Physicians and Advanced Practice Registered Nurses:
Working Together As a Team

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To the Editor—After reading the July/August 2011 issue of the NCMJ, it was clear that only one side of this discussion was being presented for the readers regarding the independent practice of advanced practice registered nurses (APRNs). We at the North Carolina Medical Society, the North Carolina Academy of Family Physicians, the North Carolina Pediatric Society, and the Old North State Medical Society wanted to use this opportunity to present another side of the conversation.

Some advocates of nurse autonomy have suggested advanced nurses will bolster primary care shortage areas of North Carolina. Our research has found that APRNs tend to practice in the same areas of North Carolina as physicians. In addition, we have not been able to find any evidence that granting independent practice to nurse practitioners changes their preference for practice location. In fact, if one looks at other states that have granted autonomous practice, it has not changed much at all. We also cannot rely on nurse practitioner independence to improve access to primary care under the current economic and payment environment.

The demand for nursing autonomy is only coming from a minority of advanced nurses. In fact, advance nurses today are increasingly entering hospital-based positions where physician supervision is a nonissue. Many advanced nurses now serve as hospitalists or as additional health care personnel for physician specialists. Hospitals are gradually replacing inpatient providers with advanced practice nurses under the supervision of a specialty physician. In this manner, the specialist can perform more procedures while the APRNs manage floor patients and consults. Thus, hospitals can afford to pay these nurses more than what they would earn in primary care. This salary difference creates a personnel vacuum, pulling more and more advanced nurses away from primary care. Like their medical student counterparts, APRNs are lured away by better reimbursement in specialty fields and in metropolitan areas.

In addition, APRN training does not come close to the amount of training of a primary care physician or other physician. For example, a family medicine graduate will complete 20,000+ hours of total training, compared with around 2,000-5,000 total hours for a nurse practitioner. Physicians are required to complete annual Continuing Medical Education training, and sit for Board recertification every 7-10 years, regardless of their level of professional practice. In contrast, about 20% of APRNs use alternate pathways available in their state to achieve licensure without advanced collegiate education. How can the public know how much experience their nurse practitioner has had without standardized training programs, mandatory recertification, and physician oversight?

APRNs can and do play a vital role in any primary care team, but are not equivalent to or a substitute for a physician. We value the role APRNs play and look forward to continuing to work with nurses to offer the highest quality of care possible for the citizens of North Carolina.

Rather than arguing over who can take care of patients better, we should all acknowledge that the best care we can provide is by working together as a team, making arguments about scope and independence meaningless. NCMJ

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