



## Response to *Advanced Nurses can do More but are Not a Substitute for Doctors*

May, 2015

Dr. Pearce:

Thank you for your nearly 35 years of practice as a surgeon and commitment to treating patients who need medical care and surgical intervention to ameliorate their health and quality of life.

We certainly understand your position championing the interests of physicians having trained and practice as a physician, as well as having served previously as the president of your state medical association (South Carolina). And we agree that team-based care among different types of medical providers like physicians, Advanced Practice Registered Nurses (APRNs), and Physician Assistants (PAs) is the ideal model to provide the patient with a diversity of expertise and skill that can be coordinated to best accommodate their needs and health condition at various points in time. However, we are concerned that many of your opinions favor the interests of your profession rather than what is paramount for patients and the healthcare system as a whole, and are in no way supported by evidence or facts.

1. "Some APRN leaders argue that they are not being supervised and they don't need to be. They feel that they do just as good a job as physicians, and that if they are given independence, it will increase the access to care. I would disagree."

Why do you disagree? You cite no evidence or facts that support your position anywhere in your opinion article. Alternatively, considerable evidence does exist indicating improved access to care when APRNs are not restricted by supervision requirements and their scope is not unnecessarily limited. Moreover, no research study published comparing physician practice to APRN practice has ever indicated any meaningful difference. That means the quality of care rendered by physicians and APRNs is equivalent (although some studies have shown that certain Nurse Practitioner (NP) outcomes are better than their physician counterparts). It also means equivalency for providers in each role to make errors or mistakes, despite physicians having "a much more intense training regimen". Interestingly enough, physicians face notably more malpractice lawsuits than APRNs, not attributable to solely the higher number of physician providers or the risk inherent in certain specialties.

2. "Physicians have agreed to the relaxation of the current statute because we want the nurses to have greater practice flexibility. But we accept these new rules as long as the Advanced Practice Nurse remains in a physician-led team."

APRNs are self-regulated professionals overseen by boards of nursing and are not, nor should be, subject to regulation by any other profession. Why must APRNs remain in physician-led teams? No evidence has shown that health-care teams must be or should be physician-led, or, provide any additional benefit. The team should be led by the most appropriate provider, taking into account their training, experience, skills, and leadership abilities. Sometimes this will be a physician. Other times this will be an APRN or a PA. Is the new attending physician who just completed residency training really the best candidate to lead the team over an NP who is doctoral-trained with 10 years of experience as an RN and 10 years of experience as an NP?

3. "Many APRNs are now being encouraged to get their doctor of nursing degree, which makes them a doctor but not a physician. Some nurses want to practice independent of physicians. The physicians of our state are opposed to this practice model."





Why? Where is the evidence to support your position against independent practice for APRNs? Nearly half the states in the U.S. permit independent practice, either for NPs or for APRNs in general. Do we see crises or catastrophes in those states?

4. “Nurses argue their training is adequate for what they wish to do. I agree that it prepares them perfectly for working with physicians. I do not believe it is adequate for the responsibility of the independent care of patients.”

Why? Where is the evidence from which your belief is derived? We certainly agree that formal physician training is more structured and longer in duration. This does not mean that more formal education leads to better providers and better patient outcomes; 30-40 years of research data clearly indicate that cannot be the case if there is no appreciable difference in comparisons between physicians and APRNs. It also does not set some arbitrary threshold for what is requisite for practicing independently.

5. “A bill supported by the medical association proposes an individualized practice agreement that would be signed by doctors and nurses. In that way, experienced nurses can have a formalized agreement that involves minimal supervision but would include chart review for quality assessment similar to what physicians do for each other all the time. Younger, more inexperienced nurses would need a closer period of supervision that can be relaxed with time.”

What about in cases of novice physicians and experienced APRNs? Should the APRNs have practice agreements to supervise and review the clinical work of these less seasoned and less expert physicians? We support chart review and quality assessment for all providers, but not merely unidirectional and physician-led. APRNs also need to be conducting such reviews and assessments on their physician colleagues and each other, especially in circumstances where they are more experienced and expert.

6. “As Rep. Anne Parks said to the nurses at the conclusion of a subcommittee hearing on March 17, ‘You (nurses) come here in a white coat and call yourselves doctor. I believe that is misleading to the patient.’ I would agree.”

APRNs are not physicians and should not be representing themselves as physicians. They are trained in the nursing model of care as undergraduates and in the medical model of care and treatment at the graduate level. They are licensed, board certified, and ultimately function with many similarities and parallels to physicians. APRNs who wear white coats, and/or don scrubs where they may appear as physicians to the lay public, should make efforts to present and clarify their title and role on the healthcare team whenever possible. This is especially important when APRNs have earned the title “doctor” through academic preparation to ensure mitigating any potential confusion to patients.

We encourage continued dialogue around access, safety, and the best care and outcomes for patients, not what is best for a particular profession. Discussions and debate need to be centered on current and comprehensive research, evidence, and evaluation of data rather than conjecture, opinion, and anecdotal encounters.

Advanced Practice Provider Executives, Inc. (APPex)  
Palo Alto, CA



## *Advanced Nurses can do More but are Not a Substitute for Doctors*

May 28, 2015

DR. H. TIM PEARCE

I have to disagree with my friend state Sen. Tom Davis about the status of Advanced Practice Nurses (APRNs) seeing patients in South Carolina.

I have been a surgeon in the Lowcountry for almost 35 years. I have been going to Hampton to see patients three to four times per month for almost 20 years. And I speak on behalf of the S.C. Medical Association as its immediate past president.

I have seen firsthand how effectively and efficiently physicians and APRNs work together in a rural health clinic, and how satellite offices in even smaller communities can be staffed by APRNs working as a part of the rural health team. I believe the majority of APRNs in our state are happy and productive in that model of health care.

Current laws require APRNs to practice with a licensed physician while both see patients as a part of a physician-led team. The word in the current statute that is at issue is the word "supervision."

Nurses are to be supervised by a physician, and it is the S.C. Board of Nursing that has been tasked with the responsibility to see that the statute is being followed.

Some APRN leaders argue that they are not being supervised and they don't need to be. They feel that they do just as good a job as physicians, and that if they are given independence, it will increase the access to care. I would disagree.

I would agree that with many clinical problems that are encountered, they do an excellent job and don't need much supervision. The medical association believes that increasing the number of nurses that can be supervised and increasing the distance they may practice in a satellite office will address the access issue.

A bill we endorse, which is supported by the S.C. Board of Medical Examiners and, for the most part, the Nursing-Board itself, also allows relaxed rules in regard to nurses writing prescriptions for some narcotics.

Physicians have agreed to the relaxation of the current statute because we want the nurses to have greater practice flexibility. But we accept these new rules as long as the Advanced Practice Nurse remains in a physician-led team.

We do not believe many nurses would open an independent practice, assume practice costs and malpractice payments in rural areas where payer mix is not conducive to small, independent practices for nurses or physicians.

Many APRNs are now being encouraged to get their doctor of nursing degree, which makes them a doctor but not a physician. Some nurses want to practice independent of physicians. The physicians of our state are opposed to this practice model. We respect our nurse colleagues greatly, and we believe patients are served better when APRNs and physicians practice together.

In regard to training, physicians have a much more intense training regimen. We start with a baccalaureate degree, then four years of medical school, then residencies that consist of three to seven years of being on call every three to four nights and every three to four weekends.

This training is intense, structured and involves comprehensive patient care with gradually less supervision. It also allows many more patient encounters, preparing us for the always possible worst-case scenario in the clinical setting.

It is this training that prepares us for the responsibility of independent practice.

Nurses have an RN degree, which focuses on nursing, then they have at most three to four years of mostly 9 a.m. to 5 p.m. clinical training after obtaining their baccalaureate degree. Their training is much less structured, and they have far fewer opportunities for clinical decision-making. They currently enter the clinical realm without any formal residency. No one is infallible. We all can make a mistake. But intense training and credentialing minimizes that possibility.

Nurses argue their training is adequate for what they wish to do. I agree that it prepares them perfectly for working with physicians. I do not believe it is adequate for the responsibility of the independent care of patients.

A bill supported by the medical association proposes an individualized practice agreement that would be signed by doctors and nurses. In that way, experienced nurses can have a formalized agreement that involves minimal supervision but would include chart review for quality assessment similar to what physicians do for each other all the time. Younger, more inexperienced nurses would need a closer period of supervision that can be relaxed with time.

The legislature is currently evaluating the two bills which address this issue with opposing views. As Rep. Anne Parks said to the nurses at the conclusion of a subcommittee hearing on March 17, "You (nurses) come here in a white coat and call yourselves doctor. I believe that is misleading to the patient." I would agree.

I hope this issue can be resolved soon. Doctors believe the public wins when APRNs and physicians work together and are not in conflict. In most parts of our state that relationship is working very well every day.

<http://bit.ly/APPex109>