Advanced Practice Registered Nurses:
Current Problems and New Solutions

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The central focus of the Task Force on the NC Nursing Workforce was the chronic shortage of nursing personnel in hospitals, nursing homes and other healthcare facilities, and the steps that can be taken to alleviate and permanently correct this problem within our state. There is not a shortage of advanced practice registered nurses (APRNs), so the problems of this segment of the nursing profession might be considered tangential to or even irrelevant to the work of the Task Force. Nevertheless, practitioners of this segment of the nursing profession presented eloquent testimony to several problems which were perceived as imposing limitations on the full function and effectiveness of their practice. These are addressed in Chapter 5 of the report and in the recommendations within the chapter.

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Three major issues were identified: joint regulation by the NC Board of Nursing (NC BON) and the NC Medical Board (NCMB), requirement for physician supervision of practice, and unequal reimbursement for services.

Regulation

Understanding the impact of these issues requires some background review. One might presume that the scope of practice of various professional groups is precisely defined in the licensure laws of these professions. Instead, the scope of practice of the health professions, including medicine and nursing, is defined in very broad and vague terms. While this has been useful in accommodating new functions, as medical and nursing knowledge and experience has grown, it generates conflicts as these professions compete for the same functions. Licensure statutes generally prohibit the practice of that profession by those who are not duly licensed or approved as a practitioner, based on education and examination. The practice of medicine is restricted to those who are licensed as physicians by the NCMB, but there are a number of exceptions, under which physician assistants (PAs), nurse practitioners (NPs), etc., meeting specified education and examination requirements, are permitted to perform medical services under supervision of a licensed physician.

The exceptions, permitting licensed registered nurses (RNs) to perform medical acts, recognize that these practitioners are also licensed and regulated by another professional board, the NC BON. North Carolina statutes provide for a subcommittee of NCMB and NC BON, to establish rules and regulations for the function of these dual-licensed practitioners. The authority of the two subcommittees, relating to NPs and certified nurse midwives (CNMs), differ in composition and authority, in that the latter has members who are not members of either Board, and has the authority to promulgate rules and regulations which do not require approval by either of the parent boards.

This legal and regulatory framework, for all its complexity, has served the professions involved well over the past quarter century. APRNs have rapidly increased in numbers and in public respect, while permitted functions have expanded, and required documentation of physician oversight has been relaxed. Nevertheless, conflicts and friction have been encountered, as evidenced by the concerns expressed by APRNs in testimony before the Task Force. One component group of APRNs, Clinical Nurse Specialist (CNS), is not defined in the statutes, and lacks the protection of its title against use by untrained individuals who do not meet the standards of the group.

As pointed out in Chapter 5 of the Task Force report, some

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states license and regulate the practice of APRNs in a very different manner than in North Carolina. About half do not require physician supervision, and regulate practice through the nursing board alone. Some APRNs would prefer that North Carolina join this group. This action would be opposed by the NCMB, by most physicians, and their professional society, the NC Medical Society. These groups strongly favor some form of oversight by physicians.

A time honored method of resolving such differences between professions is to promote the introduction of a legislative act, changing current statutes to accomplish the new intent. This approach has inherent limitations, the most important one being that the NC General Assembly has only secondhand information about the working environment in which these conflicts arise, and the practicality of the proposed remedies. In their desire to please as many of the interested parties as possible, while still protecting the public interest, they may pass legislation which does not meet the needs of either the proposing or the opposing parties.

Instead, the Task Force recommends that the NC Institute of Medicine form another task force, with appropriate membership representing the major concerned groups, to consider these issues, and recommend action. Hopefully, if new legislation is required, it will be supported by all sides on the issue as it is discussed in the NC General Assembly.

Payment Inequities

The issue of payment inequities is not one which can be solved by this approach, as reimbursement policies are set by many parties. Medicare policies are established at a federal level, and insurance company policies are set by the individual companies. Nevertheless, the new task force may want to include this issue with the others as it discusses actions for the future.

Physician Supervision

Potential legislation to resolve the issues cited in Chapter 5 may not be the most important function of the new task force. The second issue, required physician supervision, brings with it an implied hierarchy of expertise, physician over APRN, which may or may not be accurate. One can easily envision a practice setting in which a NP may have the highest level of expertise in diabetes management, in which case it might be more appropriate that the NP "supervise" the physician. The concept of collaborative practice, in which all practitioners understand and respect the abilities and knowledge of each other has merit and deserves attention by the task force. A joint statement by the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives[1] embraces this approach, and has been helpful in resolving similar problems between these two groups. The process of discussion, seeking mutual understanding and thinking together about new directions may be the single most useful function of the new task force.

Both physicians and nurses choose to enter their respective professions in order to serve their patients. Traditionally, they have worked together to accomplish this joint purpose. I hope that the suggested new NC Institute of Medicine Task Force, if it comes about, will promote and enhance this tradition, and lead to an outcome as useful and productive as that of the most recent Task Force on the NC Nursing Workforce, whose work and recommendations are summarized in this issue of the *Journal*. **NCMJ**

REFERENCES

1 Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse Midwives/Certified Midwives. Approved by the American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, October 1, 2002.

The American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) recognize that in those circumstances in which obstetrician-gynecologists and certified nurse-midwives/certified midwives collaborate in the care of women, the quality of those practices is enhanced by a working relationship characterized by mutual respect and trust as well as professional responsibility and accountability. When obstetrician-gynecologists and certified nurse-midwives/certified midwives collaborate, they should concur on a clear mechanism for consultation, collaboration and referral based on the individual needs of each patient.

Recognizing the high level of responsibility that obstetrician-gynecologists and certified nurse-midwives/certified midwives assume when providing care to women, ACOG and ACNM affirm their commitment to promote appropriate standards for education and certification of their respective members, to support appropriate practice guidelines, and to facilitate communication and collegial relationships between obstetrician-gynecologists and certified nurse-midwives/certified midwives.

** Certified nurse-midwives are registered nurses who have graduated from a midwifery education program accredited by the ACNM Division of Accreditation and have passed a national certification examination administered by the ACNM Certification Council, Inc.*

Certified midwives are graduates of an ACNM Division of Accreditation accredited, university affiliated midwifery education program, have successfully completed the same science requirements and ACNM Certification Council, Inc. national certification examination as certified nurse-midwives and adhere to the same professional standards as certified nurse-midwives.

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American College of Nurse-Midwives
American College of Obstetricians and Gynecologists