SOUTH CAROLINA MEDICAL ASSOCIATION

# All South Carolinians deserve ***physician-led*** care.

scmedical.org/protectpatients

***Myth: S.44 and S.45 are scope of practice bills.***

✅ **Fact: NPs and PAs are currently able to practice at the 'top of their license', or said another way, in sync with their education, training, and competency based on legislative reform passed in 2018 and 2019. They can diagnose, treat, and prescribe in the setting of their choosing, including owning a practice anywhere in the state.**

These bills are about one thing – whether there is any value to a physician. Government regulation of any profession should be for the exclusive purpose of protecting the public interest. The one remaining requirement left in statute – that a NP or PA must have a practice agreement with a physician – is purely about protecting the public interest – patient safety – so is a legitimate exercise of government authority.

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***Myth: Currently, physicians are 'just signing onto an agreement' and are not providing collaboration/supervision.***

✅ **Fact: In agreeing to collaborate with a NP or supervise a PA, a physician agrees to be statutorily responsible, subject to discipline by the South Carolina Board of Medical Examiners (BME), and legally liable for the care provided by the NP or PA.**

The significant ramifications of that are far from just 'signing an agreement.' Pursuant to this agreement, a physician must be available for consultation on patients, either in person or by phone or videoconference, and provide for backup when they are not; must specify conditions, treatments, and drug therapies that are within the NPs or PAs competency and situations that require direct evaluation or referral to the physician; and is ultimately responsible for the health care delivery of the NP or PA. While there may be examples of some, any physician failing to fulfill these requirements is subject to discipline by the SC Board of Medical Examiners, exposes himself to medical malpractice liability, and does not diminish the thousands of physicians who are providing this collaboration for the benefit of the patient.

***Myth: Current NP or PA education and training plus the 2,000 clinical hours required by S.44 and S.45 prepare a NP or PA for practice without a collaborating physician.***

**✅ Fact: As the below chart illustrates, there is no comparison between the training of a NP or PA and a physician.**

| Licensure Type | Education | Residency | Clinical Training |
|---|---|---|---|
| Physician (MD or DO) | 4 years of medical school | 3-9 years of medical residency from an ACGME-accredited program with a supervising attending physician and for some, a post-residency multi-year specialty fellowship | 12,000-16,000 hours provided through the rigorous structure of a residency and/or fellowship |
| NPs | 2-3 years with 60% of programs being mostly or all online | No residency requirement | 500-720 hours during school plus the 2,000 post-graduate hours required by S.45 for a total of 2,500 to 2,720 with zero standardization or requirements as to what satisfies these hours. Some may be as casual as observing a neighbor.   |
| PAs | 2-2 ½ years | No residency requirement | 2,000 hours plus 2,000 post-graduate hours required by S.44 with zero standardization or requirements as to what satisfies these hours. |

Even more concerning is the NP or PAs ability to switch between specialties. Physicians practice within the specialty in which they train through residency and fellowship and do not switch between specialties without re-training. NPs and PAs frequently switch. One day they may be a cardiac PA and the next an oncology PA but always with the supervision or collaboration of a specialist in that area. S.44 and S.45 remove this supervision or collaboration requirement after only 1,000 hours (25 weeks) supervision by a physician.

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***Myth: Many SC patients see NPs and PAs now without ever seeing a physician.***

✅ **Fact: While the patient may not 'see' the physician at each appointment, the physician is available to the NP or PA for consultation for every appointment should the need arise and is ultimately responsible for having measures in place to ensure that the NP or PA is providing quality care.**

This may mean auditing charts, requiring reports of any ER admissions or adverse outcomes, or routine meetings or trainings with the NP or PA. It's not dissimilar to being a patient in an ER. The patient may never 'see' the other physicians who are on call, but that does not mean there are not protocols in place and other specialists available should the patient and ER physician need them. Without a formal 'on call' agreement with the other specialists, no other physician would be legally or ethically responsible for assisting the ER physician or patient.

As a separate matter, hopefully patients even realize they are being seen by an NP or PA with the growing trend of mid-level providers introducing themselves as Dr. X to patients.

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***Myth: Nurse Practitioners are required to practice in rural areas of South Carolina, and physicians are not.***

✅ **Fact: Nurse Practitioners are required to spend a portion of time in a rural area OR serving an underserved population, which includes women, children, and Medicare recipients in urban areas.**

While physicians don't have the same statutory requirement, by this very broad definition, physicians practically meet this requirement even without a mandate to do so.

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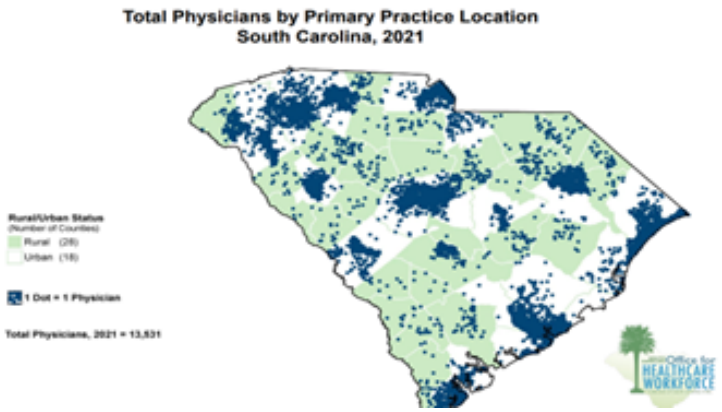
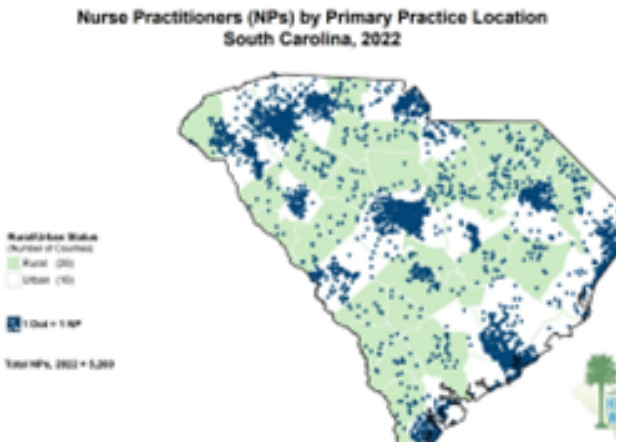
***Myth: Primary care in rural areas has improved because NPs moved to those areas after the 2018 legislation removing the mileage radius and expanding scope of practice.***

## ✅ Fact: The below maps show the primary practice locations for physicians and NPs in SC look almost identical.

Both tend to practice in the urban areas of the state. And, even with a 195% increase in NPs from 2009/2010 to 2019/2020, in rural SC, there are virtually the same number of primary care physicians (5.0) to NPs (5.7) per 10,000 population. That is not an apples to apples or fair comparison because not all of those NPs practice primary care. The data does not break down the practice area of NPs, only physicians.

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### *Myth: As a practical matter, NPs and PAs will always practice with a physician because if they practice beyond their scope of competency they will be sued for malpractice.*

## ✅ Fact: There is no bright line test to establish a practitioner's 'scope of competency.'

That is really the point; a provider must first be able to spot the issue and recognize when a patient's particular condition or situation is beyond their competency without having to order many unnecessary and expensive tests or make unnecessary specialist referrals. As illustrated above, physicians spend thousands of hours under the supervision of an attending physician observing the routine, weird, critical, and rare before they practice independently, and through these painstaking, rigorous hours, they develop the clinical, medical judgment and intuition to first determine when something is within their competency and then to treat, consult, or refer. Now, NPs have the benefit of a formal relationship with a physician to sort through this rubric since they don't have equal education and training to always do this alone. If S.44 or S.45 passes, the options, according to the bill sponsor, will be the NP or PA works through this themselves without the benefit of an established, formal relationship with a physician, and if they get it wrong, the patient can just sue them.

Even if the patient does sue them for malpractice, South Carolina courts have recognized that the standard of care for an NP or PA will be lower than that of a physician for the identical medical acts since it will be based only on what that NP or PA should have known based on his education and training.

South Carolina patients should not be put in this situation, but likely will if S.44 or S.45 pass since they make NPs and PAs 'equal to that' of a physician for practice purposes, but do not for liability purpose by failing to: 1) eliminate this distinction in the standard of care and impose equal liability on behalf of patients, and 2) establish a single licensing board charged with setting one standard of practice for specific treatments and procedures, instead of being separately regulated by the South Carolina Board of Medical Examiners and the South Carolina Nursing Board.

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### *Myth: Physicians charge $2,000 a month for the privilege of supervising a NP.*

✅ **Fact: NPs employed by a healthcare system, hospital, private practice, insurance company, or other entity, do not pay anything for the benefit of a collaborating physician.**

For the very small percentage of NPs who own a medical practice (2.79% nationally), they may have to pay for the expertise, availability, and quality control the physician provides for the NP's business and patients. This is not unlike paying for other services beyond a business owner's competency, like lawyers, accountants, or OSHA consultants. Physicians do not have to pay this fee because they invested in medical school, residency, fellowship, and board certification to gain this expertise.

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### *Myth: Fees paid by NPs to collaborating physicians drive up the cost of healthcare.*

✅ **Fact: As explained above, very few NPs pay fees for the benefit of a collaborating physician. But even for the few who do, the opposite is likely true. Multiple national studies show that physician-led care is higher quality and lower cost.**

Specifically, studies show the following:

- Non-physicians needed 2 times the number of biopsies to screen for skin cancer.
- Patients were 15 times more likely to receive an unnecessary antibiotic from a non-physician which leads to antibiotic resistance and is becoming a health crisis.
- X-ray ordering unnecessarily increased 441% among non-physicians
- In opioid prescribing, 6.3% of NPs prescribed opioids to over half of their patients compared to 1.3% of physicians.
- Patients with non-physician primary care providers had $43 higher spending per month compared to those who had a physician, which could translate to $10.3 million more in annual spending
- In an emergency department, nurse practitioners use more resources and achieve worse outcomes than physicians, especially when dealing with complex patients.

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***Myth: With the increase of PAs and NPs, they are having a problem finding collaborating physicians because they can only supervise/collaborate with 6 at the same time.***

**✅ Fact: Physicians can enter into agreements with more than 6 NPs or PAs combined; they just cannot practice in a clinical environment with more than 6 at any given time, unless granted an exception by the BME, so that the physician can ensure the quality of care and patient safety is maintained. The current number of physicians, NPs, and PAs in the state is plenty to support the existing and growing workforce of NPs and PAs.**

The statutory standard of 6 is a gracious plenty given the number of licensed physicians, NPs and PAs in SC. In 2022, there were 13,531 total physicians in South Carolina with 5,195 practicing primary care, meaning they could practice in a clinical environment with 81,186 NPs and PAs and 31,170 NPs and PAs at any given time, respectively, and enter into many more agreements. In 2022, there were a total number of 7,199 combined number of NPs (including NPs, CNMs, and CNSs) and PAs in SC.

The statutory standard of 6 is not a concern in rural areas of the state either. There are no counties without a primary care physician. While the chart shows in-county professionals, with no mileage restriction, the NPs in these rural counties are not even limited to collaborating physicians physically located in the same county. A physician in Charleston County could collaborate with an NP practicing in Calhoun or Williamsburg, for example. Hospitals that are part of a system can utilize physicians from their larger sites to collaborate with NPs in their smaller satellite sites. For the independent hospitals listed below, there are sufficient physicians to support the existing and growing workforce of NPs and PAs.

| **13 Rural Counties with the Fewest # of PAs** | **# of Primary Care Physicians** *(Does not count the physicians practicing other specialties)* | **# of NPs** | **# of PAs** | **# of NPs Existing Primary Care Physicians Could Supervise** *(Total # of Physicians x collaborating/ supervisory ratio of 6 at any given time)* |
|---|---|---|---|---|
| Williamsburg | 7 | 9 | 2 | 42 |
| Calhoun | 1 | 2 | 0 | 6 |
| Chester | 4 | 9 | 2 | 24 |
| Cherokee | 29 | 26 | 5 | 174 |
| Laurens | 34 | 27 | 5 | 204 |

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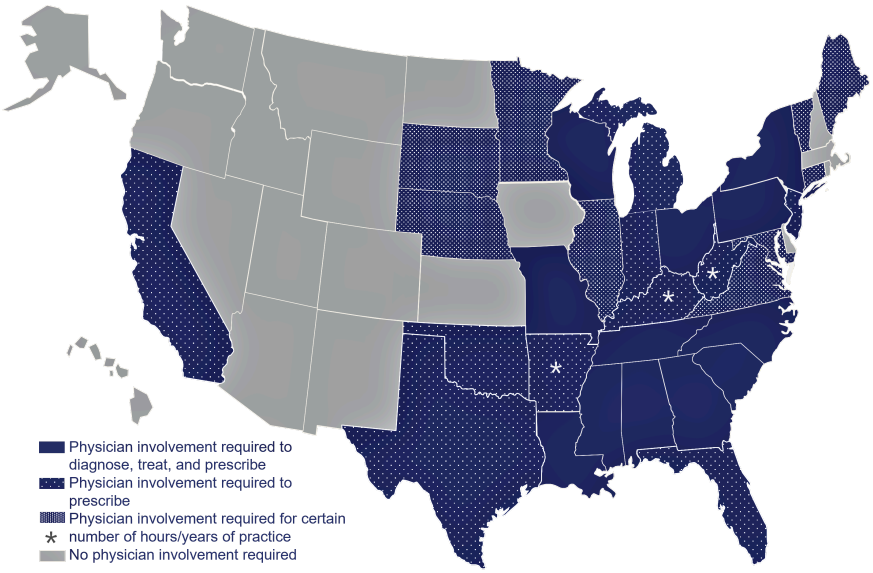
|---|---|---|---|---|
| Newberry | 22 | 18 | 6 | 132 |
| Abbeville | 13 | 9 | 3 | 78 |
| Saluda | 6 | 6 | 2 | 36 |
| McCormick | 4 | 3 | 0 | 24 |
| Edgefield | 14 | 9 | 4 | 84 |
| Lee | 3 | 6 | 0 | 18 |
| Barnwell | 8 | 10 | 1 | 48 |
| Berkeley | 74 | 73 | 31 | 444 |
| | | | | |
| **Hospitals** | | | | |
| Aiken Regional Medical Center | 126 | 110 | 35 | 756 |
| Allendale County Hospital | 6 | 9 | 0 | 36 |
| Beaufort Memorial Hospital | 147 | 176 | 79 | 882 |
| Carolina Pines (Hartsville) | 41 | 45 | 8 | 246 |
| Colleton Medical Center | 27 | 24 | 12 | 162 |
| Lexington Medical Center | 247 | 333 | 76 | 1,482 |
| Newberry County Health | 22 | 18 | 6 | 132 |

*Myth: 27 other states allow independent practice if NPs are practicing within their competency.*

✅ **Fact:**

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*Myth: NPs are leaving the state to practice elsewhere.*

✅ **Fact: It's not clear what data is being relied upon to support this statement, but even if this is true, from 2019/2020 to 2021/2022 (the latest data book published by SCAHEC), the number of NPs in South Carolina grew by 16.8%.**

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*Myth: South Carolina patients are comfortable with the elimination of physician-led healthcare in SC.*

✅ **Fact: According to a recently conducted survey by Starboard Communications, the opposite is true:**

- **85% of South Carolinians** (84% of Republicans and 88% of Democrats) believe it is important that a physician be involved in their own or their family member's diagnosis and treatment decisions.
- **96% of South Carolinians** (97% of Republicans and 94% of Democrats) believe that is important for a physician to be involved in services and treatments that require anesthesia, surgery, or other invasive medical procedures.

- **74% of South Carolinians** (77% of Republicans and 68% of Democrats) oppose allowing nurse practitioners to open independent practices with no physician oversight.
- **83% of South Carolinians** (87% of Republicans and 76% of Democrats) oppose allowing nurse practitioners to manage an emergency department with no physician oversight.
- **76% of South Carolinians** (80% of Republicans and 65% of Democrats) oppose allowing physician assistants to open independent practices with no physician oversight.
- **81% of South Carolinians** (84% of Republicans and 72% of Democrats) oppose allowing physician assistants to manage an emergency department with no physician oversight.
- **74% of South Carolinians** (80% of Republicans and 61% of Democrats) believe that if the proposed changes to scope of practice are made and more health care professionals without a medical degree are allowed to perform medical procedures and practices procedures would be less safe.

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### *Myth: This is a turf war, and physicians are just trying to protect themselves.*

### ✅ Fact: Physicians believe that NPs and PAs are highly trained professionals, capable of superb patient care.

The current healthcare system could not operate without them, and physicians are thankful for the expertise, care, and value they bring to SC patients. Physicians are uncomfortable even discussing this issue because it feels as if the professions are pitted against one another when they should be operating as a team.

For the patients' sake, physicians do not believe, however, that NPs and PAs training and education prepare them to practice independently without the benefit of physician collaboration or supervision. It is not a personal limitation of the individual. Many NPs and PAs are capable of graduating from medical school, completing a residency, and pursuing a fellowship, but they have chosen not to. Instead, they have chosen to pursue less schooling, training, and education.

Every member of a healthcare team is essential. Diverse training, individual roles, contributed talents, and shared accountability are necessary for each party to operate together as a whole. However, when there is a deviation from the plan, things go wrong, new or complicated scenarios arise, split-second decision making is required, or a patient presents with a condition beyond the competency of the NP or PA, it is essential that the most highly trained member – the physician – is leading the team and available for consultation to avert disaster, keep costs as low as possible, and maintain the highest quality of care and protect public safety.