

## EDITORIAL

# “Deadly spin” on nurse practitioner practice

In the months leading up to the passage of the Patient Protection and Affordable Care Act in March 2010, the American public was inundated by news reports that were as polarized as the political standpoints held by members of Congress. Depending upon the source, facts were buried in words with a tone of opinion and rhetoric, seemingly intended to sway rather than inform. Amidst tense debate, Wendell Potter, a man with longstanding and high-profile ties to the health insurance industry, emerged from a comfortable retirement to shine a spotlight on the subversive tactics used by health insurance companies who placed the demands of stockholders above the needs of individuals to whom they verbalized support and assurances of quality health care. In June 2009, Potter, former communications chief for The CIGNA Corporation, made national headlines when he testified before a Senate panel on healthcare reform, highlighting the ways in which insurers took steps to “confuse their customers and dump the sick” (Yee, 2010). He admitted to his part in crafting the industry’s deception-based public relations strategy on two fronts: (a) a highly visible “charm” offensive spinning an image of insurance companies as advocates for reform, and (b) breeding fear amongst groups in an effort to disseminate misinformation and lies (Potter, 2010). In his book *Deadly Spin* Potter describes several “Rhetorical Tricks” used in public relations campaigns to skew political debate and spread propaganda. These public relation ploys are described in Table 1.

Interestingly, over the past several years, large physician organizations have addressed advanced practice nursing in a similar manner, the difference being that the spotlight illuminating the truth did not come from within their own ranks. Examples of the “tricks” or ploys utilized by these groups are highlighted in Table 2.

Advanced practice registered nurses (APRNs) include certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs), and certified nurse practitioners (NPs). Despite great strides made toward a consensus in the educational preparation, certification, accreditation, and licensing of these professionals (Fulton, Lyon, & Goudreau, 2009), as each state independently determines the APRN scope of practice, there continues to be significant discrepancy in roles and level of practice across the nation (Institute of Medicine [IOM], 2011, p. D6). These discrepancies are largely a result of the efforts of physician organizations that command respect and “charm” policymakers while

perpetuating fear among consumers through misstatements. Such statements foster an impression of APRNs as nurses with inconsistent levels of education assuming expanded roles in the healthcare arena while lacking the necessary knowledge and skill. As highlighted in a landmark effort by the IOM and the Robert Wood Johnson Foundation (IOM, 2011), nothing could be further from the truth.

While presented as the oldest and largest organization of physicians and medical students, the American Medical Association’s (AMA) membership currently includes only about 12%–13% of the practicing physicians in the United States, with its ranks declining each year (Peck, 2010; Staiger, 2009). Still the AMA intimates that they represent all physicians and hold only the best interests of the public in mind; such statements are reminiscent of the public relations “doublespeak” proffered by Mr. Potter and his colleagues in the insurance industry (Potter, 2010).

In 2009, the AMA singled out 10 distinct healthcare professions seeking scope-of-practice expansion that were considered by the AMA to be potentially harmful to the public. They issued a “Scope of Practice Data Series” report for each, with a claimed purpose of “educating policymakers on the qualifications of a particular non-physician health care profession, as well as on the qualifications [that] physicians possess [which] prepare them to accept the responsibility for full, unrestricted licensure to practice medicine in all its branches” (AMA, 2009, p. 4). Two of these reports were directed at APRNs (NPs and CRNAs) and were disseminated to state medical associations and policymakers in an effort to emphasize the AMA’s position that “the health and safety of patients may be threatened as a result of unwarranted scope-of-practice expansions sought by non-physician health care providers” (AMA, 2009, p. 4; Carlson, 2009). The AMA further incorporated this series into a “truth in advertising” campaign to “create transparency and reduce public confusion,” which was presented in February 2010 as a definitive position on the scope of practice in the United States at the World Health Professions Conference on Regulation in Geneva, Switzerland (Maves, 2010). In reality, this campaign facilitated the dissemination of partial facts and global misrepresentations, further confounding the truth.

In the *AMA Scope of Practice Data Series: Nurse Practitioners* (2009), information is presented regarding the basic education and licensing of registered nurses. While a

**Table 1** Rhetorical tricks/public relation plays (Potter, 2010)

Fear	Information presented is intended to highlight the worst scenario, whether or not such an occurrence is likely, with the intended goal to make an individual or organization appear as the villain.
Glittering generalities	Phrases that evoke strong positive emotion are used to promote one's own position, while those evoking negative emotions are used to denigrate an opposing party or position.
Testimonials	Eliciting support of famous personalities in an effort to sway public opinion. Such endorsements can be paid or provided voluntarily.
Name-calling	Targeting insults or accusations toward an opposing party or position leaving another on the defensive, causing damage even when unfounded.
Plain folks	Efforts to identify oneself with the general public to solicit support for "one of their own" to be held in higher esteem than one viewed as "an outsider."
Euphemisms	Words chosen which obscure actual meaning or intent, making situations or events appear less offensive; sometimes referred to as "doublespeak."
Bandwagon	Promoting an appearance that "everyone" supports a certain position in an effort to elicit a greater following. Opinion polls often utilized to give an illusion of support. Results are reported with a goal toward influencing the position of others.
Transfer	Similar to testimonials where respected individuals or organizations lend their name or position to a cause they wish others to support.

master's degree is generally required for advanced practice, comments are offered in this document regarding how "amazingly...NPs are not required to take a second, separate standardized licensing exam" (p. 37). Comparisons are drawn to the field of medicine where physician training is much longer (including a required internship or residency), and testing for licensure is more comprehensive. Only passing commentary is given regarding the fact that most states require NPs to pass a national certification examination within a specific specialty, and the emphasis upon NP certification for licensure to practice within a specialty is lost.

No one disputes that NPs do not undergo the same type of training as physicians. In fact, to a fair extent, an adult NP does not share the same type of training as a neonatal NP, and preparation as a primary care provider is not the same as training to practice as an acute care clinician. The key element put forth in healthcare reform discussions centers around permitting individuals with advanced knowledge and skill to practice to the full extent of their education and licensure; the argument has never been that APRNs are trained as physicians and are prepared to practice in all areas of medicine.

Research demonstrating the positive outcomes of NP practice is plentiful (for a summary of key studies and

reviews, see *Quality of Nurse Practitioner Practice*, available at <http://www.aanp.org/NR/rdonlyres/34E7FF57-E071-4014-B554-FF02B82FF2F2/0/QualityofNPPPractice4pages.pdf>). Over the years, study after study has demonstrated that NPs are perceived by patients to be competent in meeting their primary healthcare needs in a variety of settings (Brown & Grimes, 1995; Budzi, Lurie, Singh, & Hooker, 2010; Greene & Dell, 2010; Pinkerton & Bush, 2000). A landmark randomized trial further compared NP and physician practices given the same degree of independence, in addition to direct comparisons of patient outcomes, health status, and patient satisfaction, and found no significant differences at 6 months (Mundinger et al., 2000) and 2 years (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004). Despite clear evidence of comparable outcomes between care provided by NPs and physicians, opinions of individual physicians and groups continue to appear in the medical and lay literature suggesting that NPs are not competent to provide care, and patients cared for by NPs are placed at risk for harm.

Given a closer look, however, it would appear that the central concern is not really NP practice, per se, but the fact that NPs practice autonomously. Although the duration of training, lack of required residency, and functional roles of NPs and physician assistants (PAs) may

**Table 2** "Rhetorical tricks" applied to nurse practitioner practice

Fear	The health and safety of patients may be threatened as a result of unwarranted scope-of-practice expansions sought by nonphysician healthcare providers (AMA, 2009).
Name calling	Nurse practitioners are unsuited to the role of primary care provider, and place patients at risk (Fletcher et al., 2007).
Glittering generalities	Physician training is much longer (including a required internship or residency), and testing for licensure is more comprehensive (AMA, 2009).
Euphemisms	Nurse practitioners are important members of physician-led teams (Fletcher et al., 2007; Maves, 2010).

hold many similarities, the AMA poses no objections to PA practice. This discrepancy is likely because PA practice is not independent, and although doctoral programs have been established for PAs, there is no discussion of doctoral level preparation becoming a practice requirement.

A growing number of doctorally prepared APRNs, coupled with the American Association of Colleges of Nurses' (AACN) proposal for the doctorate to become the entry level of practice for NPs by 2015, precipitated a boiling point within the AMA. Somewhat tolerated up until now, the AMA targeted disciplines where providers practice in an area of medicine and/or there was a possibility that providers may be addressed as "doctor" (i.e., NPs, CRNAs, oral surgeons, podiatrists, optometrists, pharmacists, audiologists, psychologists, physical therapists, and naturopaths). Notably missing from such intense scrutiny was the PA, for reasons previously cited.

Disregarding the fact that clinicians who achieved doctoral level education have been entitled to be addressed as "doctor" for centuries, aggressive efforts were mounted to legally prohibit all providers not holding a medical degree from using this title. Lobbyists relentlessly sought to protect "physician only" terminology in pending legislation, against all statements of intention by the current administration that "provider neutral" language would be utilized. Physicians' close ties with insurance carriers further influenced the use of exclusionary language so that when legislation permitted an expanded scope of practice, payer policies prevent reimbursement to those who were not physicians. A prime example of this was the proposed federal legislation permitting NPs and PAs to certify the need for home care services for Medicare patients. Physician groups were in support of this measure to the extent that these services were "ordered" by a physician (an obstacle still being addressed by pending legislation in many states).

A seminal work focused upon the future of nursing practice (IOM, 2011) explored all areas of the nursing profession, considering its history, journey, and the current and future healthcare environment. In this publication, Dr. Barbara Safriet (2011) contributed her legal perspective on ways to maximize the value of APRNs in providing quality, cost-effective health care. Referencing a closely held sociologic construct, she noted that health care in the United States has long been organized around the dominance of medicine over other disciplines. Perpetuation of this construct through subtle and overt messages by physician organizations, insurance carriers, pharmaceutical companies, and mass media were noted to prevent the public from forming an understanding of the multifaceted nature of health care today (Safriet, 2011, p. H12). Many of these tactics are reminiscent of Potter's (2010) analysis of a "deadly spin."

In 2007, Fletcher and colleagues conducted a descriptive study within the Veteran's Administration system to identify NP and physician views about NP practice. They found that while most NPs saw their role as autonomous with physician backup, physicians viewed NPs more as physician extenders. When asked about NP strengths, physicians typically commented on patient education and communication skills leading to greater patient satisfaction. However, most physicians surveyed in this study emphasized the importance of imposing a limited scope and medical supervision upon NP practice, viewing them as "unsuited to the role of primary care provider" (Fletcher, Baker, Copeland, Reeves & Lowery, 2007, p. 360). In their conclusion, these investigators identified one issue to be the physician's desire for "someone to reduce their workload without usurping their professional territory" (p. 361). Given the unfolding of events since this study was conducted, it would appear that these authors were correct in their assessment that physicians are not against the role and scope of practice of the NP, as much as they are against the loss of title, control, and prestige historically extended to physicians alone.

While current healthcare reform initiatives promote changes that are beneficial to NPs and their patients, wisdom gained from past events teaches us to be continually alert to the "tricks" utilized by others in their efforts to restrict the NP's scope of practice, and to limit opportunities for equitable compensation. It is crucial for all APRNs to learn to identify rhetorical tricks such as fear statements, name calling, glittering generalities, and euphemisms, and to counteract them with facts and evidence to reframe the debate. Advice previously offered by Timmons and Ridenour (1994) continues to ring true: more than ever, NPs must become politically active and pursue legal pathways to ensure that NPs' contributions are recognized, and that fair practice and reimbursement policies are adopted.

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