

Are You a Mid-Level Provider, a Physician Extender, or a Nurse?

I surely am not the only nurse whose spine tingles when I hear the phrase mid-level provider (MLP) or physician extender (PE) used to describe an advanced practice nurse (APN), am I? Just for the record, I also suffer apoplexy when I see employment ads asking for a nurse practitioner (NP) or physician assistant (PA) to fill a job vacancy. The lack of distinction between an NP and PA and nonrecognition of the unique domain of advanced nursing practice is very disconcerting.

Michael Ackerman, DNS, RN, ACNP-BC, FCCM, FNAP, FAANP, director of the Sovie Center of Advanced Practice at the University of Rochester Medical Center, offers an intuitive appraisal and advises considering the following in terms of this contemporary nomenclature: "Just think about what you are implying when you use the term MLP. Within a hierarchical framework, you are relegating the nurse at the bedside to a distinct position of inferiority. If an APN (usually a nurse practitioner) is considered an MLP, then bedside nurses must be low-level providers. This is in sharp contrast to the alignment of the physician at the apex, or highest level of proficiency and authority" (Michael Ackerman, personal communication).

As an MLP then, you are about halfway there on the totem pole of importance. I suggest that, while we share a significant grey zone of concern with medical colleagues, nursing's own contribution to patient care is both singular and irrefutable. No nurse is, nor should they consider themselves, an intermediate provider of care nor an extension of a physician.

Nurse leader and APN champion Brenda Lyon, DNS, RN, FAAN, characterized nursing's unique phenomena of expertise to include four constructs: (a) viewing the patient from a holistic rather than a disease-focused perspective, (b) caring, (c) connecting at some level with the subjective or lived experience of the patient, and (d) meeting patients' needs for assistance (Lyon, 2010). Even with a more medically oriented prescriptive NP role, nursing's focus should comprehensively address the functional problems and conditions that

result from the presence of disease or pathology. Oncology nurse luminary Pamela Hinds, PhD, RN, FAAN, also reminds us that it is oncology nurses' willingness to be more than present—to connect with and care about the patient's life and his or her illness—that distinguishes them within the professional domain (Hinds, 2011). All nurses, regardless of role definition, must practice with this unparalleled contextual lens that is typified by mastery of connectivity, complexity, and compassion.

Why aren't social workers and pharmacists with master's degrees identified as physician extenders? Social workers share with physicians the common concern about social needs and coping issues as they relate to the patient's response to physical illness. Pharmacists are linked with medical colleagues by drug therapies. However, graduate-level social workers and pharmacists have not embraced the need to blend their identity with that of physician colleagues.

In cancer care, ongoing discussions in the literature supporting MLPs and PEs are generated from anxiety about the increasing shortage of oncologists (Bunnell & Shulman, 2010; Erickson, Salsberg, Forte, Bruinooge, & Goldstein, 2007; Warren, Mariotto, Meekins, Topor, & Brown, 2008); it has not emanated from the realization of the value-added benefit of having an APN's unique set of eyes, holistic approach to managing symptom distress, or the development of prescriptive advice for wellness. As reimbursement and fee-for-service debates increase in magnitude, it becomes increasingly important to distinguish elements of nurse mastery of patient care. Nurses at the bedside and in expanded roles need to document what they do and the difference they make. This will help validate and solidify the unique contributions of nurses. High patient satisfaction scores (viewed prominently and positively by administrators), symptom distress ratings (which improve in a quicker, cost-effective timeframe), early surveillance, and effective patient navigation, all mastered within a complex healthcare environment where patients frequently fall into an abyss of anonymity, can become hallmarks of nursing competence and, ultimately, indispensability.

I find myself increasingly disheartened by this distancing trend from our collective nursing identity. What really rankles me is when APNs actually prefer the use of the terms MLP or PE to describe themselves. Is the word "nurse" so aversive that it needs to be dropped from the vocabulary? Personally, I feel that if you want to be or call yourself a MLP or a PE, then go for it. But in doing so, you forfeit the honor and reputation of being one of society's most cherished professionals—a nurse.

As a clinical nurse specialist, I poignantly and repeatedly counter any depiction of my practice as being an extension of a physician or a mid-level anything. I am a nurse with a distinct set of skills and a hard-won, highly specialized graduate degree, and proud of it. Don't ever call me anything but a nurse.

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