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INDEPENDENT REGULATORY
REVIEW COMMISSION

5 December 2008

Mr. Arthur Coccodrilli, Chairman
Independent Regulatory Review Commission
333 Market Street
Harrisburg, Pennsylvania 17101

Re: Regulation No. 16A-5124 (CRNP general revisions)

Dear Mr. Coccodrilli:

I am writing to you concerning the proposed regulations drafted by the State Board of Nursing which would significantly expand the scope of practice parameters for certified registered nurse practitioners. I hold the positions outlined by the Pennsylvania Academy of Family Physicians as a private family physician who has employed and instructed midlevel providers-- both physician assistants and CRNP's – in the past and who continues to do so today. Additionally, I serve on the PA Academy of Family Physicians Board of Directors, the Evangelical Community Hospital Board of Directors, and as Medical Director for the Riverwoods Skilled Nursing Facility in Lewisburg. I am a strong advocate for primary care medicine in Pennsylvania and for a team approach to solving the tremendous challenges of providing primary care to the citizens of our Commonwealth. I emphasize the word team because I firmly believe that the solution to our healthcare problems of access, affordability, and evidence-based care lies in building strong, collaborative teams where the "gifts," skills, and different training perspectives of the individual practitioners work for the common good of our patients. I most strongly feel that the proposed changes to the scope of practice parameters undermine this team approach by holding up the skills of one set of physician extenders over those of another and over physicians, in general. This, I believe is a dangerous precedent and occurs in these proposed changes in weakening the collaborative agreement among physicians and CRNP's, in weakening the supervisory ratios among these groups, in broadening the CRNP scope of practice without requiring the same type of CRNP training that a physician must undergo (i.e. an accredited residency program in the specialty of family medicine after graduation from an accredited medical school), in broadening prescriptive powers including controlled substances without adequate accountability and tracking systems to guarantee prevention of misuse (some would argue that an adequate tracking system is not in place for the Commonwealth for all providers at this time), and finally in misleading patients in the identity of Doctors of Nursing/Nurse Practice being

synonymous with Doctors of Medicine/Doctors of Osteopathic Medicine and particularly those who have undergone Board certified training in the discipline of Family Medicine.

A specific example that causes me concern is that in the time of employment of a CRNP that I helped train, and who happened to be quite experienced with advanced degrees and nursing experience, a problem occurred that would not have necessarily been discovered had adequate supervisory roles not been delineated in my practice. In my practice it is the custom to review each patient chart, encounter, or phone transaction at the end of each day. This practice was clearly outlined in the collaborative agreement with the CRNP in our employ at the time. As a matter of fact, both physicians review each other's charts as well as all calls made by our nurses to patients each day. This will continue as we implement our electronic record because we feel it is in the best interest of our patients' safety and of each other, educationally and professionally. Upon one visit of a patient of the practice, who presented with a headache, the patient was told that she had a migraine and that she should rest and take an anti inflammatory drug by our CRNP. It was noted that the headache was "the worst headache I have ever had" by the CRNP. Luckily, the patient was seen near the end of the day and her husband had driven her to the appointment. Upon the chart review within approximately ½ hour of the visit, both MD's questioned the history and physical findings of the CRNP, and the patient was called. By that time, she had developed a slight slurring of speech and minor visual changes, and "911" was summoned. The patient had an aneurysm and had immediate surgery at a tertiary care hospital later that night. This example was not used in any punitive way, but even though this is a tough diagnosis to make, disaster was averted because of the close, collaborative arrangements and supervision of the physicians in my practice. We would expect a CRNP or PA-C to question us as well if any part of the history or physical findings needed further scrutiny or clarification. To me, this is the way medicine should work – a team approach under the guidance of a physician (s), within a primary care-centered, patient "medical home" where the knowledge, skills, gifts, and unique training perspectives of all providers are used to deliver the safest and highest quality care to our patients. Every team, however, does have a captain or in this case, co-captain, and I strongly feel this should remain the role of the physician.

I am not "old school," and I am well respected as a "team player" in my community and in my professional roles. I continue to teach medical students, PA-C's, and CRNP students and have a high level of respect for what each group and unique individual brings to the whole picture of healthcare delivery during this very challenging time. The system is broken, and we all need to work together to fix it by building strong, collaborative, interdisciplinary teams. I have reviewed some of the other letters from colleagues in support of these changes. I fear these are opinions rendered by thinking that speaking against the proposed changes means speaking against the very positive attributes of CRNP's and that by doing so, further duress will be incurred to the physician(s) monitoring the CRNP's in their employ. In the haste of lessening the demand on physicians during a time of real physician burn-out and stress in the Commonwealth of Pennsylvania, they speak in favor of the changes. I hope, however, I

provide a different, more cautionary, yet still highly respectful opinion on how the real needs and challenges of all groups involved can be taken into account with patient safety as the foremost concern.

Thank you for your consideration of these comments.

Sincerely,

Douglas A. Spotts MD

CC: The Honorable Robert M. Tomlinson, Chair Senate Consumer Protection and Professional Licensure Committee, Room 362, Main Capitol Building, Harrisburg, PA 17120-3006

The Honorable P. Michael Sturla, Chair, House Professional Licensure Committee Room 333, Main Capitol Building, Harrisburg, PA 17120-2096

- Ms. Ann Steffanic, Board Administrator, State Board of Nursing, PO Box 2649 Harrisburg, PA 17105-2649