THE SCOPE OF ADVANCED NURSING PRACTICE

Merian Litchfield RGON, PhD., FCNA(NZ)
Researcher, Educator, Consultant

The paper, a response to the Ministerial Taskforce on Nursing, has been developed to contribute to the current discussion about nursing practice. The evolving conceptualisation of the scope of practice in New Zealand is scanned as the backdrop for critique of the current trend. An overview of some aspects of developments in the United Kingdom and United States serves to highlight some significant issues concerning the potential for nurses to contribute innovatively to health care in the new era of change. An alternative conceptualisation of practice in three nurse role categories is presented as the inter-relationship of scope and expertise to illustrate how the trend to specialisation might be incorporated in a service scheme founded in the discipline of nursing.

KEY WORDS: advanced nursing practice, clinical nurse specialist, nurse practitioner

INTRODUCTION

The introduction of nurse prescribing and the ongoing delegation to nurses of other traditionally medical activities again raises the issue of how nursing practice is conceptualised, a variation of the old question: what is nursing? We must articulate nursing practice in the context of the new and still reforming health system. The 1998 Ministerial Taskforce on Nursing (MTN) report acknowledges the significance of "advanced practice" to influence greater effectiveness and efficiency in health care. This paper is developed in response to that report. Through a critical overview of the New Zealand trend and with reference to developments in the United Kingdom and United States, I point to some important issues and concerns about the evolution of professional practice.

Of necessity, the paper is a broad scan of a complex topic. As a personal perspective, it is intended to evoke an expanded dialogue, to invite other possibilities of creating nursing practice for the future, and to raise questions about what "advanced practice" means in New Zealand. I believe that to expand the debate we need to review trends, critique, and examine some envisaged models as illustrations of what might be. The outline and model of an integrative nursing practice scheme, relevant in the New Zealand context is presented for this purpose.

The meaning of "scope of practice"

The meaning of scope of practice is developed in this paper as the expression of the discipline of nursing in the work of the nurse: the characteristics of practice that express the "nursing perspective" or "nursing focus". It is what gives the intention to our research, and is supported and expanded by the enquiry. Scope of practice gives shape to the basic educational curriculum for nursing, and determines how newly registered nurses will find a niche in the health workforce. The scope of "*Advanced* nursing practice" has meaning only in relation to this *beginning* scope of practice. Job descriptions express the scope of practice expected of nurses by service providers. In the new health system, nurses with *advanced* expertise can, in principle, negotiate

their own scope of practice. How each of us articulates it reveals our professional participation in contemporary society, and our ethical foundation in honouring a social contract. How it is defined and addressed within national structures has profound implications for the extent to which nursing as a profession can survive and, further, for how nurses might make an innovative contribution to the quality and cost containment of health care in the future. Thus scope of practice embraces all that nursing is and can be.

Attempts to define the scope of nursing practice began in the 1980s as part of the profession's on-going efforts to be explicit about nursing and its value to society. In 1981, Bee Salmon, in a paper entitled Nursing on the Move (Salmon, 1982), urged the preparation of a statement of the nature and scope of nursing practice. She had spent the previous decade "endeavouring to present nursing to university administrators and colleagues" (p.118) to convince them of the significance of advanced nursing education in the university. For the profession to advance, a statement of its contract with society, our social mandate, was seen to be needed. She referred to the American Nurses' Association (1980) Social Policy Statement's outline of elements of scope of practice to prompt our own statement with respect to the boundaries relating to health needs, the intersections amongst nurses and other professionals, the core distinguishing phenomena of concern, and dimensions concerning the practitioners, settings and accountabilities. "Scope of practice" is complex, contextual and *dynamic*.

The 1984 statement that was developed by the New Zealand Nurses Association (NZNA) was distinctly different from the medicalised definition in the American Nurses Association which refers to "The diagnosis and treatment of human responses to actual on potential health problems" (ANA, 1980 p.9). The former presented nursing as attending to the uniqueness of clients and the variability of health changing through time. It acknowledged their active participation in their own health care and the importance of context. As well it emphasised the relational process nature of nursing to which the nurse brings particular knowledge: *"a specialised expression of caring concerned primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situations"* (NZNA 1984, p.6). The stated scope of practice was derived from this core set of phenomena that reflected our particular New Zealand nursing perspective at that time.

However changes in the health sector during the 1990s brought a very different context for nursing. The new funding structure required a new configuration of service delivery and a different sort of health care. Practitioners had to become flexible, adaptive and innovative within a new set of constraints. Further, consistent with an international trend, nursing scholarship in our universities was moving into the postmodern era with its rejection of universality and acceptance of plurality and diversity. The up-dated Social Policy Statement (New Zealand Nurses Organisation (NZNO), 1993) reflected these changes. The statement of nursing was retained indicating continuity in our identity and purpose (the *how* and *why* of practice), but there was no attempt to describe a particular scope from it. The document turned attention to nurse participation in social policy development, framed in terms of where power lies. The shift in orientation was from a description of our contribution to health, to *who* we are as a collective of professionals and providers.

Hence, in the 1990s, the national statements of nursing were seen to have little relevance. If nurses were to become fully professional practitioners they would need to be able to clearly articulate the scope of their own practice in terms of what it contributes to health within their own work context. What was required was a "shift in emphasis away from the rights and privileges of professionals more toward obligations, responsibilities and accountability" (NZNO, 1993. p.9). The devolutionary shift is seen in the proliferation of different clinical career paths around the country. It has become a requirement for nurses to become responsive to health need as it presents in the flux of system change, a point which the MTN (1998) report acknowledges.

CURRENT TREND

Through the later 1990s, the organisation of the profession has moved to a focus on formalising the regulation of the scope of nursing practice (MTN, 1998; Nursing Council of New Zealand (NCNZ), 1995, 1997, 1998; Nurse Executives in New Zealand (NENZ), 1998; Nurse Educators in the Tertiary Sector (NETS) & NENZ, 1997) without reference to any particular social mandate. Given the discipline vacuum, a pragmatic trend to increasing standardisation of structure and process is occurring with reliance on "enforcement" of standards by our statutary body rather than on professional accountability. The implications of this trend for the innovativeness and autonomy of nurses need to be addressed. Some significant features are identified here:

1. The nursing workforce supports and is responsive to the requirements of the extant services. Documents cited above (eg, MTN,1998; NENZ, 1998) suggest that scope of practice is to be defined by broad "enforceable competencies", "national consistency" in post graduate education to address "service-provider interests", and registration processes for "nationally consistent titles" which will support "a national framework of advanced practice roles" within the current service structure.

2. Advancement in practice is a linear progression from beginning (new graduate) to specialty to advanced levels. This occurs through the preparation of practitioners to a specified level of competence denoted by a formal qualification attached to particular educational programmes: "a cumulative process building on previous competencies" (NCNZ, 1998. p.18). The qualification is tied to nationally regulated roles/titles within standardised clinical career pathways (MTN, 1998; NENZ, 1998).

3. Advancement is increasing specialisation. The idea of specialisation is based on the view that the scope of practice varies according to a "specific focus and body of knowledge" (NCNZ, 1998, p.9) associated with a particular group of clients e.g. children, elderly, mental health clients, diabetic clients (MTN, 1998). Traditionally these fields are defined by the medically oriented service structure and funding.

4. Advancement involves increasing clinical expertise that is instrumental: practice is prescriptive, focused on achieving predetermined outcomes through evidence-based assessment, diagnosis, planning, intervening ("initiate treatment") and monitoring (MTN, 1998; NCNZ,

1998; NENZ, 1998). Nursing practice is defined in relation to the medical purpose of the identification, cure, prevention and treatment of disease and disability.

5. Advancing specialist knowledge and clinical expertise enable nurses to pick up activities that have traditionally been part of medical practice e.g. assessments to identify pathology, ordering laboratory tests, referral to specialist medical practitioners, and prescribing medications. Nurses will, if regulated, carry out these activities independently (MTN, 1998). Extension of nursing practice will be effective in controlling disease processes while reducing the need for and cost of medical intervention.

6. The main focus of professional attention remains the hospitalisation event and the technological management of health problems. Advancement in practice is extension of involvement before and after the episode of a client in hospital, to create what is referred to as a "community-inpatient-community continuum" (NENZ, 1998, p.4).

7. Advancing practice is framed as having two threads: an intensifying focus in a clinical field while an increasingly broadening concentration on the management aspects of the service: administration, staff and service development, monitoring, research (MTN, 1998; NCNZ, 1998; NENZ, 1998). Scope expands from personal health care (individual to group) to institutional/system support. Activities become more concerned with the generalised "best practice" and "clinical pathways" than expert personal care.

Some assumptions can be drawn from this overview. Nursing is directed more by a services/system/professionals orientation in health care than by a health need orientation. Advancement in nursing practice is towards medical practice but subsumed within health system management. Nurses' work is shaped in support of the effectiveness and efficiency of the service and increasingly removed from direct personal care that is responsive to the immediate unique client need. By supporting the traditional conceptualisation of health and diagnosis-intervention processes aimed at addressing the abnormality of disease (medically inspired discourses), the holistic approach of nursing (e.g. "the specialised expression of caring") is compromised. The existing fragmentation of health care into person/body level and service sector level is accentuated.

Together the trends present an interesting but somewhat muddled situation. While the health sector reform and our professional rhetoric have opened the way for, and require, practitioners to be autonomous in practice, innovative and responsive in scope, we are ourselves creating a situation that imposes standardisation within the here and now and ties nursing to existing services. While the regulatory processes are intended to have a protective function for both the public and nurses, the current view of health need and the health system is continuing to change unpredictably. Therefore if scope is not flexible both practitioners and the public become vulnerable in the longer term. Further, the "enforcement" of a defined linear trajectory of "expanding" scope of practice within specified roles, titles and career paths reconstructs a centralised hierarchy, which is counter to the general social trend in New Zealand.

Where scope is fixed in time to provide the workforce for exisiting health services today, and regulated within bureaucratic structures, the dynamic responsive nature of nursing is submerged. The reach of a nurse into the medical domain might well show efficiencies under today's methods of measurement, but if it does not come from a clear foundation in the nursing discipline, the support of the already costly trend in the medicalisation of everyday living has a much more pervasive and long-term cost to society. Within such a framework caring, non-interventionist processes appear as add-on luxury, thus limiting what nurses might contribute if they were to practice within their own paradigm. Medical and nursing practitioners are placed in competition making the provision of health care likely to be contentious (as noted in the MTN, 1998 report). Health care will only be enhanced through collaboration if nursing and medical paradigms are complementary.

INTERNATIONAL DEVELOPMENTS

It is useful to consider trends in New Zealand in the context of developments in other countries, particularly the United Kingdom and the United States. Nurses in these countries are coming to the understanding that advanced nursing practice refers to a whole sphere of professional practice, reaching beyond beginning practice, that acknowledges a discipline of nursing in its own right (ANA, 1995; Brown, 1998; Cronenwett, 1995; Redfern, 1997; Scott, 1998; United Kingdom Central Council for Nursing, Midwifery & Health Visiting (UKCC), 1992, 1997b), but are polarised in their views about developing its scope. The present analysis draws on some official documents of nursing organisations, authoritative articles in recent literature, and my dialogue with scholars in these countries.

As in New Zealand, nursing in the United Kingdom and United States of America is defined to reflect the nature of nurses' participation in their respective health systems, and is embedded in the history of the profession. The American definition (ANA, 1995) is behaviourally focused with its references to diagnosis and treatment, and responses to health problems, in a manner that mimics medical practice. Nursing knowledge is made to be complementary to that orientation. In the United Kingdom Royal College of Nursing (RCN), 1992), the statement refers to the purpose of nursing and the professional framework within which this will be addressed variably by nurses. In the United States of America, it concerns the *what* and *how* of the individual practitioner's practice. In the United Kingdom, it is the *who* and *why* of nursing within a multidisciplinary team approach to health outcomes. The New Zealand statement concerns the *how* and *why* of nursing tending more to the individual nurse orientation of the United States of America than the collective orientation of the United Kingdom, but acknowledging the nurse-client relational process. All elaborate their statements from the assumption that the prescriptive process based on assessment is the process of nursing, situating it within an empirical paradigm.

Autonomy is accorded to nurses to advance their practice in the United States of America through a credentialling process, including state licensure and certification by a recognized professional organization. Graduate educational programmes *prepare* nurses for this practice with standard core and role specific competencies. Taking the opposite approach in the United Kingdom,

accountability is devolved to individual practitioners to expand their own scope of practice. After considerable consultation over several years the UKCC (1997b) has categorically stated that it will "avoid setting specific standards" associated with advancing nursing practice. Instead, scope is determined by each nurse through reference to a statement of responsibilities (UKCC, 1992), accountable to the UKCC. Pre-registration education prepares nurses for professional practice and thereafter nurses may choose to study further in one of the designated occupational fields, but responsibility for *seeking* the knowledge and skills necessary for expanding the practice s/he envisages remains with the individual.

In the United States of America, practitioners are protected by licensure within the privatised, competitive and largely for-profit system. There the profession aims for consistency in expressing the discipline and works for consensus within one scope of practice. Whereas within the United Kingdom publicly funded National Health System, practice is to be advanced by the practitioners expanding relevant knowledge and skill that is complementary within multi-disciplinary teams (UKCC, 1997a). By contrast the profession envisages multiple scopes of practice. Relative to New Zealand, both countries have large populations that support multiple specialisms, educational and career opportunities. The health system in New Zealand requires greater flexibility for its fewer practitioners and greater effort to integrate health care.

In both countries, as in New Zealand, nursing has responded to health system demand for specialisation, including the adoption of some medical activities, and has conceptualised advanced practitioners accordingly (Brown, 1998; Cronenwett, 1995; Scott, 1998; UKCC, 1997b). In the United States of America they include nurses with the existing regulated roles/titles (Clinical Nurse Specialist, Nurse Practitioner, Nurse Midwife, Nurse Anaesthetist (Cronenwett, 1995)). In the UK advanced practice is not to be defined (UKCC, 1997b), it is the "continuing development of the profession in the interests of patients, clients and health service" (UKCC cited in Scott, 1998 p.560). All consider practice at this level to be a combination of direct care, managing health care delivery systems and professional role activities. How the distinct, sometimes conflicting accountabilities this presents can be reconciled is unclear. In the United States of America there is emphasis on competencies to identify advancing levels (Brown, 1998), while in the United Kingdom it is considered that "a concentration on 'activities' can detract from holistic nursing care" (UKCC, 1992, p.8).

In all the three countries specialty refers to a part or an area of the whole nursing sphere. Despite debate (Brown, 1998; Scott, 1998), the question of how specialisation could be reconciled with a holistic conceptualisation of nursing remains unexplained. While specialisation was originally associated with medical specialties, it is now associated in the United States of America with the establishment of multiple professional organisations that certificate practitioners based on education and experience, and in the UK with the educational programmes based mainly on traditional occupational divisions of the nursing workforce. In both the United States of America and United Kingdom, there is avoidance of defining scope(s) of practice in law thereby promoting hierarchical roles. In neither country are competencies, educational standards, roles, titles, licensure, and clinical career paths tied together as

seems to be the intention in New Zealand. Considering the New Zealand service context, the autonomy, responsiveness and innovativeness that NZ nurses need to demonstrate is not consistent with the "top down" credentialling process that is appropriate in the United States of America. It is difficult to understand the anxiety expressed about "too many different specialties or advanced roles developing..(as a)..risk of fragmentation and rigidity" (MTN, 1998, p.27).

As with nurses in the United Kingdom and United States of America, there is now a tendency in New Zealand for emphasis to be placed on the prescriptive problem-oriented processes and a view of health and disease consistent with the medical view. With a hierarchical structure of advancement involving activities traditionally within the medical sphere, and in the absence of any other paradigm, nursing practice is being subsumed as a subset of the dominant medical practice. This positions nurses in competition with medical practitioners as happens in the United States of America and inevitably works to the detriment of health gain.

Now as the health system evolves, as in the other countries, we have the challenge to be innovative in providing health care and at the same time meet the urgent presenting need for expert specialist practitioners. I believe that, by expanding the conceptualisation of practice so that it is open to innovative scopes and roles, with a clear disciplinary focus on health need rather than on a service/system, and by more selectively instituting processes and structures for regulation (as in the United States of America and United Kingdom) nurses would have more opportunity to make a significant, flexible and caring collective contribution to health.

AN ALTERNATIVE FRAMEWORK FOR DIFFERENTIATING PRACTICE

To illustrate one way these issues might be addressed, I present an alternative conceptualisation. The scheme developed from a pilot project of case management (Litchfield et al, 1994) exploits the dynamic nature of nursing practice and the wide distribution of nurses throughout the health system. This approach introduces the concept of complementary nursing practice to show how individual practitioners can differentiate their particular form of practice, yet still be a collective force contributing to a common nursing purpose.

To present the variability in form of practice I separate scope from expertise. "Expertise" advances cumulatively for all nurses. "Scope" expands as distinct trajectories of advancement in broadly differentiated role categories, and for each practitioner it will vary uniquely within the role category.

Scope is "the reach of the nurse": what the nurse attends to and the sphere of nursing actitivity within the professional partnership. Interdependent elements of scope are identified:

- *Work* parameters for the nurse: conditions of employment/role, credentials, service setting
- The *client* characteristics of e.g. state/status, unit/institution/community group, geographical locality.
- Health care *need*: "need" that focuses the nurse-client encounter expressed in the criteria for entry to and ending of the partnership (admission/discharge).
- The nature of the *process/es* by which the nurse encounters the client (access and care) and health care workers; including but not limited to assessment, planning and intervention.

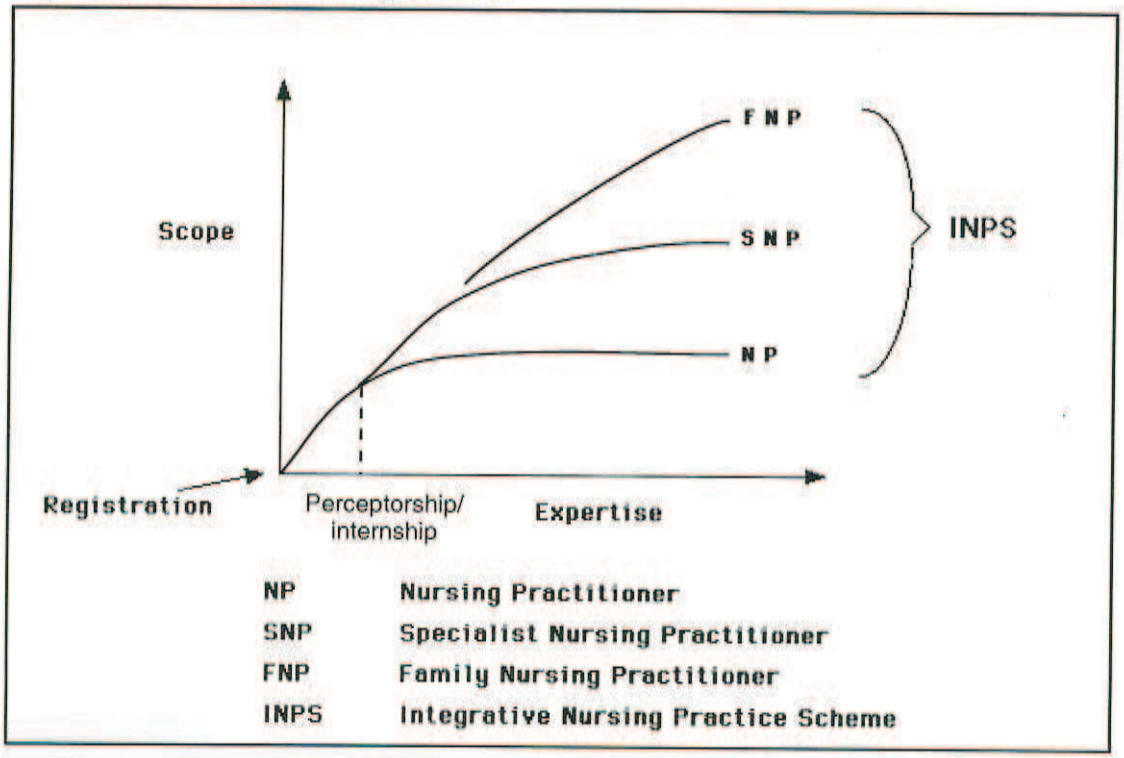
- The meaning of *health* : the perspective the nurse has of "health" in relation to disease, illness and disability, that focuses action.

Expertise is the capability of nurses to express the scope of their practice within their particular workplaces. In all role categories nurses advance in expertise. Within each role category expertise would be cumulative. Competencies might identify expertise for a particular component of that scope. As in the UK, each nurse would elaborate the scope of her practice with advancing expertise in relation to the nursing purpose and service context. My experience, research and theorising has led me to envisage three interdependent role categories relevant for nursing in the New Zealand health care context. The label "nursing practitioner" (NP) is used as a generic descriptor. Two additional descriptors are used to differentiate the *form* of their practice and the view of the nature of "knowledge" in it: specialist (SNP) and family (FNP). These are complementary in scope and not hierarchical. The scheme would incorporate all registered nurses who are practising nursing directly with clients beyond a period of preceptorship/internship.

For the purposes of this paper, I have elaborated a focal disciplinary statement to provide a brief explanation of the practice within the role categories.

> *Based on an ethic of concern for the humanness of people's experience in health matters, a caring ethic, nursing is a form of partnership through which nurses attend to what people need to get on with life and living (as families/whanau/communities and as citizens) with their particular pattern of health circumstances: the complexity of their predic-*

Figure 1a. Advancing practice: differentiated



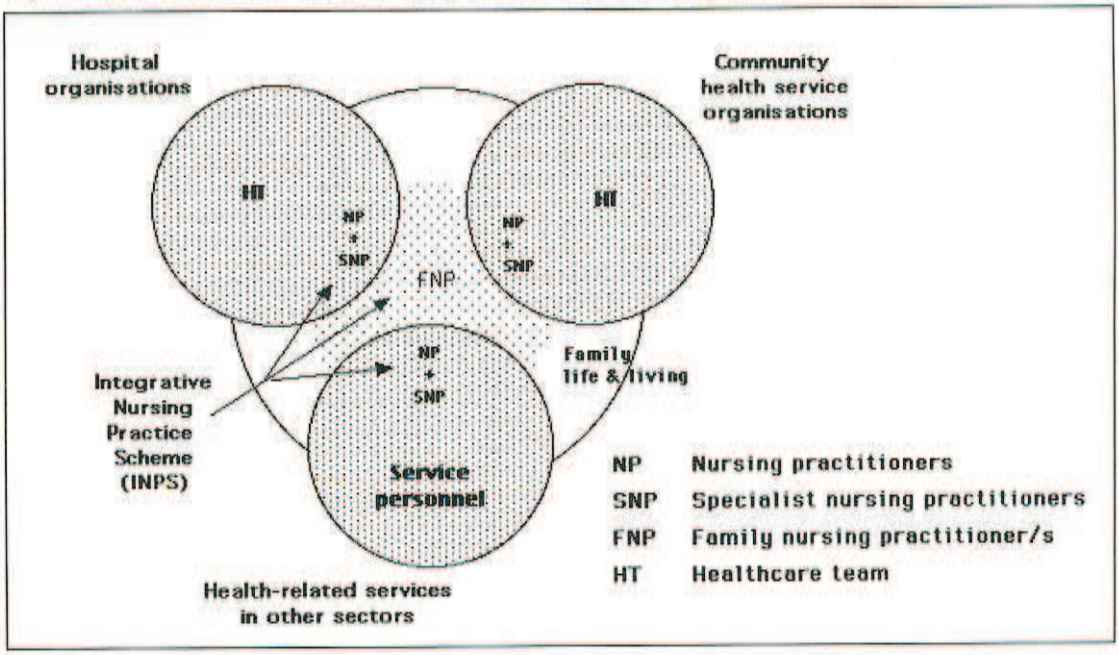
aments, the implications of disease/disability, its medical diagnosis, treatment, strategies for monitoring and prevention, their involvement with health, welfare and other related services.

This view of nursing incorporates features of our various efforts over past years to articulate the significance of nursing practice (Christensen, 1990; Connor, 1995; Litchfield, 1993, 1997; Litchfield et al, 1994; NZNA, 1984, 1985; NENZ, 1998; NCNZ, 1998; Salmon, 1982). It is also consistent with a recent statement of our New Zealand health focus which draws on a comment by health ethicist Seedhouse "Good health enables peoples to participate in society and provide the 'means by which people can pursue their goals in life'" (National Health Committee, 1998, p.20).

All NPs enter the profession with expected beginning expertise (competencies) to work within a defined scope of practice, and would have the opportunity to expand and consolidate an appropriate scope within a preceptorship/internship arrangement of the workplace (MTN, 1998). To advance nursing practice, some NPs would pursue their professional careers by selecting from the other two paths.

To create the integrative scheme the FNP role introduces a new scope of practice (Litchfield, 1998). The primary concern of the FNP would be the families/whanau/groups with *the most complex of health circumstances* whose needs are not met by other professionals. Here the scope of practice is defined neither by a "specialty body of knowledge" nor a "clinical-therapeutic process". It is defined wholly by the processes of partnership and pattern recognition, created in the process of practice (Litchfield, 1993, 1997). It occurs prior to, or perhaps simultaneously with, the specialised assessments and activities of the NPs and SNPs and other health professionals. Although involving open movement in time and place wherever family members are, the partnership is unlikely to extend

Figure 1b. An integrative nursing practice scheme (Modified from Litchfield, 1998)



over more than two months. The FNP is pivotal in the integrated scheme, connecting with NPs, SNPs and their interdisciplinary teams as the need arises. *As yet this role does not exist;* the scope of practice has not been defined by nurses in the current health system.

SNPs could be self-employed or employed in roles within an existing service organisation. Their scope of practice expands within criteria of client characteristics in the specialty field. The client is an individual, the health issues addressed in the context of family. Both the roles identified by NENZ (1998) and categories of competencies identified by NCNZ (1998) fit with this SNP role.

Within such a scheme SNPs and FNPs would *seek* higher education to prepare themselves to define and negotiate their own distinctive scopes of practice, similar to the advancing of nursing practice in the United Kingdom (UKCC, 1992). It is likely that postgraduate degree programmes would be needed to achieve the appropriate integration of research and theory development. The course content and competencies as outlined in the NENZ (1998) role framework might be seen as necessary *preparation*, as in the United Kingdom and United States of America, for those choosing to extend their scope of practice to incorporate medical actitivities. Credentialling in each role category would be addressed separately.

This envisaged model of practice, in separating scope from expertise, allows for expansion from the linear hierarchical conceptualisation of "advancement" to the conceptual-isation of complementary roles. It would free nurses from a system orientation within the services of the here and now. With a shared nursing purpose they could become autonomous as professional practitioners addressing health need wherever they are employed. There would be room for more selective regulatory processes to address particular competencies in terms of scope of practice within the distinct role categories. The newly adopted medical activitivies would be embedded in *nursing* practice. Such an arrangement would incorporate and move beyond the "accountability" approach of the United Kingdom and the "credentialling" approach of the United States of America to provide flexibility, responsiveness and innovation in health care provision.

CONCLUSION

In this paper I have taken up the challenge to review the meaning of professional nursing practice beyond registration so that in keeping with a new health era nursing is positioned more effectively. "Scope of practice" has been reviewed as the expression of our discipline, and our current actions to define it emphasised as vital to our future as a profession. I have taken an overview of the current efforts to articulate scope of practice in the context of the New Zealand trend, away from a nationally defined professional framework of the 80s toward individual responsibility for practice in the 90s. In this way nurses can become flexibly responsive within the health sector reforms. Unfortunately conformity is being sought through national regulatory structures. In the absence of a clear disciplinary foundation nursing is being defined and tied within the extant health service configuration just at a time when there is opportunity for nurses to claim their full professional status within inter-disciplinary health care initiatives. I contend that if we find ways to work together as practitioner collectives with a common purpose, inspired by our traditional social mandate to address

the humanness of people's experience by means of "a specialised expression of caring", we can develop scopes of practice innovatively. We would be able to be responsive to the complexity of health need, contributing new approaches to effectiveness and efficiency.

This model of professional practice has been presented as illustration of how the above goal might be achieved, given a particular nursing disciplinary stance and a view of all nurses advancing in their professional practice inclusive of, but more than, specialisation. This is possible if the tight regulation of nursing is selective, operating only where necessary, and if all nursing practitioners are supported in their autonomy, with responsibility promoted, yet each allowed the freedom to be innovative. Comparison of developments in the United Kingdom and United States of America surfaced some ideas of how this might happen.

I conclude with the suggestion that a new view of who we are as a professional community would be a helpful preliminary to moving on to the future. The opportunity for dialogue at all levels is essential to address the need for practitioner responsiveness, professional accountability, safety and legitimacy of practice. Without this dialogue we will remain invisible and reactive to the whims of others shaping health care.

References:

American Nurses' Association (1980). *Nursing: A social policy statement*. Kansas City: Author.

American Nurses' Association (1995). *Nursing's social policy statement*. Washington DC: Author.

Brown, S. (1998). A framework for advanced practice nursing. *Journal of Professional Nursing, 14*(3), 157-164.

Christensen, J. (1990). *Nursing partnership: Hauora takirua*. Wellington: Daphne Brassell.

Connor, M. (1995). *The web of relationship: An exploration and description of the nature of the caring relationship in a nurse case management scheme of care*. Unpublished masters thesis, Victoria University, Wellington.

Cronenwett, L. (1995). Molding the future of advanced practice nursing. *Nursing Outlook, 43*(3), 112-118.

Litchfield, M. (1993). *The process of health patterning in families with young children repeatedly hospitalised*. Unpublished masters thesis, University of Minnesota, Minneapolis, Minnesota, USA.

Litchfield, M. (1997). *The process of nursing partnership in family health*. Unpublished doctoral thesis, University of Minnesota, Minneapolis, Minnesota, USA.

Litchfield, M. (1998). Developing a new model of integrated care. *Kai Tiaki Nursing New Zealand, 4*(9), 23-25.

Litchfield, M., Connor, M., Eathorne, T., Laws, M., McCombie, M-L. & Smith, S. (1994). *Family nurse practice in a nurse case management scheme: An initiative for the New Zealand health reforms*. Wellington: Centre for Initiative in Nursing & Health Care.

Ministerial Taskforce on Nursing (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing*. Wellington: Ministry of Health.

National Health Committee (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health.* Wellington: NHC.

New Zealand Nurses' Association (1984). *Nursing Education in New Zealand: A review and a statement of policy.* Wellington: Author.

New Zealand Nurses' Association (1985). *Nursing: A social policy statement.* Wellington: Author.

New Zealand Nurses Organisation (1993) *Social policy statement.* Wellington: Author.

Nurse Educators in the Tertiary Sector & Nurse Executives in New Zealand (1997). *Joint position paper on post-registration nursing education.* Author.

Nurse Executives of New Zealand (1998). *Developing and supporting advanced practice roles: Clinical nurse specialist, nurse practitioner.* Auckland: Author.

Nursing Council of New Zealand (1995). *Code of conduct for nurses and midwives.* Wellington: Author.

Nursing Council of New Zealand (1997). *Competencies for entry to the register of comprehensive nurses.* Wellington: Author.

Nursing Council of New Zealand (1998). *Framework, guidelines and competencies for post-registration nursing education.* Wellington: Author.

Redfern, S. (1997). Reactions to nurses' expanding practice. *Nursing Times, 93*(32), 45-47.

Royal College of Nursing (1992). *Nursing: The nature and scope of professional practice. London:* Author.

Salmon, B. (1982). *A profession in transition: Issues in nursing in New Zealand over two decades 1961-1981.* Wellington: C.L.Bailey Nursing Education Trust.

Scott, C. (1998). Specialist practice: Advancing the profession? *Journal of Advanced Nursing, 28*(3), 554-562.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting (1992). *The scope of professional practice.* London: Author.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting (1997a). *Scope in Practice.* London: Author.

United Kingdom Central Council for Nursing, Midwifery & Health Visiting (1997b, Spring). Advancing professional practice. *Register, 19,* 5.