Guest Editorial About Nurses' Titles Garners Appreciation

Thank you so much for your opinion piece about title terminology in a recent issue of the *Oncology Nursing Forum* (Boyle, 2011). I could not agree with you more about the distress that comes from mislabeling nurse practitioners as mid-level providers (MLPs) or physician extenders. Frankly, it bothers me to type the words! However, I would like to suggest that the reason social workers and pharmacists do not suffer the same inequity of position or title is that neither could be considered a primary care provider. In our current and future healthcare environment, it is not only possible for NPs to serve as independent primary care providers, it is likely they (we) will. This is disconcerting at best for our physician colleagues.

I would also like to respectfully point out that while you very eloquently made your case about inequitable healthcare titles, you did so with an (unintentional, I'm sure) insulting cultural reference. Specifically, you said, "As an MLP then, you are about halfway there on *the totem pole* of importance." While I very much appreciate your point of view, it seems to me that as we defend our own nursing culture, we should not do so to the detriment of someone else.

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I agree with your sentiments on this subject. I recently received an invitation in the mail from a drug company to attend a continuing education session on Parkinson's disease. The invitation, in large letters, indicated that this program was directed toward mid-level providers. I, too, took offense to being referred to in this way and e-mailed the company letting them know my displeasure and my thoughts on the subject. They mirrored yours. Thank you for addressing this topic and know that you are not alone in your feelings.

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I thoroughly enjoyed reading your recent editorial, "Are You a Mid-Level Provider, a Physician Extender, or a Nurse?" As a nurse anesthetist since 1977, I have run across this situation many times. Patients and family will often refer to me as an anesthesiologist. I gently remind them that, though we provide the same service, I am a certified registered *nurse* anesthetist. My rule is to correct someone twice. After that, I feel that it becomes counterproductive to go through the explanation over again.

The longer discussions on this matter have been with the nursing students with whom I interact. When I provided anesthesia services in a labor and delivery unit for 17 years, we had one nurse and one physician anesthesia provider on the unit together. The students would often ask about the perplexing similarity of our jobs, yet one was a nurse, the other a physician. My common explanation was similar to your thoughts. While the skills we performed were identical, it was the thought process that often varied. Most of the anesthesiologists were definitely disease oriented and usually ignored all family members in any aspect of caring for the patient. My process was certainly more holistic and involved those who the mother-to-be had selected to be with her and support her.

In anesthesia, there is no MLP. You either provide anesthesia at the same level as everyone else, or you don't provide anesthesia at all. I like to think that as a nurse, I provide anesthesia at the same level as an anesthesiologist, with the added benefit of simultaneously providing great nursing care.

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Reference

Boyle, D.A. (2011). Are you a mid-level provider, a physician extender, or a nurse? [Editorial]. *Oncology Nursing Forum, 38,* 497. doi:10.1188/11.ONF.497

The Author Responds

I would like to thank the respondents to my recent editorial. However, I am a bit confused by Dr. Burke's concern about a potential cultural transgression inferred from the piece. The use of the reference to totem poles was meant to provide an analogy to a commonly applied perception about interpersonal relationships.

In the absence of a written language, totem poles were historically a form of communication for Native Americans in the Pacific Northwest. Totem poles are symbolic arrangements of images whose purpose is to convey a story, share a legend, reflect kinship, or recount clan lineage. The vertical order of the symbols on the totem pole are thought to be representative of importance, with the higher figures being the most highly regarded (hence the common phrase "low man on the totem pole"). The use of this analogy within the context of the editorial on the advanced practice nurse role was intended to demonstrate hierarchical, rather than complementary and reciprocal, role relationships, and in no way inferred any cultural insignificance.

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