

Editorial

Patients' acceptance of "emergency nurse practitioners"

病人對「急症護師」的接受程度

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Editor-in-Chief

The public's perception of nurses is changing as a result of their enhanced level of education and training, with many of them now attaining academic qualifications at the same level as doctors, or even higher.¹ Nurse practitioners staffing emergency departments are well established in Australia, Canada, UK and USA. Historically, they were introduced to provide medical care in rural and remote or isolated communities,² but financial and resource constraints in public health systems in the 1990's generated impetus for their further growth and development,³ resulting in nurse practitioners staffing such areas as minor injury units or emergency department observation wards in recent years.^{4,5}

In addition to traditional nursing duties, the scope of practice of emergency nurse practitioners (ENP) is extended and their clinical accountability enhanced.^{1,2} Their exact privilege of practice varies from countries to countries and from hospitals to hospitals, either independently under written clinical practice guidelines and protocols or collaboratively under the direct supervision of doctors, and may include:²⁻⁶

- Taking patient histories, carrying out physical examinations, inserting intravenous drips, splinting soft tissue injuries and performing simple surgical

procedures such as suturing, incision and drainage, and administration of nerve blocks;

- Ordering and interpreting basic laboratory tests;
- Initiating diagnostic imaging, such as plain X-rays, ultrasound studies and even computed tomography;
- Prescribing medications, such as vaccines, local anaesthetics, intravenous fluids, antipyretics, antiemetics, oral or parenteral analgesics, and oral or intravenous antibiotics;
- Signing leave or absence-from-work certificates, writing referrals to specialists, admitting and discharging patients;
- Performing more demanding procedures such as the removal of corneal foreign bodies, endotracheal intubation, reduction of simple joint dislocations (patella, shoulder, finger), insertion of chest drain and even lumbar puncture under supervision; and
- Executing other professional duties such as patient education, health promotion, illness prevention, counselling, research, quality improvement, administration, training, and communication with other disciplines.

In essence, ENP take up some of the responsibilities traditionally held by doctors, and become *de facto* 'physician extenders' or 'physician's assistants'.^{1,3} Examples of conditions that can be assigned to ENP include limb injuries or infections, wound management, Plaster of Paris complications, minor burns, vomiting and diarrhoea, upper respiratory tract infections, fever and cough suggestive of pneumonia, urinary tract infections, breast pain and inflammation, loin pain suggestive of renal colic, and calf pain suggestive of deep vein thrombosis.⁶

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Perceived and cited benefits of ENP include the following:^{1,4-8}

1. Reduced patient waiting time and/or length of stay;
2. Increased patient satisfaction;
3. Holistic care, blending nursing and medical practice from triage through discharge as the ENP also serves as the patient's nurse;
4. Enhanced professional status of nursing, increased staff morale and job satisfaction, and better career opportunities that may improve recruitment and retention of nurses;
5. Improved accuracy and adequacy of documentation;
6. Improved communication and referrals;
7. Improved adherence to standardised optimal clinical practice; and
8. Increased health promotion opportunities.

Although in some Asian countries, nurses have already taken up part of the above practices, e.g. history taking, point-of-care testing, simple suturing, incision & drainage, tetanus toxoid immunisation, prescription of antipyretic for fever, the status and role of ENP have never been officially defined. In this issue, Ong et al carried out "a patient survey" to obtain information on public acceptance of "nurses treating patients in the emergency department". Their results showed that 55% of patients with minor illness or injury would only accept nurses for assessment and treatment if the waiting time for medical consultation was relatively long – 4 to 6 hours. In another article in this issue, Goh et al determined the efficiency and safety of "emergency department triage nurse initiated pain management". The authorisation of triage nurses in initiating analgesic prescription was only a small step towards the ENP concept but, of the patients with pain scores ≥ 5 , 54% refused analgesia offered by the triage nurse. Subsequently 44% of this group received analgesia after the medical consultation, implying that they still preferred waiting for a doctor, even though it would mean an extra hour or more before pain relief. The results of these two studies suggest that Asian patients still have greater confidence in doctors than nurses, and prefer treatment by the former.

A number of key issues need to be addressed before implementation of ENP becomes possible in Asian

countries, such as cultural, medico-legal, professional and financial implications. Even in western countries, obstacles are still common. Perceived barriers to ENP include:^{1,4,8}

1. Patient reluctance to be seen and treated by nurses;
2. Lack of legal authorisation or provision;
3. Resistance to change, e.g. hospital management, older nursing colleagues;
4. Professional jealousy (perceived threat) among nursing colleagues;
5. Conflict of roles with doctors;
6. Conflict with service providers such as the radiology department and the laboratories;
7. Lack of standardised training programs, qualification or professional re-certification.

Can ENP be implemented in Hong Kong? One important consideration is the manpower factor: nurses here are actually in higher shortage than junior doctors. Another contentious issue is the financial 'gain' argument. The 2005 pay scale (monthly) for Hong Kong Hospital Authority employees are: resident HK\$ 33,355-54,255 (mid-point 43,940); registered nurse HK\$ 17,145-30,430 (mid-point 24,135); and advanced practice nurse (general) HK\$ 31,860-45,240 (mid-point 38,285). For the public to accept ENP confidently, it is logical to ensure that the latter are recruited from advanced practice nurses rather than simply registered nurses. As can be seen, the financial saving from employing ENP instead of junior doctors in emergency departments is insignificant, if any.

In summary, the concept of emergency nurse practitioner is worthy of consideration, but there are still a lot of cultural, medico-legal and professional hurdles to be overcome before it can be implemented in Asian countries. A pilot trial in remote areas or outlying islands may, hopefully, promote and ultimately lead to its general acceptance.

Acknowledgement

The author is grateful to Dr. Billy Tao of Flinders Medical Centre, South Australia for his invaluable advice on the manuscript.

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