.

[http://www.apna.org/files/public/APNA Project Plan Revised 2.3.10.pdf](http://www.apna.org/files/public/APNA_Project_Plan_Revised_2.3.10.pdf)).

No explanation of the meaning of this statement is provided in the Project Plan. This document is still listed on the Web page associated with the link provided here but, as of December 2014, the PDF file is corrupted and the suggestions for downloading the file on the APNA Web page do not work. This PDF file can be retrieved by contacting the APNA.

The results of this APRNVoces study demonstrate that there are conflicting voices within PMH nursing community and it is coming from APRNs over 40 with years



and decades of experience in APRN practice whose professional work and livelihood is being threatened by the dominance of NPs whose practice model is being portrayed as superior. That is a recipe for internal conflict within the discipline of nursing. The stories gathered in this study suggest that the implementation of the CM as LACE while moving forward well for NPs and certain schools of nursing is not going well for others. In fact, others' experiences of the policy shifts in advanced practice nursing suggest that the methods used to create change and navigate transition have been uncivil at best. The definition of professionalism as the "autonomy" and "unusual independence in defining the scope and application of their expertise" has become twisted by those who would use their power and cultural dominance and the group desire for consensus to trigger a splitting action in the integrity of the profession of Advanced Practice Nursing as a whole.

### **Construction from Dissensus**

The benefits of consensus aligned with uniformity that can result from implementing a CM in nursing are widely acknowledged. But there are potential significant costs of consensus that are not well discussed and yet fully experienced and identified by the APRNVoices. The APRNVoices represent *dissensus*, which has been identified by some as a more desirable approach to statutory construction. One article by Leib and Serota (2010) published in the *Yale Law Journal-Forum* states that without openness to dissensus, decision-making becomes "more doctrinaire and less deliberative," a quality typically valued in process of the construction of statute. "Interpretive consensus is reductive...it can exclude consideration of relevant sources of meaning...consensus ignores the reality that different statutory contexts may warrant different methodological approaches" (Leib & Serota, 2010).

Diversity that is embraced in open deliberation "allows our legal system to absorb a mix of the values underlying various interpretive approaches that might not otherwise be produced in a unified interpretive regime" (Leib & Serota, 2010). While ambiguity about APRN practice state-to-state may cause anxiety and concern related to potential lack of control, the alternative of creating uniformity in consensus might ultimately be counterproductive in the implementation of the policy changes. Judges state that being "forced into a methodological consensus regime often produces poor results" and that "hard cases require debate, contestation, transparency, and an airing of all grievances, and we think that is something only dissensus can provide" (Leib & Serota, 2010).

The very nature of the drive to seek and achieve consensus diverts discussion to the back room. This is what has occurred in the development of LACE. Attendance at LACE meetings is by invitation. At the NCSBN annual meeting on the state of the CM in April 2013, one meeting leader stated that there would be no discussion about whether the CM was to be implemented; the only issue on the table now was how to make it happen in all 50 states. This statement is understandable from the perspective of those "moving forward" with LACE. This study, however, suggests that there are important matters of concern to APRN-CNSs in particular that still need to be addressed if they too are to be able to move forward.

The concerns about the CM and LACE continue to be real for many nurses, APRNs, educators, and policy makers. Change and transition are realities of membership in any social or professional group and those processes are often recognized in the birth and death of group ideas, practices, and structures. The APRNVoices in this study strongly represent a death in terms of their perceived loss of professional vision and identity. A new identity is being birthed and many hope that there will be “consensus” across all 50 states as to what that identity will be and not be.

The target date for achieving full national consensus is scheduled for January 2015. At this time, the NCSBN reports state-by-state “progress toward uniformity” on the organization website under APRN Maps (<https://www.ncsbn.org/5397.htm>). As of August 2014, 11 states are listed as having earned 28 points, which is equal to 100 percent compliance with the CM. Another 11 have earned 21 to 27 points. Twenty-eight states have fewer than 21 points. Eight states do not legally recognize all four APRN roles. Nearly half of the states have ascribed independent practice to the various four roles of APRN.

There are two maps that seem to indicate consensus. The requirement for an MSN degree for APRN licensure is recognized in all but two states (South Dakota and Indiana) and a national board certification exam is required in all but four states (California, Kansas, Indiana, and New York). Equating consensus with uniformity is a tremendous challenge in any human endeavor. It is unclear at this time of transition as to whether or not achieving uniformity state by state will ultimately be able to be equated with reform, suggesting that growth, improvement, evolution, and positive change have occurred. A full historical study of the implementation of the CM later on may suggest stronger evidence for the possibility of reform.

### **Solutions Through Storytelling**

Is social reform possible without the acceptance of multiple views? Pluralism rather than consensus/uniformity guides the building of caring peaceful community. Valuing pluralism and realizing the potential benefits of dissensus promotes community building and peace. Marginalization does not. Marginalization breeds prejudice based on mindlessness as belief and habit. Solutions to bigger global and national social problems than APRN state-to-state practice have been found through methods and models briefly alluded to here. The dissolution of apartheid in South Africa, for example, was the result of dialogue and negotiation within dissensus (Kahane, 2004). Adam Kahane, who took part in the negotiation of transition away from apartheid, also wrote of his experience in working with Argentineans during that government’s collapse that, “In Argentina, consensus means that ‘you agree with me’...The only solutions I heard people mention were ones imposed from outside or above: a new, strong, dynamic president—like Peron; an economic regime imposed by the International Monetary Fund; a military government” (Kahane, 2004, p. 96). He then proceeded to work with Argentinean citizens and the government to successfully create solutions to form a new government through dialogue.

One way to start dialogue when attempting to solve tough problems is to tell stories. Stories provide a platform for learning through experience as groups struggle toward community (Peck, 1987). That is what was done in Argentina and that is what we have attempted in

this study. We opened the dialogue for storytelling. That was the purpose of the oral history study and it has been achieved.

Creativity flows when there is open dialogue. Dialogue opens the door for the possibility of the emergence of new solutions. Caring communities such as advanced practice nursing have the potential to meet great ideas in the air, catch them as story and generate new solutions in health care. But in a culture that values consensus as uniformity, the stories of dissensus must be caught too. Those who listen carefully to the dissensus stories actually benefit from the process. Within the dissensus stories lies evidence for the gaps or holes in the fabric of transition. There are always holes in policy; we know, because some person somewhere will find that hole and walk through it or fill it. Holes are part of nature. They are part of the nature of being human.

LACE is an interesting choice of acronym for this controversial policy in the history of American advanced practice nursing. Lace, a fabric, is actually a very fitting metaphor for the current state of the APRN CM in the US. There are holes in consensus and dissensus. There are holes in the CM too. The most striking feature of lace is that its delicate beauty is as a result of holes in the fabric. Traditionally, though the holes are formed as the lace is made—they are not cut out afterwards. According to the Lace Guild ([www.laceguild.org](http://www.laceguild.org)) established in 1976, despite the effect of the industrial revolution and the emergence of bobbins and machine copies of handmade laces, the craft of handmade lace making still exists today. It takes time to make and may be more costly, but some still prefer traditional handmade lace.

It may take more time and it may be costly, but this study suggests that there must be a kind and generous solution that would allow the valuable caring tradition represented in the stories of the APRNVoices to be preserved within the emerging CM. It is perhaps the good people represented by the APRNVoices who may be just the right size and shaped “holes” of dissensus that will beautify the LACE.

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## Appendix A

### Introduction to APRNVoices Project – Web-based

The APRN Consensus Model is a regulatory model in nursing designed to align licensure, accreditation, certification, and education (LACE) of advanced practice nurses. It is believed that the model will provide a “more uniform system of new opportunities through the possibility of ease of mobility across state lines” and is designed to “elevate the role of APRNs and increase job satisfaction through opportunities to practice more independently.” (ANCC FAQ, 2012)

More than 40 nursing organizations have participated in the development of the APRN Consensus Model and now the implementation of LACE. There are many APRNs and APRN educators who are satisfied with this historic change and have experienced the transition with ease. However, there seems to be more and more evidence of a different story emerging as we get closer to the scheduled implementation date (January 2015). There are many practitioners, nurse leaders, and educators in the field who have significant concerns. These concerns range in intensity from the stressors imposed on family and practice, to prohibitive costs of compliance, to evidence for restraint of trade. Two of the most prevalent concerns acknowledged by regulatory bodies is the ability to become compliant with frequently changing regulations and the seeming inability for some experienced APRNs to continue to practice at the level of their education and experience. This is particularly disturbing given this time of shortages in experienced health care providers.

Many APRNs, particularly new graduates, may be satisfied with the changes represented by the current Consensus Model and LACE guidelines as well as with the emerging consensus forming around philosophical underpinnings of those adopted guidelines. Their voices are often given forum for expression, such as in the media campaigns promoting the support of the Consensus Model in all 50 states. However, we hypothesize based on informal surveys and anecdotal evidence collected over the past nine months that while all APRNs may support consensus as an ideal, there are some very practical and professional issues. There are “voices” for those issues that may not have a place for expression or for being heard because they seem contrary to the emerging uniformity and conformity. Some of the reasons for opposition are related to:

1. Concerns about the feasibility, resources, and conflicts in the implementation of the Consensus Model
2. Concerns for the loss of expertise of senior APRNs who are considering retiring or resigning rather than spend the time and resources to become compliant with new regulations
3. Fear that speaking out might jeopardize current employment

Therefore, we are inviting you to share some of your history with the Consensus Model/LACE here. Our plan is to take the history that we collect from participants and organize the story that we can then tell to others. We don't know what that story will be, but we think that your history and your story are important.

History is a record of human events over time. Often the history that is written is a record of the "Voices" of those with power. The time is now to "drop your pebble in the pond" and watch the ripples connect with others. (Picture on website of this) Claim your power now and add your APRNVoice!

## Survey and Storytelling Space

\*\*Indicates Participation Criteria: The person seeking participation was removed electronically by the survey if they did not meet the inclusion criteria.

I have read the consent form for the APRNVoices2013 study and understand my rights and responsibilities. (\*\*Agree or Disagree/Do not understand)

How do you rate your overall experience of all aspects of APRN practice under the current Consensus Model / LACE Guidelines? (No Concerns or \*\*Average or \*\*I have Concerns)

What is your Gender? (Male or Female)

What is your age group?

Did you graduate from a formal education (Master's-level) Program? \*\*Yes or No

In which states do you hold an active APRN license? List additional states in custom field. How long have you been practicing as an APRN? (With/without board certification or licensure - some states do not require)

What APRN Board Certifications do you hold? Check All That Apply.  
If you have been denied board certification or state licensure as an APRN due to issues related to the new Consensus Model / LACE Guidelines (as opposed to legal violations), please write in the state and the rationale given for denial.

Do you hold prescriptive authority?

What is your population of care? Check All That Apply.  
(Adults, Peds, Infants, Across the Lifespan, Family)

What is your specialty in care? Check All That Apply.  
(Holistic, PMH, Med-Surg, OB, Peds, Other)

What best describes your employment status? Check All That Apply.

Which of the following best describes your annual income?

We invite you to tell your story: How have the changes to advanced practice in your state and the nation related to the Consensus Model/LACE/ and any associated regulatory changes affected your practice? (1000 characters)

Continue Your Story Here if Needed (1000 characters)



## Appendix B

The House of Delegates Proceedings from the 161<sup>st</sup> Annual Meeting June 16-20, 2012 in Chicago, Illinois (pp. 177-178; [www.ama-assn.org](http://www.ama-assn.org)) includes the AMA's guidelines on medical licensure that address issues similar to those in the CM for APRN practice. The following are related excerpts:

- (10) urges all physicians to participate in continuing medical education as a professional obligation;
- (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
- (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
- (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;
- (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons of protecting the health, safety, and welfare of the public;
- (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
- (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
- (21) urges licensing boards to consider completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement.