Nurse practitioners in Canadian emergency departments: An idea worthy of attention or diverting our attention?

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This issue of the Journal contains 2 articles on the introduction of nurse practitioners (NPs) into the emergency department (ED). Both raise interesting points, and the authors should be applauded for investigating this issue and allowing us the opportunity to consider the potential role of NPs. Careful consideration of this nature is consistent with the recommendations made in the "human health resources" section of CAEP's submission to the Romanow Commission, a submission in which I actively participated.[1]

The study by Thrasher and Purc-Stephenson[2] examines the facilitators and barriers to the introduction and integration of NPs into the ED. The authors highlight 3 major issues that are associated with NP implementation: the environment and culture of the ED, role clarity and NP recruitment. The "strain" created by patient volumes and the increasing use of the ED by patients with non-urgent and primary health care needs are cited as important reasons for the cultural facilitation of the introduction of NPs into EDs. However, ED culture is also identified as a barrier to NPs, particularly in those departments where physicians are remunerated on a fee-for-service basis and NPs impact physician income. Another significant barrier identified in this study is in the interface between RNs and NPs, and the issue of role clarity. Prior ED experience, both on the part of ED staff with NPs and of the NPs with the ED staff, is identified as a facilitator. In my view the authors are correct in their conclusion that ultimately, given the complex equation of facilitators and barriers and the diversity of emergency care in Canada, an NP may not be appropriate for all EDs.

The study by Carter and Chochinov[3] reviews the international literature and examines the impact of NPs on ED cost, quality of care, patient satisfaction and wait times. While they are interesting, the findings of this paper provide little additional insights beyond those published in my review of NPs in the Canadian ED in 2003.[4] I agree with the authors that NPs are capable of looking after non-urgent medical problems and of providing a high degree of patient satisfaction, albeit with a low overall throughput and at a higher cost than physicians. However, I disagree with the authors contention that NPs will have any role in reducing the problem of ED overcrowding, a suggestion for which I believe there is little evidence.

Both articles propose that the principle role of NPs should be in the management of those patients with non-urgent problems and both suggest such patients are the cause of ED overcrowding despite increasing evidence to the contrary. Forget the use of NPs to "pick the low hanging fruit." It is my opinion that any introduction of NPs into the ED should bring some value-added component to the existing level of service, rather than simply a being a substitute for an existing service provider. Both articles would also have been strengthened by an acknowledge-

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ment that there is no "one size fits all" with respect to NPs in the ED.

Currently, the role of NPs is in evolution, and largely depends on the nature of the facility in which they work. An example of an intriguing use of NPs expertise would be in the interface of those emergency patients with chronic disease states and high rates of recidivism. It is these patients who constitute the majority of CTAS 3's (Canadian Triage and Acuity Score[5]) and who actually contribute to ED overcrowding. Changing the focus of NPs to such things as chronic disease management, patient education and advocacy for the patient's smooth sailing through our complex health system could be a major advantage for both patients and a smooth functioning ED.

Further, after reading both articles, I was left with a certain visceral sense of "so what?"

Yes, nurse practitioners can provide primary care equivalent to resident staff, but since when were residents the gold standard for care delivery? Yes, patients have a high acceptance rate for being treated by NPs in the ED, but if the alternative is an 8 hour wait for assessment and care that takes 10 minutes is this surprising? Yes, NPs can participate as important members of the emergency health care team, but why are they receiving such an extraordinary emphasis from government and health care planners, particularly when there are widespread shortages of emergency physicians and emergency nurses?

It is the last question that makes me pause and wonder why human health resources planning, as it relates to emergency services, seems to have gone awry.

Rather than expending great energy and time on the introduction of new and alternative health care providers into Canadian EDs — be they NPs, physician assistants or paramedics — I would suggest the current major priority should be fixing the existing personnel problems: the shortages of experienced, trained and enthusiastic emergency physicians and nurses.

On reflection of my 20 years as an advocate for an improved emergency medical system, I have come to understand 4 unfortunate, fundamental truths:

1. there is a noticeable lack of a unifying national vision for what an ideal emergency health service should look like;
2. "system planning," in the Canadian context, is a misnomer;
3. changes to emergency health services are reactive in nature, with systemic improvements usually forced by negative publicity such as the findings of a coroner's inquest or a judicial enquiry; and
4. the human resources component of the emergency health system is, at best, taken for granted and, at worst, studiously ignored. To be blunt, it is my view that emergency physicians, as with emergency nurses, are misunderstood, unappreciated and undervalued.

These 4 points of concern were crystallized when I read yet another pair of papers about the purported benefit of NPs in the ED. Does the introduction of NPs represent the fulfillment of a vision for Canadian emergency services? Wouldn't we be wise to spend some time deciding on the number, distribution and type of EDs to meet society's needs in the intermediate and long-term before deciding who should staff them?

Is the introduction of alternative health care providers into Canadian EDs merely reactive to yet another series of media stories about staffing shortages and threatened closures?

Wouldn't it be wise to spend at least equal time developing strategies to provide emergency nurses with full-time, career opportunities? Wouldn't it be nice if somebody, anybody, would think about introducing a strategic plan to develop an effective emergency physician workforce for our nation's needs?

In a journal like *CJEM*, I wonder why there has been such a paucity of literature on the very real human resource problems that beset our EDs? Where are the papers on the national requirements for well trained emergency physicians or nurses? What has happened to the debate on the distinctions between our 2 routes of emergency physician certification and the merits of a unified training system for Canadian emergency physicians? Where are the papers defining the role of family physicians in the ED? Where is the literature examining Quebec's attempts at devaluing emergency medicine as a specialty in its introduction of Bill 114 in 2003? Why has there been no analysis of the staffing crises that affected nearly 20 urban EDs in Ontario in 2006?

The failure to thoughtfully address the essential human resource requirements of Canada's approximately 850 EDs, and to appreciate the knowledge and skill sets of emergency physicians and nurses and acknowledge their intrinsic value to the maintenance of the health care safety net, ultimately threatens the well-being of those Canadians who make up the 14 million annual visits to our EDs.

The failure to provide emergency nurses with full-time career opportunities, the refusal to train sufficient numbers of qualified emergency physicians, the lack of attention to providing family physicians with sufficient skills so they feel comfortable in the ED environment, and the abysmal failure to promote career longevity for those already trained in emergency medicine and working in our EDs

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lead to prematurely shortened careers, inadequate staffing, service disruptions and threatened ED closures; they also contribute substantially to the problem of ED overcrowding and access block.

What is needed, therefore, is a thoughtful, comprehensive approach and vision to emergency health care planning. We need:

- A definition of the number and categories of EDs required to adequately meet the emergency health care needs of our population.
- An understanding of the staffing needs for both emergency physicians and registered nurses.
- An understanding of the essential qualifications, training and standards of those who provide emergency service.
- A tangible expression of the intrinsic value of emergency service providers to Canadian society.

Then, and perhaps only then, should we consider the wholesale introduction of alternative health providers such as NPs into the nation's EDs.

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References

1. The future of emergency medicine in Canada: submission from CAEP to the Romanow Commission. Part 2. Can J Emerg Med 2002;4:431-8.

2. Thrasher C, Purc-Stephenson RJ. Integrating nurse practitioners into Canadian emergency departments: a qualitative study of barriers and recommendations. Can J Emerg Med 2007;9:275-81.

3. Carter AJE, Chochinov AH. A systematic review of the impact of nurse practitioners on cost, quality of care, satisfaction and wait times in the emergency department. Can J Emerg Med 2007;9:286-95.

4. Drummond A, Bingley M. Nurse practitioners in the emergency department: a discussion paper. Can J Emerg Med 2003;5:276-80.

5. Beveridge R, Clarke B, Janes L, et al. Canadian Emergency Department Triage and Acuity Scale: implementation guidelines. Can J Emerg Med 1999;1(Suppl 3). Available: www.caep.ca.

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