By Lester A. Picker

A RELATIONSHIP FOR THE Making

Are physicians and advanced practice nurses colleagues or competitors?

ILLUSTRATION BY WHITNEY SHERMAN

"They can bring to (the practice) special skills which you may not want to do or you may not like to do. It expands the options to the patients. It's an absolute plus."

—Arthur Bassin, MD practices with Barbara Jones, RN, CNP in Torrance, California. Bassin says that nurse practitioners have improved his practice and widened its appeal.

UNLIKE OTHER PHYSICIAN PRACTICES, ARTHUR BASSIN'S GROUP practice doesn't consist of only physicians. The Torrance, California, gynecologist works with two nurse practitioners, and is a supporter of physician-nurse practitioner group practice. "There's no question in my mind that my nurse practitioners have improved our practice," he says, reflecting on his experience. "They helped our practice grow and they definitely widen its appeal to patients."

Barbara Jones, a registered nurse (RN) and certified nurse practitioner (CNP), agrees with her colleague's assessment. "Our practice is a very equal situation," she says of her 13-year stint working with Bassin. "There are patients who still love to see him, but also see me if he's not here and there are patients who love to see me and will see him if I'm not here. There's more of a team effort in our practice, a lot of camaraderie and respect."

With the experience of physicians like Bassin making the case for the benefits that advanced practice nurses bring to patient care, why are medical societies throughout the country up in arms over laws aimed at broadening their scope of practice? In Maryland, for example, the state legislature recently passed a law allowing HMO patients to choose from among the state's 1,600 nurse practitioners as their primary care provider, but only

Continued

Continued from previous page

Tips for Better Collaboration

In spite of what the headlines might lead the public to believe, nurse practitioners and physicians work collaboratively every day. Here are 10 tips for more effective collaborations, gleaned from some of the country's top experts.

Interview carefully. Since patient care and business success are at stake, both physician and nurse practitioner should conduct an in-depth interview. "From the physician's perspective, you need to look for someone who really is ready to make a commitment to a practice, just as you would when you choose a new resident coming out of training to join your practice," suggests gynecologist Arthur Bassin. "You want somebody who is willing to build a practice, please the patients and work hard."

Delineate roles. "Each side has to have a clear understanding of their respective roles," says Janet Selway of The Johns Hopkins University School of Nursing. "Each person needs to know and respect each other's areas of expertise. The literature shows when doctors and nurses work together patient outcome is improved."

Meet regularly. Communication is critical to a successful practice. Aside from sidewalk consults during the day, weekly meeting times should be carved out to develop medical protocols, discuss business practices, and review patient charts. "We have bi-weekly meetings," says Bassin, "where we'll discuss the various patients. We all bring to the table patients that are different or unique or just a medical or therapeutic challenge, as we used to do in residency. Many times my NPs will suggest something and I find myself saying, 'you know, I didn't think of that'."

Take time to train. "A physician needs to take the time to train the nurse practitioner, to really develop the same patient clinical philosophy that you have," says Bassin.

Make productivity expectations known. Each side needs to know what is expected in terms of productivity in order for the practice, clinic, or department to thrive. "Productivity expectations need to be stated up front," says Selway. "Be specific. The nurse practitioner should ask: 'How many patients do I have to see in a day?' 'How much time is reasonable for certain problems?' 'How much time should we allot for a comprehensive physical?'"

Value each care model. Nursing and physician training are based on different, but complementary care models. "I don't know if physicians always understand this, but nurse practitioners are nurses, so a lot of the care that we give is outside of the strict medical model," Selway reminds providers. "It's time intensive to listen and counsel, so it's not always a priority in some practices. But it's a really important service that we provide. It's often why patients choose to see us."

Provide support staff. Nurse practitioners are direct health-care providers. They need adequate support staff, office space, and continuing education, similar to the practice's physicians.

Offer patients a choice. It is important to have an understanding that patients have a choice of nurse practitioner or physician. Says Barbara Jones, a certified nurse practitioner: "I think that there are times when women, especially in Ob/Gyn, like to see a woman. If I say to a woman, 'This may hurt a little bit,' they know that I know what I'm talking about because I've been there. It's been very beneficial for the practice for patients to have a choice."

Empower the nurse practitioner. With more than 15 years under his belt working with nurse practitioners, Bassin has a unique slant on their development. "Yes, the doctor needs to teach them, but they also need the liberty to grow and to then go on and specialize." The NP Bassin has employed for nearly 15 years started as a general nurse practitioner in the office but went on to specialize in infertility and has been certified in ultasonography. "They can bring to it special skills which you may not want to do or you may not like to do. It expands the options to the patients. It's an absolute plus," Bassin says.

Market smart. If a group employs lower-cost nurse practitioners to simply churn patients through in 10-minute consults, the practice may build higher profits, but erode its own foundation. Instead, pitch your practice to potential patients by emphasizing the strength, skills, and experience of each of its components. Many patients want the educational and prevention skills that the nursing model provides. ■

Continued from previous page

PHOTO/ ©2001 CHRIS USHER

after vigorous opposition from the state medical society that stretched over a period of several years. However, even as House Bill 473 lay on the Governor's desk awaiting his signature, the medical establishment lobbied hard for his veto. Ultimately bowing to pressure from physicians' groups, the Governor vetoed the bill at the last possible moment.

"Sometimes physicians view us as competition. I think I would rather look at it as a collaborative model. Both of us want the same thing, namely quality care for the patient. That's the bottom line."

—Carolyn Montoya, MSN, a certified pediatric nurse practitioner, the director of the family nurse practitioner program at the University of New Mexico's College of Nursing, and the president of the Board of the American College of Nurse Practitioners.

A Changing Universe

Nurse practitioners have come a long way since 1965, when Henry Silver, MD and Loretta Ford, RN started the first formal training program at the University of Colorado to offset a regional shortage of pediatricians. Currently, there are approximately 65,000 nurse practitioners in the United States, according to the American Academy of Nurse Practitioners, and that number is expected to grow by 63 percent to more than 106,000 by 2005. During the same time period, the number of primary care physicians is expected to grow by only 10 percent.

But, it is not the shear growth in numbers of nurse practitioners that has medical societies in the United States concerned. Rather, it is the growing acceptance of nurse practitioners as primary care providers. In 21 states and the District of Columbia, nurse practitioners are allowed to practice independently of physicians, that is without the requirement for collaboration with or supervision by a medical doctor. Yet even in the states that require physician supervision, only one requires that the physician actually be present when care is provided.

In 12 states and the District of Columbia nurse practitioners have

Continued from previous page

completely independent prescriptive authority, including for controlled substances. In the remaining 38 states they have prescriptive authority in collaboration with a physician. In fact, in 1999 nurse practitioners wrote more than 53 million prescriptions, up more than 50 percent from 1998. However, most analysts feel that number is low since many nurse practitioner prescriptions are often credited to the supervising physician. One pharmaceutical industry research company estimates nurse practitioners will write more than 250 million prescriptions in 2001.

The federal government joined the physician-nurse practitioner fray with the passage of the 1997 Balanced Budget Act. In part, the Act allowed Medicare reimbursement to nurse practitioners, albeit at 85 percent of the physician rate. Many medical societies viewed this as a "foot in the door," providing legitimacy to a scope of practice for nurse practitioners that they believe is unproven and may even be dangerous to patients.

A Question of Care

In resisting the trend toward allowing nurse practitioners to practice independently, the American Medical Association, regional and local medical societies point to the training disparities between physicians and nurses, even those nurses with advanced practice degrees.

"I don't believe that nurse practitioners should have independent practice," says Carol E. Rose, MD, the president of the Pennsylvania Medical Society, which formally opposes independent practice by nurse practitioners. "The fact of the matter is, they are not doctors to begin with, therefore they may not know an appropriate time to make a referral. When patients are being seen by a physician, they are being seen by someone who knows the entire body physiology and multiple medical specialties. And even if they are a family practitioner they need to know about diabetes, and they need to know about the effects that diabetes has on the eyes and the kidneys and the legs and the heart and the peripheral vascular status. That means that they need to know a lot about those other specialties. I don't believe that it's appropriate for a patient to get all of their medical care from a non-medical doctor. We go to medical school because we learn a wide range of information."

Dr. Rose

Rose's comments echo those of other medical doctors—and the formal position of medical societies throughout the United States—who see a threat to quality of care if nurses are allowed to practice independently.

Carolyn Montoya, MSN, is a certified pediatric nurse practitioner and the director of the family nurse practitioner program at the University of New Mexico's College of Nursing. She is also the president of the Board of the American College of Nurse Practitioners, and she disagrees strongly with Rose's assessment.

"There've been lots of changes that physicians have had to adapt to with managed care. However, I think that the fear they have of nurse practitioners is unrealistic. We've been around since the '60s, and we're not going away. We're not going to suddenly stop. The AMA's House of Delegates regularly puts out resolutions that say that we should not have independent practice, that we should be under the supervision of physicians. We don't agree with that. I am certainly going to work to maintain our level of independence. We know the battle will not be easy. It's been uphill in every single state. But now we're beginning to amass data that shows our effectiveness."

Convincing Data

The data Montoya points to with a certain degree of pride includes a recent landmark study conducted by Mary Mundinger, DPH and others. Mundinger is the dean of the Columbia University School of Nursing. Set in an urban New York City setting, the study compared patient outcomes in a nurse practitioner group and a primary care physician group.

In an editorial accompanying publication in the Jan. 5, 2000 issue of the *Journal of the American Medical Association* (*JAMA*), Harold Sox, MD, of the department of medicine at Dartmouth-Hitchcock Medical Center, lauded the study and summarized it by saying that, "according to the authors of this well-designed, well-executed randomized clinical trial, the care provided by nurse practitioners led to the same outcomes as care provided by primary care physicians." Although Sox took issue with the short-term (six-month) follow-up and the fact that patients were not broadly representative, Mundinger's study has been the catalyst for attempts in many states by nurse practitioners to allow them independent practice authority and to require third party reimbursement.

The insurance industry is carefully watching the evolving role of the nurse practitioner, according to Edward Koza, MD, the senior patient management and medical director for Aetna US Healthcare's Capitol Region. "We actually don't pick the providers for people, they pick them themselves. We provide a network and choices for our members. Then we let the member make that decision. If they choose a certified nurse practitioner, we pay them for that service. In general, as there are more nurse practitioners and their role becomes validated by members selecting them and

Continued from previous page

getting services from them and being pleased with those services, I don't think there's going to be any problem with insurance companies reimbursing them."

The Benefits of a Collaborative Model

Despite their differences over independent practice, most physicians and nurse practitioners agree that collaboration between them benefits patients the most. "Sometimes physicians view us as competition," Montoya says in frustration. "I think I would rather look at it as a collaborative model. Both of us want the same thing, namely quality care for the patient. That's the bottom line."

Rose agrees, citing a key difference between the formal education of physicians and nurses, namely a nurse's training in patient education and prevention. "I think that physicians who wish to enhance their practice can do so quite nicely by working with and supervising nurse practitioners. Nurse practitioners are really very good educators. And patients like to work with them."

While the warring medical and nursing organization factions make headlines, the everyday collaborative model prevails in the trenches of medical care. By most estimates, only about two to four percent of all nurse practitioners practice independently. The majority work within an existing group practice, or in a health center or hospital setting, their nursing care model interfacing nicely with physicians' medical and disease treatment models.

That is a point emphasized by Janet Selway, a clinical instructor at The Johns Hopkins University School of Nursing and a nurse practitioner for 13 years. "In some practices I've been asked to take care of a specific problem, because I'm more familiar with it, or maybe I can handle it better. In other cases I may ask a doctor to help interpret an EKG so I can finish taking care of my patient. There's a lot of really good camaraderie and professional relationships out there in the trenches. We respect each other's skill sets."

With the skills that nurse practitioners bring to the health provider setting come other advantages to physician and health center practices, such as staffing flexibility for vacation and weekend coverage. Several studies have shown that nurse practitioners are more willing to conduct home visits and to serve patient populations that are typically underserved.

HMOs are increasingly using nurse practitioners, finding that their prevention and education model is consistent with their own operating philosophy. Until recently, even HMOs have been reluctant to use nurse practitioners more widely due to concerns over patient care. But with outcome studies such as the one done by Columbia University now receiving widespread attention, that perceptual barrier is steadily eroding.

Behind the public discussion over quality of care, there is another advantage to physician-nurse practitioner collaborations that is privately recognized as an enormous benefit to practices struggling to earn a profit under the constraints of managed care. Nurse practitioners are typically more cost effective to a practice than hiring another physician, since they are typically paid about half to two-thirds what a physician is paid. However, even then a practice should know beforehand what the expectations are of the nurse practitioner, since their prevention and education role is often more time consuming than a physician's treatment model.

"It's critical for the team to agree on how much time is going to be allowed in the practice to do certain types of patient encounters," says Selway. "A lot of the care that nurse practitioners give is outside of the strict medical model and it's time intensive. That may not be a priority to some doctors, but it's a really important service that we provide. It's often why patients choose to see us. A reasonable expectation for productivity for a nurse practitioner would be 20 to 25 patients a day. And that's a mix of new patients, established patients, and various codes."

A fear of competition?

Yet, no matter the synergies of the current relationship between nurse practitioners and physicians, there is a great degree of edginess in the medical community about the future role of advanced practice nurses.

In his *JAMA* editorial, Sox acknowledged that the increasing numbers of nurse practitioners will eventually compete with family physicians and general internists for patients, especially if studies such as Mundinger's show little or no difference in patient outcomes, a point that is conceded by most nurse practitioner leaders. However, Montoya and others dispute Sox' point that nurse practitioners may establish more independent practices as a result of the confidence the public may put in them when it learns of these patient outcome studies. "Independent practice will be difficult for us," Montoya says, "but it will continue to be difficult for physicians also. However, group nurse practitioner practices that operate independently of physicians will grow." Those groups will certainly have ties to physicians as nurses refer out or consult on more difficult cases. Montoya, Selway, and other nurse practitioner leaders see the threat of economic competition as the real reason physician societies are against the evolving role of nurse practitioners.

But, even physicians who heavily rely on nurse practitioners to run a successful practice disagree that economics is the prime motivator against broadening the

Continued from previous page

scope of practice for nurse practitioners. "There has to be some supervision, even though they provide very good care," says gynecologist Bassin. "They don't have the depth or breadth of knowledge or the experience that physicians do. So, I believe someone has to supervise them and take responsibility for the patients."

Rose also worries about the ability of nurse practitioners to refer out at critical junctures in a patient's care, a notion that both Montoya and Selway dismiss outright. "I think the fear there is how can a nurse practitioner handle an independent practice? The fact is that there is no health care provider today who would be so foolish as to think they are totally independent," says Montoya. "Physicians consult with each other all the time. When we have a case that is beyond our scope of practice, we consult—exactly the way a physician does who is beyond their scope."

Selway agrees. "In Maryland our scope of practice says that we can diagnose and treat common illnesses and we can take care of people with chronic illnesses when they are stable," she says. "But, you need a medical school education to diagnose and treat those complicated illnesses, especially when they are unstable. But, there is a lot of role overlap. I have the skills to decide whether or not someone with chest pains is presenting an evolving myocardial infarction or has esophageal reflux disease. If I think it's an evolving myocardial infarction, then I want a physician to take over."

Whatever the eventual outcome, there is clearly a trend toward expanding independent practice for nurse practitioners. In 1989 there were only eight states that allowed independent practice. Today there are 22 with bills pending in several others. In 1994, the Pew Health Professions Commission study recommended doubling the number of nurse practitioners to make up for the critical shortage of primary care physicians, as doctors turn to more lucrative specialties in light of managed care.

"The studies are out there that nurse practitioners tend to be more cost efficient and the quality of care is the same," Montoya is quick to suggest. "But, it will take a bit more time for the system to get used to nurse practitioners. I personally think we're one of the best-kept secrets in health care. I think we're the answer to a lot of the health-care problems in this country. The needs of the elderly are going to shoot up, and people with chronic illness are taxing the resources of the health system. Based on the nursing education model, we are very able to handle that. Nursing focuses much more on behavioral and preventative issues, which we're well equipped to deal with." ■

Les Picker is a regular contributor to Unique Opportunities. *His article about abandoning HMO contracts appeared in January/February.*