

Wednesday, February 27, 2013

Senator Gerratana, Representative Johnson, Members of the Public Health Committee:

Re: Raised Bill 6391, An Act Concerning the Practice of Advanced Practice Registered Nurses

My name is Henry Schneiderman. I am an internist-geriatrician who lives in Bloomfield, CT; I here offer support of Raised Bill 6391, An Act Concerning the Practice of Advanced Practice Registered Nurses also known as APRNs, with its crucial purpose to remove the requirement that, APRNs practice in collaboration with a licensed physician. Safe patient care does not require any such collaborative agreement nor the kind of consultation it stipulates, which in fact is not universally practiced, typically because of failure by a physician to do so, not an APRN.

APRNs have proven their efficacy and dedication for decades. They are exceptionally vigilant to minimize any patient risk. APRNs know when they are out of their depth and when to consult: Just as I can take care of 95% of the kidney problems of my patients without a nephrologist, so too an APRN can render superb primary or subspecialty care, depending on training and experience, for more than 95% of issues that ail her or his patients. Just as I know when to obtain consultation, so too does the APRN. An overlay of regulation merely burdens time and efficiency, and conveys inappropriate disrespect.

The requirement for a collaborative practice agreement becomes a major barrier for APRN practice because physician willingness and availability for collaboration is often lacking. Some doctors resist augmenting the scope of APRNs, viewing them as “unfair” economic competitors. That posture ignores the universally accepted reality that the present undersupply of primary care physicians will worsen sharply for decades to come, due to economic disincentives, overwork, lack of respect from hospitals, employers, insurers, pharmacies and the public, as experienced by every primary care practitioner. The care and health of human beings depend heavily on APRNs, and will to an increasing degree. This reality is most striking in branches of medicine that lack reimbursable procedures, since current fee structure rewards procedures (including those of little or no benefit) and undercompensates cognitive services, time spent with patients, meticulous physical examination and a comprehensive approach to the biopsychosocial need of patient and patient-family unit. Yet those intense professional efforts define good primary care, internal medicine, primary care pediatrics, geriatric care of frail elders whether in community or in a nursing home, and psychiatry. Each of the above is an area where APRNs shoulder a disproportionately large workload, to their eternal credit.

Experience working daily with APRNs informs my opinion: I have collaborated closely in care of patients in long-term care and in hospital since 1995, with both geriatric and geropsychiatric APRNs, and have long taught in Yale’s APRN program. APRNs show consistent admirable willingness “to get their hands dirty” and to meet the patient where he or she lives – physically, medically, emotionally. My intense respect for

APRNs includes a deep sense of trust. We complete Collaborative Agreements per regulation, but talk about patients together for the same reason that I talk with physician colleagues: mutual regard, and recognition that insight flows in many directions, and that a cohesive team takes better care of a human being more effectively than any single individual, regardless of title.

I am proud to be a physician and feel confidence in my long training; but I'd be a fool to undervalue the post-training clinical experiences that mold any health care worker. The psychosocial skills of APRNs and their hands-on approach recall what used to be most highly prized in physicians; such skills have eroded among physicians to the detriment of patient care and of the prestige of physicians. APRNs represent a vital force in the reinstatement of practices and values. They provide a counterweight to some runaway costs in health care (though medications, procedures and long-term care cost our society far more than all provider billings).

It's time for APRNs be empowered to practice independently as they so deserve to do. Our health-care system will operate more efficiently and effectively once we get there. We are also overdue to acknowledge, empower, license and support APRN practices that function without physician presence. Intense fiscal pressures on the health care system lead to the same conclusion. So does the issue of provider supply: consider Massachusetts, and the impact of universal coverage without enough primary care providers; and the result when too many physicians refuse to enroll ill-remunerative patients on Medicaid. APRNs represent an indispensable element in achieving universal health care rather than a repellent two-tier health system. Any such noble vision must not break the bank of local, state and federal budgets, as the present system does; APRNs are a large part of the solution.

New Jersey has just put forward a bill to allow full scope of practice to APRNs; our state of Connecticut should do the same; there is every reason to do so, and no down side.

Sincerely,

Henry Schneiderman MD,
Vice-President for Medical Services and Physician-in-Chief, Hebrew Health Care; and
Professor of Medicine and Associate Professor of Anatomic Pathology,
University of Connecticut Health Center; and
Clinical Professor, Nursing, Yale University
860-523-3854 FAX 860-523-3828 hschneiderman@hebrewhealthcare.org