

**BOARD OF MEDICAL EXAMINERS/BOARD OF NURSING
JOINT STANDING COMMITTEE MEETING**

227 French Landing Poplar Room
Heritage Place MetroCenter
Nashville, TN 37243
September 11, 2008

MINUTES

Call to Order: Cheryl Stegbauer called the meeting to order at 2:00 p.m.

Members Present: Cheryl Stegbauer, PHD, APN, RN, Donna Roddy, MSN, RN (by telephone), Marilyn Dubree, MSN, RN, Dennis Higdon, M.D., Barrett Rosen, M.D., Note: Mitchell Mutter, M.D., joined the meeting in progress.

Member Absent: None

Staff Present: Elizabeth Lund, Executive Director, BON, Rosemarie Otto, Executive Director, BME, Larry Arnold, MD, BME Consultant, Donna Fairchild, Nursing Consultant, Martha Barr, Nursing Consultant, Alison Cleaves, Deputy General Counsel, Wilma James, Deputy General Counsel, Matthew Scanlan, Deputy General Counsel, Libby Miller, Director Health-Related Boards, Marsha Arnold, Administrative Director, BME, Sandra Powell, ASA III, BME, Sheila Bush, Administrative Manager, BON

Discussion: A roll call was taken to identify for the record members present. The minutes from the July 17, 2008 meeting were approved. The discussion regarding use of consultants which was placed on the agenda at the request of the members of the Committee at the last meeting was deferred until Dr. Mutter arrived. The Committee then began a discussion of supervision of advance practice nurses. Ms. Stegbauer provided a historical overview of the development of prescriptive authority for advanced practice nurses. She provided a handout for members, staff and the minutes. History of advance practice nursing began in 1973. Tennessee was one of the first states to have advanced practice nursing training. Vanderbilt was first, followed by the University of Tennessee. Public health nurses were on the leading edge of the movement and development of advanced practice nursing. Tennessee would come to have some of the best trained advanced practice nurses in the country. Then, the law had to catch up.

In 1974 the Board of Nursing created a rule that allowed nurses to expand their roles so long as they did so with protocols. Then the Board of Pharmacy had some concerns regarding the absence of statutory authority for pharmacists to fill prescriptions for advanced practice nurses. Things slowed at this point until the law changed. The law then evolved to give prescriptive authority for nurse practitioners under a certificate of

fitness to prescribe. That began a nationwide trend. Now, virtually every state in the union has a separate license for advance practice nurses. There are four categories of advanced practice nurses: nurse midwife, clinical nurse specialist, nurse anesthetist and nurse practitioner. They all fit under the broad category of advanced practice nurse and hold a separate license. Dr. Mutter asked about training programs in specialty areas such as cardiology. Ms. Stegbauer explained that there are doctor/nurse practice programs (one in particular at UT Memphis) which allows a nurse to enter and go through “generalist” training (i.e., acute care), then once completed they can specialize. There was a discussion about the number (2%) of medical students who are going into internal medicine/primary care. Internal medicine is less lucrative and not as attractive as some of the other specialties. With this number and other considerations, the question becomes who is going to provide the care?

Dr. Rosen indicated that he thought he was most responsible for putting “supervision” on the agenda and expressed concerns about oversight of advanced practice nurses. The medical board has jurisdiction over the physician who is not fulfilling his/her role as “supervisor” properly. However, if the advanced practice nurse is not fulfilling his/her role properly he/she is not under the BME. One of the goals for Dr. Rosen is to help develop joint guidelines to insure that both the doctor and the nurse are doing the right things and that if a patient walks into an office, irregardless of whether or not a physician or nurse sees them, they can be assured that what happens is what is supposed to happen.

The question arose as to whether or not there have been any complaints regarding supervision in the Department? For example, do we have complaints where protocols or guidelines are not met and there is poor review of charts? Neither the Department nor the Boards have the ability to just go out and check to see if protocols are being managed appropriately. That is a limitation! At this point, the Committee asked Denise Moran, Director of the Office of Investigation to provide some data on the breadth of the problem in the state of Tennessee.

Ms. Stegbauer stated that the BON is just now starting to get some cases regarding advanced practice nurses, but not many. She described a very recent case in which an advanced practice nurse was fired because of an impairment issue. In this case, the supervising physician took very immediate action.

That raised another issued about whether or not “collaborative responsibility” ought to be the model rather than “supervision.” Each professional is legally responsible and should be held accountable for their actions. That is the responsibility of the respective Boards. Further, no nurse should ever perform services beyond the scope of his or her training. They have an obligation to not do so. The Committee should look for a workable model that holds people accountable for their actions.

There was a discussion of the supervision of Certified Registered Nurse Anesthetists. Dr. Higdon indicated that the model is a national model driven by Medicare. Dr. Higdon indicated he would bring information to the next meeting regarding “Medical Direction and Supervision” of CRNAs.

Staff will provide the Committee with information on what is happening in other states regarding supervision of physician extenders.

There was a discussion about the rural nature of the state of Tennessee. Access is a problem so is supervision. BON staff indicated that they can provide information to the Committee about the locations of advanced practice nurses and will do so at the next meeting. Additionally, information from the Federation of State Medical Boards will be available regarding what other states are doing to regulate physician extenders.

The Committee discussed the data they need: (1) How many cases have actually been brought that deal with supervision? (2) What is the geographic distribution of advanced practice nurses in the state and how far away is the supervision? (3) What are the numbers regarding prescriptive authority? This is what they will look at during the next meeting.

There was a brief discussion regarding re-entry into practice of physicians who have been out of practice for an extended period of time and wish to return. What does the BON do with nurses re-entering practice after extended leaves of absence? What are their criteria for re-entry? This will be something for the Committee to grapple with at a later time.

There was a discussion regarding consultants. Dr. Mutter reiterated his view that the use of consultants is very necessary. Expertise is necessary, both medical and nursing consultants. Also, need consultants for the Office of General Counsel to assist the legal team.

There was a discussion about allowing a board member (either BME or BON) to follow a case all the way through the system to see what actually happens. Of course, that person would not be able to hear the case, but they could report on the process.

There was a reiteration of one of the goals of the Standing Committee is to share best practices in an open forum.

The Standing Committee will meet next on December 4, 2008 at 2:00 p.m. They will review the data and continue their discussion of supervision.