Testimony of
The Pennsylvania Medical Society
Before the House Professional Licensure Committee
On House Bill 765

Good morning. My name is Dr. Karen Rizzo. I am the current President of the Pennsylvania Medical Society and a practicing otolaryngologist in Lancaster. On behalf of PAMED and the physicians, residents, and medical students we represent, thank you for providing us with this opportunity to present our position on House Bill 765, legislation which would allow nurse practitioners (NPs) in Pennsylvania to practice independently.

For over 150 years, PAMED has worked to advance quality patient care and the ethical practice of medicine in the commonwealth. Central to that mission has been our dedication to demanding rigorous training and education standards for all health professionals, commensurate with scope of practice.

In Pennsylvania, NPs are currently required to collaborate with physicians in order to diagnose, treat and prescribe to patients. Collaboration is defined as "a process in which a CRNP works with one or more physicians to deliver health care services within the scope of the CRNP's expertise."

This process, established in state law, requires three components:

1) Immediate availability of a licensed physician to the CRNP through direct communications or by radio, telephone or telecommunications;
2) A predetermined plan for emergency services; and
3) A physician available to a CRNP on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics, and cosigning records when necessary to document accountability by both parties. (63 P.S. §212).

In systematically linking every NP with a physician and defining a complementary working relationship between the two, the collaborative agreement ensures that every patient has a physician involved in the management of their care – an assurance which is critical when that care requires a more highly trained professional. Collaboration also guarantees that NPs have immediate access to a physician for consultation and referral when complex medical issues arise.

Despite these key components of the collaborative process, however, supporters of HB 765 claim that the collaborative agreement is nothing more than a "business contract" which impedes their ability to care for patients. HB 765 seeks to eliminate the collaborative ties that exist between NPs and physicians, allowing NPs to diagnose, treat and prescribe independently and without physician involvement. In essence, this legislation would allow NPs to do everything a physician can do with equal clinical authority and autonomy, yet without the necessary education and training.

The Value of Medical Education and Training

While most people have a general sense of what it takes to become a physician, relatively few fully understand the process of medical education and training or how it compares to an NP's preparation.

After completing an academically rigorous undergraduate course load in order to gain acceptance to medical school, a primary care physician must complete four years of graduate medical education, followed by 3 years of supervised clinical training, commonly referred to as residency. Whether you

see a physician in Pennsylvania or in California, he or she has completed this highly structured and standardized process. Through it, a primary care physician acquires over 16,000 hours of direct patient-care, supervised by an attending physician, *before* they are permitted to practice independently.

In contrast, the average NP completes only 1 ½ to 3 years of additional training after a bachelor's degree, during which he or she acquires an average of 500 to 720 hours of direct patient-care experience. There is wide variation in the education standards of NP programs—which continue to evolve—both among schools and between states. A growing number of master's of nursing programs can be completed part time and/or almost entirely online, with some programs providing nursing students with clinical learning experience through simulated patient labs utilizing patient actors.

Perhaps most critical, however, is the fact that NPs lack a post-graduate clinical training requirement—comparable to a physician's residency—and the necessary exposure that experience provides to treating real patients in a supervised clinical environment. Such limitations in NP training may explain why a study published in the American Journal of Nurse Practitioners in 2007 found that only 10 percent of NPs surveyed felt "very well prepared" for actual practice after completing a master's level nursing program. The majority of respondents – 51 percent – reported that their NP programs had made them "only somewhat or minimally prepared to practice."[1]

The contrast we are making between the education and training of a physician versus that of an NPis not meant to devalue the expertise of NPs or the critical role they play in delivering patient care. NPs are a vital part of our health care workforce and their preparation is appropriate for effectively dealing with patients who need basic, preventative care, or treatment of straightforward acute illnesses and uncomplicated chronic conditions. Like the vast majority of physicians, I have worked with many NPs and believe that they are a valuable asset to the health care team.

However, the depth and breadth of NP training does not sufficiently prepare them for the wide array of challenges that regularly confront an independent practitioner. There is a reason why primary care physicians are educated and trained so extensively. The primary care physician must not only be prepared to treat common ailments, but able to recognize a broad spectrum of disease states presented in both typical and atypical symptoms. The necessary body of knowledge and experience required to efficiently make such differential diagnoses, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of a patient's overall health condition is vast. Far from being "over trained," it is the extensiveness of a primary care physician's training that strengthens his or her diagnostic skills.

Access to Care and Geographic Distribution of Providers

Organizations pushing for independent licensure of NPs claim that such a policy change will lead to better access to care, particularly in rural and underserved areas. The evidence fails to support this assumption.

First of all, nothing in Pennsylvania law requires that NPs practice in the same geographic location as their collaborating physicians. In the event that an NP is having difficulty finding a collaborating physician within reasonable distance to provide support, assistance and oversight, PAMED would be very much willing to assist them and facilitate such important work. Thus, given the absence of such legal or regulatory hurdles and the many options for connectivity in this day and age, it's unreasonable

---

[1] Hart A, Macnee C. "How well are nurse practitioners prepared for practice: results of a 2004 questionnaire study." *Journal of the American Academy of Nurse Practitioners.* 2007, Vol. 19, No. 1, p. 37.

to suggest that the collaborative agreement requirement is what prevents NPs from providing care in rural and underserved communities.

The majority of states continue to require NPs to have physician collaboration or supervision in order to practice. Moreover, in states where NPs have gained the authority to diagnose and treat patients independently, neither access to care nor cost savings have substantially increased. Save for an overall growth of the NP profession in recent years, a geographic distribution of the health care workforce shows that there has not been a significant migration of NPs to rural areas after gaining independent practice authority in statute. NPs continue to practice in the same areas where physicians practice; and these states continue to seek solutions to the same access-to-care problems that plague Pennsylvania.

In reality, the factors that impact the ability of physicians to practice in rural communities also affect nurse practitioners, and nurse practitioners are therefore no more likely to practice in these areas than physicians. The fixed costs of establishing a rural medical practice, the maze of burdensome federal and state laws and regulations, and relatively low patient populations are just a few of the reasons access problems exist in rural areas. Not to mention, practitioners face the additional clinical challenges associated with practicing in a community where medical infrastructure and a network of support are often lacking. Physicians would contend that such isolation calls for rural practitioners to have *more* expertise and an even broader skill set in order to provide comprehensive patient care.

Questions of Quality and Cost of Patient Care

Proponents of HB 765 also argue that this legislation will conveniently result in reduced health care costs, higher patient satisfaction, and the same, if not better, outcomes when compared to physicians. They point to number of studies that substantiate their claims.

Yet an extensive review of published research on the topic looked at 4,133 relevant studies and identified only 26 that met their criteria for methodological quality. Additionally, when the level of nurses' clinical autonomy in these studies was considered, authors determined that while nurses made independent decisions to perform certain tasks, the majority still required minor support or contact with physicians. Authors concluded that current evidence assessing the substitution of physicians by nurses is "substantially limited by methodological deficiencies." They recommended more methodologically rigorous research on health outcomes and costs before changes in the way primary health care is delivered are implemented.[2]

A number of published peer-reviewed studies and reports have also directly contradicted claims of cost savings and superior quality of care provided by NPs. For example, nurse practitioners have been found to order more diagnostic imaging tests than physicians, make more unnecessary and poorer quality referrals of patients to specialists, and are more likely to prescribe drugs to patients.[3][4][5] Two of the nation's largest professional liability programs for nurse practitioners strongly recommend that they

---

[2] Martínez-González, N. A., Djalali, S., Tandjung, R., Huber-Geismann, F., Markun, S., Wensing, M., & Rosemann, T. (2014). Substitution of physicians by nurses in primary care: a systematic review and meta-analysis. *BMC health services research*, *14*(1), 214.

[3] Hughes, D. R., Jiang, M., & Duszak, R. (2015). A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA internal medicine*, *175*(1), pp. 101-107.

[4] Lohr, R. H., West, C. P., Beliveau, M., Daniels, P. R., Nyman, M. A., Mundell, W. C.,... & Beckman, T. J. (2013, November). Comparison of the quality of patient referrals from physicians, physician assistants, and nurse practitioners. In *Mayo Clinic Proceedings* (Vol. 88, No. 11, pp. 1266-1271). Elsevier.

[5] Roumie C. and Halasa N. Differences in antibiotic prescribing among residents, physicians and non-physician clinicians. *American Journal of Medicine*. June 2005, Vol. 118, No. 6, pp. 641-648.

actively consult and collaborate with physicians to mitigate risk and enhance quality of care and patient safety.[6]

How Collaboration Improves Access-to-Care

Contrary to claims that this is just a "turf battle" for physicians and we want to hold nurses back, physicians *support* NPs and other non-physician providers practicing to the full extent of their training. The collaborative agreement, which serves as a patient safety net to catch those instances that go beyond a NP's scope, enhances rather than impedes the ability of NPs to deliver quality patient care.

With the complexity our healthcare system ever increasing, patients need *both* physicians and nurse practitioners, coordinating care and sharing information for the benefit of the patient. The team-based model of healthcare delivery—as epitomized by the patient-centered medical home concept— brings the best of each provider's training to the care of patients and the cure of disease. Research has repeatedly shown that interprofessional collaboration and a highly functioning healthcare team leads to increased efficiency and reduced costs, while providing improved quality and comprehensive, patient-centered care.

Eliminating collaborative agreements and granting NPs a newfound authority to practice independently would do exactly that – allow NPs to practice independently. In so doing, HB 765 would only further enable and encourage provider isolation, to the detriment of collaboration.

Working together toward a solution

At the end of the day, simply increasing the number of physicians or expanding the role of nonphysician practitioners will not solve our access-to-care problems in rural and underserved communities. Rather, policies and programs which specifically target those areas and directly address the barriers to practicing there have the most potential for success. Increased opportunities for educational loan forgiveness in exchange for service, the creation of additional primary care residency slots, further utilization and integration of telemedicine, and expansion of team-based care are just a few of the effective strategies that can help us meet our growing health care needs.

But we will only succeed through collaboration, not further fragmentation. The Pennsylvania Medical Society supports a physician-led, team-based approach to patient care, which emphasizes increased collaboration and integration among health care providers, rather than provider autonomy. Eliminating the ties that currently exist between NPs and physicians is contrary to these proven concepts and would only serve to further fragment patient care by eliminating the healthcare team's most highly-trained member – the physician.

[6] CNA and NSO Nurse Practitioner 2012 Liability Update: A Three Part Approach. Rep. Chicago: CNA Financial Corporation, 2012.