EDITORIAL
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Military Nursing…Licensure That Transcends Borders

Ever wonder why nurses all take the same examination but have to have a license in every state in which they practice? Although it is a complex issue, the various branches of the military have long had a system for credentialing nurses with licenses from all 50 states. Care may be in different venues compared with civilian life, but the same level of competence is expected from these nurses.

The tradition of nurses in the military dates back to more than 100 years. In the United States, George Washington is credited with communicating the need for nursing care to Congress in 1775 (Ulmer, 2001). Nurses are found in the Army, Navy, Air Force, and National Guards. Congress formally established the Army Nurse Corps in 1901 (U.S. Army, n.d.) and the Navy Nurse Corps in 1908 (Navy Nurse Corps Association, n.d.). The Air Force Nurse Corps, the youngest of the military nursing corps, just celebrated its 60th anniversary (Pockett, 2009). Each of these groups requires a registered nursing license for active duty employment. A license from only one state is required, although they will most likely practice in facilities around the world. This concept of interstate and beyond-state-based licensure begs the question, why does it not work that way in the civilian world?

Healthcare regulation begins with state government under the concept of “police power.” This includes the power to enact reasonable laws to protect the public health, safety, and welfare (Tate & Moody, 2005). In the early part of the 20th century, states’ rights were a very hot topic. The need to police those who practiced medicine resulted in states regulating nursing practice through licensure (Simpson, 2008). The primary mission of boards of nursing is to ensure public safety through safe nursing practice. The board’s responsibilities include establishing standards, issuing licenses monitoring licensees’ compliance with these standards, and disciplining those who engage in unsafe practices. Measuring competency through examination has been common practice for decades. The first step toward ensuring that all nurses have the same minimum competency level was adopting an examination that would be used by all states. The National Council of State Boards of Nursing (NCSBN) continues to develop the National Council Licensure Examination (NCLEX) for registered nurses. State and territorial boards of nursing have used this examination for many decades to assist in making licensure decisions. Recently, the examination has gone global and there are at least 13 countries outside the United States that are pilot sites for NCLEX examinations (Pearson Education, Inc., 2006).

The state-based licensure model presents many challenges for telenursing, disaster responsiveness, and the nursing shortage. As the world’s borders rapidly disappear with the evolution of the Internet and telephone technology, nursing practice has tried to evolve with it. With the passage of the Telecommunications Act of 1996, the Department of Commerce, Department of Health and Human Services, and other agencies began analyzing the impact of telecommunications on healthcare (Simpson, 2008). Telenursing raises concerns about whether the nurse providing the care in a state or country other than the state of licensure is practicing without a license. Considering this is a felony; it is not a minor issue. Other areas of concern include reimbursement, risk management, and liability.

Disasters, natural and man-made, create an incredible increase in need for qualified registered nurses. The terrorist attacks of 2001 added a sense of urgency for disaster preparedness. In spite of emergency management laws and disaster management programs, the Gulf Coast hurricanes of 2005 highlighted significant deficiencies in the ability to deploy physicians, nurses, and other healthcare practitioners to disaster-stricken areas. Licensure and competency ranked high in the list of challenges.

Nursing shortage concerns are causing multiple organizations to look beyond the state-based licensure...
model. The Health Resources and Services Administration (2006) projected that the shortage of nurses would grow to more than 1 million by 2020, with some states having greater issues than others. More nurses are expected to be needed as baby boomers age and their need for healthcare increases (Tate & Moody, 2005). To make matters worse, nursing school enrollment is increasing slightly but not nearly enough to meet the projected demand of 90% more graduate nurses (Health Resources and Services Administration, 2006).

With all the discussion of these issues, some progress is required to make nursing practice in multiple states easier while ensuring the public safety. Concerns about the rapid advances in telecommunications opening the door to interstate practice and nursing shortages prompted the NCSBN to investigate the concept of a mutual recognition model of nursing regulation in 1996. These models allow a nurse to have one license and practice in multiple states. The Nursing Licensure Compact (NLC) became a reality in 2000 when legislation was passed into law by the first participating states, but there are still only 23 states participating. The NLC comprehensively addresses concerns about administration, legislation, discipline, licensure, and practice. Organizations that have endorsed the NLC concept include many state nursing associations such as the American Association of Nurse Executives and the American Association of Occupational Health Nurses, several state hospital associations, the U.S. Department of Commerce, the Center for Telemedicine Law, the Telehealth Leadership Council, and the Citizens Advocacy Center.

Today, all 50 states have ratified the Emergency Management Assistance Compact, which allows state and locally employed licensed healthcare practitioners to practice in states without having to be licensed in the affected state. Federally employed healthcare practitioners may also be deployed without compliance with state licensure laws. In addition, § 2801 of the Public Health Services Act, 42 U.S.C. § 300hh recognized the Medical Reserve Corps and § 3191 of the Public Health Services Act, 42 U.S.C. § 247d-7b provided funding to establish Emergency Systems for Advance Registration of Volunteer Health Professionals (The National Conference of Commissioners on Uniform State Laws, n.d.). These programs do not result in interstate recognition of licenses. The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) was approved in 2006 (The National Conference of Commissioners on Uniform State Laws, n.d.). The act’s provisions address several areas of concern related to deploying volunteer healthcare professionals from the private sector during disasters. Registration systems and the recognition of current and valid licenses in other states are key areas of focus. Each state must enact the UEVHPA. From 2006 to 2008, only six states enacted the UEVHPA. In 2009, one state enacted it and another nine states introduced the legislation. Even if all 50 states enacted the UEVHPA, it would not address volunteer healthcare professionals attempting to provide care to underserved populations.

It is time, maybe even past time, for licensure to catch up with modern technological advances. Space travel has begun to even further stretch our boundaries. Nurses all take the same examination as a measure of the minimum competence for licensure as a registered nurse. It is hard to believe that systems that have worked for the military for more than 100 years cannot be adapted to civilian processes. This issue of Plastic Surgical Nursing features articles detailing the experiences of some of our military nurses as well as the implications for postconflict wound management. Nurses in the military care for those who volunteer to protect our way of life often times put themselves in harm’s way. Please join me in thanking them for their special contributions to the field of nursing.

Please feel free to forward your comments to the editorial board and me by writing us at Plastic Surgical Nursing, American Society of Plastic Surgical Nurses, 7794 Grow Drive, Pensacola, FL 32514-7072, or send an e-mail to Candise Flippin at psnjournal@att.net.

REFERENCES


Telecommunications Reform Act, 47 USC (1996).

