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March 27, 2020

The TNA has responded to the opinion piece [*Nurse practitioners can’t solve primary care physician shortage*](https://www.tennessean.com/story/opinion/2020/03/25/nurse-practitioners-cant-solve-primary-care-physician-shortage/2911795001/), which was issued in the March 25 edition of The Tennessean, from members of the Physicians for Patient Protection advocacy group – Dr. Carmen Kavali and Dr. Vidya Bansel.

We felt compelled to respond, not as counterpoint to their opinion, but to clarify several factual inaccuracies stated by the authors. We’ve provided responses that demonstrate the factual inaccuracy of these claims below:

**Claim:** *On Feb. 5, state Rep. Bob Ramsey and Sen. Jon Lundberg introduced controversial legislation (HB 2203/SB 2110) that would allow nurse practitioners, certified nurse midwives, certified registered nurse anesthetists and clinical nurse specialists to practice nursing without supervision or formal collaboration with physicians. The bill allows for full prescribing privileges, including hormone replacement therapy, but excludes procedures involving the spine. It also allows physician assistants to certify disability papers but excludes PAs from other independent practice.*

**Fact:** The notion that [HB2203/SB2110](http://www.capitol.tn.gov/Bills/111/Bill/HB2203.pdf) included a provision to allow physician assistants (PA) to certify disability papers is incorrect. PAs were not included in this piece of legislation. In fact, there is a separate bill, HB2101/SB2761, that addresses the role of PAs and advanced practice nurse practitioners in Tennessee’s Workers’ Compensation program.

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**Claim:** *While nurse practitioner lobbyist groups argue that NPs can fill the gap in care in rural areas, the reality is that NPs are choosing not to work in these underserved areas, with workforce data showing that both NPs and physicians tend to practice in the same concentrated areas. Further, in states that have adopted independent practice, there has been no increase in nurse practitioners practicing in rural areas.*

**Fact:** This is an unfounded statement. Studies have shown that primary care nurse practitioners (PCNPs) are more likely to practice in rural areas.

Visiting professor at the Vanderbilt School of Nursing, Peter Buerhaus, PhD, RN, FAAN, FAANP(h), issued a 2018 study [titled Nurse Practitioners A Solution to America’s Primary Care Crisis](file:///C:\Users\hallc\Documents\TNA\Buerhaus%20study%20re.%20quality%20and%20rural%20access%20multiple%20references.pdf), that revealed primary care nurse practitioners (PCNPs) were more likely to practice in rural and underserved areas compared to primary care medical doctors. See excerpts from his study below:

*“Further, we find, as do other studies, that compared to primary care medical doctors, primary care nurse practitioners (PCNPs) are more likely to practice in rural areas, where the need for primary care is greatest. “*

*“And where are these patients and providers located? The study revealed that PCNPs caring for Medicare beneficiaries were significantly more likely to practice in a federally designated Health Professionals Shortage Area and in rural areas compared to PCMDs. These findings are supported by the results of other investigators (see Appendix A), who have also found that NPs provide primary care to vulnerable populations and that PCNPs are more likely to practice in rural and underserved areas.”*

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**Claim:** *The arguments that NPs will fill the gap in primary care and rural shortage areas are patently false and being used to legislate a right that they are not properly trained for: the independent practice of medicine.*

**Fact:** This statement is inaccurate. [HB2203 / SB2110](http://www.capitol.tn.gov/Bills/111/Bill/HB2203.pdf) is legislation for the right to practice nursing – not the practice of medicine.

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**Claim:** *While NPs wish to provide medical care independent of physicians, they argue that they are practicing nursing and not medicine, therefore avoiding oversight by the Board of Medical Examiners, the body that monitors the quality of care provided by physicians.*

**Fact:** The Board of Medical Examiners should not oversee the practice of nursing; only the Board of Nursing should oversee the practice of nursing.

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**Claim:** *Whether the Board of Nursing is capable of properly monitoring “advanced nurses” is in question.*

**Fact:** The Board of Nursing is capable of properly monitoring advanced nurses in question. A 2020 report issued by the Comptroller’s Office of Research and Education Accountability (OREA), studied the opioid prescribing patterns of the state’s doctors, nurses, dentists and other licensed practitioners and the disciplinary responses taken by the licensing boards for any prescribers found to be “significantly statistically abnormal.”

The report titled [*Opioid prescribing patterns and prescriber discipline in Tennessee*](https://www.comptroller.tn.gov/content/dam/cot/orea/documents/orea-reports-2020/OpioidSnapshot113.pdf) found that the Department of Health determined that the licensing boards have taken appropriate disciplinary action against any prescriber for which the department sought the need for discipline.

Based off 2017 prescribing patterns, the OREA identified 62 prescribers, including APRNs, medical doctors, osteopathic physicians, physician assistants and dentists for further investigation. Nine APRNs and 22 medical doctors were included in that total.

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**Claim:** *For example, the Board of Nursing has not yet complied with the 2008 Advanced Practice Registered Nurse Consensus Model, which states that nurses must practice only in the field in which they have received nursing certification.*

**Fact:** States with restrictive APRN practice have not fully implemented this because it states that there must be independent practice or independent prescribing to comply with the compact language.

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**Claim:** *There are real solutions available to increase the supply of primary care physicians in Tennessee that the legislature may choose to pursue instead. Graduate physicians are physicians who have graduated from medical school but have not yet completed a residency year. However, they have many more clinical hours of training beyond that of an NP or a PA -- 4,000 versus 500 and 2,000 hours, respectively. They would be fully supervised -- even more so than the law requires of NPs and PAs -- and a bill for this has already been introduced (HB810/SB672).*

**Fact:** [Minutes from the Tennessee Board of Medical Examiners’ (TBME) regular board meeting](file:///C:\Users\hallc\Documents\TNA\ME031919.pdf) on March 19 and March 20, 2019 show that the TBME urged against the Graduate Physicians Act (HB810 / SB672) and determined that this legislation was not an appropriate avenue towards licensure for assistants for physicians.

The minutes show that TBME vice president, Melanie Blake, MD, determined that there was “no way to define the physician overtime” (referring to the number of clinical training hours) because there was “no pathway to board certification or a way to get them eligible as a full unrestricted medical doctor.”

Furthermore, this is a position that even the American Medical Association opposes. In 2014, the AMA’s House of Delegates adopted the following resolution:

*RESOLVED, That our American Medical Association oppose special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate U.S. medical education.*

In fact, during a legislative hearing on Feb. 19, 2019, Commissioner Lisa Piercey, MD stated that in the previous year, there were 24 unfilled residency slots in Tennessee – with about half of those in primary care. If medical school graduates wish to practice primary care in rural settings, there are pathways already in existence for them to match with unfilled residency slots and complete their educational training.