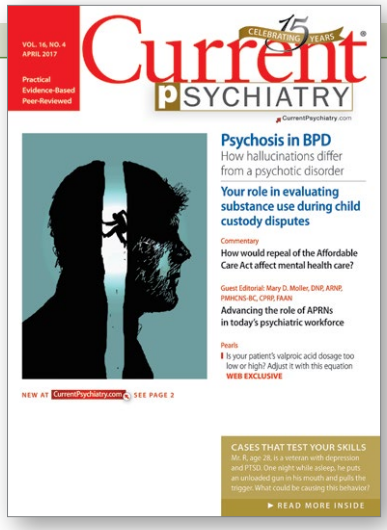


April 2017

## The role of psychiatric APRNs

In Dr. Mary Moller's Guest Editorial "Advancing the role of advanced practice psychiatric nurses in today's psychiatric workforce" (Current Psychiatry. April 2017, p. 15-16,18-20), she asserts that the American Psychiatric Association (APA) should take a stand against the American Medical Association (AMA) because AMA lobbyists pose a barrier to allowing advanced practice registered nurses (APRNs) to engage in autonomous practice. She argues that physician supervision is nothing more than a means of earning extra money for some physicians, calling it a "cottage industry." Although she states that psychiatric APRNs provide skilled psychiatric care from a "nursing perspective" and argues that we "come together to respect our given scopes of practice," the implication is clear: "to remove unnecessary barriers to practice and promote a unified and collegial workforce" is to assert that APRNs can do anything psychiatrists do. As physicians, we all know this is not the case. To support autonomous practice is to promote a reckless endeavor that endangers our patients.

Dr. Moller cited a source from the Federal Trade Commission[1] that encourages the autonomous practice of APRNs to increase competition. This again implies the false equivalency between physicians and APRNs. Competition implies that the players are providing the same service. If, as nurse practitioners argue, they practice "nursing," then they are not practicing "medicine." Physicians and APRNs do not have the same background. Although both are charged with the care of patients, nursing is not medicine, nor should it be. Both are important and needed, but nursing was never designed to be an autonomous practice. According to the American Association of Colleges of Nursing, "Nursing and medicine are distinct health disciplines that prepare clinicians to assume different roles and meet different practice expectations."[2] In fact, the curriculum and requirements to become an APRN vary depending on the program, and some programs do not even require a BSN.[3] There are online programs available for earning an APRN degree. Additionally, APRNs are only required to have 500 to 700 total hours of patient care,[4] compared with the >10,000 hours physicians have once they have finished a 3-year residency, which when combined with their education amounts to >20,000 hours.[5] This doesn't account for those who have longer residencies or fellowships to further specialize in their area of training.

Dr. Moller's main argument is that there is a dire shortage of psychiatrists and that the only way to meet this need for more providers is to make APRNs autonomous. However, no data indicate that autonomous practice of mid-level providers leads to an influx of these providers in rural areas, where the need would be greatest. Although current data on this are quite sparse, some studies indicate that the majority practice in urban areas, even in states with independent practice authority.[6,7] Dr. Moller cites a source that only reviewed home zip codes of psychiatric APRNs but did not include zip codes of employment.[8] Only 13% of psychiatric APRNs live in rural areas across the United States. Therefore, it is a false assertion to state that these APRNs are found primarily in rural and less populated urban areas. It is also false to imply and assume that these APRNs practice in the rural areas.

In 2017, there were 43,157 registered physician applications, with 35,969 active applications for 31,757 residency positions in the United States, and at least 11,400 medical school graduates were unmatched.[9] Imagine how much more we could serve our patients by matching these graduates, whose training far surpasses that of a mid-level provider. The Resident Physician Shortage Reduction Act of 2017 aims to address this problem by increasing Medicare-funded graduate medical education (GME) residency programs in the United States.[10] We can make a difference by contacting our members of Congress to encourage them to

continued on page 8

## Keep in touch!

The Editors welcome your letters on what you've read in Current Psychiatry

Write to:

**letters@currentpsychiatry.com**

**OR**

**Comments & Controversies**
Current Psychiatry
7 Century Drive, Suite 302
Parsippany, NJ 07054

All letters are subject to editing.

continued from page 6

support this bill. In addition, the AMA is advocating to save funding for GME and provides an easy-to-use Web site (https://savegme.org/take-action) to contact your legislators directly to show your support for GME.

Nurse practitioners have tremendous value when their role is a part of a team; however, they should not practice without supervision, and physicians who supervise them absolutely should be providing adequate supervision. I applaud the APA and the AMA for standing up for the practice of medicine and for our patients. I hope that they continue to do so, and I encourage them to increase their efforts.

**Laura Kendall, MD**
Assistant Professor of Clinical Psychiatry
Department of Psychiatry and Behavioral Sciences
Keck School of Medicine
University of Southern California
Los Angeles, California

**References**

1. Koslov T; Office of Policy Planning. The doctor (or nurse practitioner) will see you now: competition and the regulation of advanced practice nurses. Federal Trade Commission. https://www.ftc.gov/news-events/blogs/competition-matters/2014/03/doctor-or-nurse-practitioner-will-see-you-now. Published March 7, 2014. Accessed July 26, 2017.
2. American Association of Colleges of Nursing. DNP talking points. http://www.aacnnursing.org/DNP/about/talking-points. Updated July, 2014. Accessed August 12, 2017.
3. Keyes L. MSN without a BSN? MastersInNursing.com. https://www.mastersinnursing.com/msn-without-a-bsn. Accessed August 12, 2017.
4. Iglehart JK. Expanding the role of advanced nurse practitioners—risks and rewards. New Engl J Med. 2013;368(20):1935-1941.
5. Primary Care Coalition. Issue brief: collaboration between physicians and nurses works. Compare the education gaps between primary care physicians and nurse practitioners. http://www.tafp.org/Media/Default/Downloads/advocacy/scope-education.pdf. Published November 1, 2010. Accessed October 11, 2017.
6. American Medical Association. Issue brief: independent nursing practice. https://www.ama-assn.org/system/files/media-browser/premium/arc/ama-issue-brief-independent-nursing-practice.pdf. Updated 2017.
7. Tabor J, Jennings N, Kohler L, et al. The supply of physician assistants, nurse practitioners, and certified nurse midwives in Arizona. University of Arizona. http://azahec.uahs.arizona.edu/sites/default/files/u9/supply_of_pa_np_cnm.pdf. Accessed October 11, 2017.
8. Hanrahan NP, Hartley D. Employment of advanced-practice psychiatric nurses to stem rural mental health workforce shortages. Psychiatr Serv. 2008;59(1):109-111.
9. 2017 NRMP Main Residency Match the largest match on record [press release]. Washington, DC: National Resident Matching Program; March 17, 2017. http://www.nrmp.org/press-release-2017-nrmp-main-residency-match-the-largest-match-on-record. Accessed October 11, 2017.
10. Resident Physician Shortage Reduction Act of 2017, HR 2267, 115th Cong, 1st session (2017).

## The author responds

*I would like to thank Dr. Kendall for her passionate letter about my editorial and provide the following response. I neither asserted the equivalency of doctors and nurses or that APRNs can do what MDs do. Rather, APRNs are educated to provide highly qualified, specialty-specific advanced practice nursing, according to the tightly regulated scope of practice defined by individual states. As stated in my editorial, psychiatric mental health (PMH) APRNs engage in the practice of advanced practice PMH nursing. Is there overlap with medicine, social work, and psychology? Of course, but we are not criticized by social workers and psychologists when we engage in various psychotherapeutic approaches; rather, we are collegial and refer to each other. Why are we criticized by physicians when we prescribe from our tightly regulated legend drugs or conduct a psychiatric intake and develop a differential diagnosis and formulation that may save a life in the absence of an available psychiatrist? I would offer that PMH-APRNs are proud of their vast history of collegial relationships with psychiatrists, and that in states where turf is not an issue, there is remarkable respect and mutual referrals based on the ultimate need of finding the most appropriate care for a patient and/or family struggling to live with a psychiatric disorder.*

*Currently, 26 states have legislated independent practice for APRNs. This legislation was passed after decades of compiling data on the safety and efficacy of patient care outcomes in those states, and then was submitted as testimony to the legislature. State legislature decisions often are influenced by the fact that malpractice claims are decreased in areas where APRNs are independent and increased when APRNs are associated with MDs. A 2009 study[1] found that between 1991 and 2007—the first 17 years that the National Practitioner Data Bank was in operation—payments were made on behalf of 37% of physicians but only 3.1% of physician assistants (PAs) and 1.5% of nurse practitioners. The study concluded: "There were no observations or trends to suggest that PAs and APNs increase liability. If anything, they may decrease the rate of reporting malpractice and adverse events."[1]*

*To respond to Dr. Kendall's comment, "nursing was never designed to be an autonomous practice," nursing at the entry level of registration was originally conceived by Florence Nightingale as an autonomous profession working side-by-side with physicians, each performing different yet complementary aspects of patient care, each answering to a different hierarchy. Her work in the Crimean War attests to the positive effects of nursing on saving soldiers' lives, which was heretofore unknown due to all the measures she initiated and meticulously documented. This autonomy, however, was gradually usurped in the private sector. Comparing RNs with MDs is like comparing apples with oranges. We would need to compare all MDs with the 3.4 million registered nurses in the United States, and that is not what my editorial addressed.*

*For >50 years, master's prepared advanced practice nurses in psychiatry have been independent in their ability to have private practices, initially focusing on the provision of individual, group, and family psychotherapy. Psychiatrists did not object to this because it opened services they were unable to provide. As psychopharmacologic treatments for psychiatric disorders emerged, APRNs who had the minimum of a master's degree and substantial psychopharmacology education, which was mandated and regulated by states, were*

*gradually allowed to prescribe starting in the late 1970s. Most typically, these practices were in collaboration with or under supervision of an MD, but as data and outcomes were collected, legislatures began to drop this requirement.*

*Regarding hours, we could compare the >2,000 classroom and clinical hours and years of clinical experience accumulated by PMH-APRNs in their undergraduate and graduate psychiatric nursing curricula with the 60-hour Psychiatric Medicine course taken in the second semester of the first year of medical school.*[2] *For many physicians, this often is the only psychiatric education they receive when going into primary care. When we consider that 70% of psychiatric care is now provided in a primary care setting, we all should be concerned and be attempting to recruit highly qualified PMH-APRNs to assist in the development and delivery of integrated primary care.*

*Regarding APRNs working in rural areas, Hanrahan and Hartley*[3] *found that psychiatric APRNs were more likely than psychiatrists to live in rural areas. I contend that the issue is not the zip code of the psychiatric APRN, but rather the need to fix the problem of providers not being drawn to practice in rural and underserved populations due to salary.*

*Promoting autonomy for PMH-APRNs in all states is not the only way to solve the provider supply shortage, but it is a reasonable way. Unfortunately, there will be a shortage of psychiatric providers no matter what we do. Those of us who are dedicated to providing care to this vulnerable population should be finding ways to maximize our efforts and efficiencies to lessen the critical shortage. Anything less only adds to the problem and sends a negative message to the public. If we psychiatric providers cannot be supportive of each discipline practicing to the full scope and authority of their hard-earned licenses, then we are saying that we are more interested in protecting turf than providing desperately needed care.*

**Mary D. Moller, DNP, ARNP, PMHCNS-BC, CPRP, FAAN**
Associate Professor and Coordinator
PMH-DNP Program
Pacific Lutheran University
School of Nursing
Director of Psychiatric Services
Northwest Integrated Health
Tacoma, Washington

**References**

1. Hooker RS, Nicholson JG, Le T. Does the employment of physician assistants and nurse practitioners increase liability? Journal of Medical Licensure and Discipline. 2009;95(2): 6-16.
2. Columbia University Medical Center. Medical student education in psychiatry. https://www.columbiapsychiatry.org/education-and-training/medical-student-education-psychiatry. Accessed November 16, 2017.
3. Hanrahan NP, Hartley D. Employment of advanced-practice psychiatric nurses to stem rural mental health workforce shortages. Psychiatr Serv. 2008;59(1):109-111.