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## ARTICLES

### THE NURSE PRACTITIONER AFTER SERMCHIEF AND FEIN: SMOOTH SAILING OR ROUGH WATERS?

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In 1983 and 1985, two respective state supreme court decisions impacted greatly on the nurse practitioner's practice.<sup>1</sup> The effects of this impact have been widely debated.<sup>2</sup> This article will review briefly the history of nursing licensure and the nurse practitioner movement, discuss the *Sermchief* and *Fein* cases, and pose implications for the future of the nurse practitioner's practice after *Sermchief* and *Fein*.<sup>3</sup>

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1. The cases are *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983) and *Fein v. Permanete Medical Group*, 695 P.2d 665 (Cal. 1985).

2. See *infra* text and accompanying notes.

3. This article will utilize the following definition of a nurse practitioner: "one who assesses the physical and psychosocial status of clients by means of interview, health history, physical examination, and diagnostic test, . . . interprets the data, develops and implements therapeutic plans, and follows through on the continuum of care of the client . . . implements these plans through independent action, appropriate referrals, health counseling and collaboration with other health-care providers." AMERICAN NURSES' ASSOCIATION CONGRESS FOR NURSING PRACTICE, THE SCOPE OF NURSING PRACTICE: DESCRIPTION OF PRACTICE, NURSE PRACTITIONER, CLINICIAN, CLINICAL NURSE SPECIALIST (1976), cited in Geyman, *Is There a Difference Between Nursing Practice and Medical Practice?*, 5 J. FAM. PRAC. 935 (1977). Currently, the more well known nurse practitioners include pediatric nurse practitioners, family nurse practitioners, school nurse practitioners, and geriatric nurse practitioners. A. RHODES & D. MILLER, *NURSING AND THE LAW* 33 (4th ed. 1984). This article will group these specific nurse practitioners into the broad term "nurse practitioners." Specifically excluded from the definition for the purposes of this article are nurse-midwives and nurse anesthetists. These two

### HISTORY OF NURSING LICENSURE

The concept of licensing nurses to practice their profession was not a new or innovative one. In fact, nursing licensure followed the American Medical Association's support, through state and local medical societies, to license physicians.<sup>4</sup> The first registration act for physicians took place in 1873,<sup>5</sup> and by 1895 all states had passed registration acts for physicians.<sup>6</sup>

Nursing's history in relation to licensure did not develop as easily or as quickly as did medicine's. To begin, the mere fact that medicine licensed its members first allowed medicine to define its practice without interference from other health professions. As a result, those professions that licensed members after the medical profession had to avoid usurping its domain, and nursing was no exception.<sup>7</sup> Additionally, acceptance of licensure in nursing was not as quickly accepted in final form as it was in medicine. Where a rather rapid acceptance of registration acts in medicine took a mere twenty-two years, nursing licensure has undergone tremendous change over years. This change can be seen by examining the phases of nursing licensure.

The first phase in the development of American nursing licensure has been coined the era of early registration acts, and took place from 1903-1938.<sup>8</sup> During this time period, states struggled with whether or not to register practicing nurses. The early registration acts<sup>9</sup> provided minimum qualifications for those registering with the state, such as attendance at an acceptable nursing program and the successful completion of some type of examination.<sup>10</sup> Weaknesses in the early acts existed, however. First, the

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groups raise additional, and most often, very different practice issues than do their nurse practitioner colleagues.

4. Bullough, *The Current Phase in the Development of Nurse Practice Acts*, 28 ST. LOUIS U. L.J. 365, 365 (1984).

5. Roemer, *Legal Systems Regulating Health Personnel: A Comparative Analysis*, 46 MILBANK MEMORIAL FUND Q. 431, 431-471 (1968), reprinted in *POLITICS AND THE LAW IN HEALTH CARE POLICY* 233-273 (J. McKinley ed. 1973).

6. DERBYSHIRE, *MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES*, 7, 9 (1969).

7. See generally, Bullough, *Licensure and the Medical Monopoly*, *THE LAW AND THE EXPANDING NURSING ROLE* 14-22 (B. Bullough 2d ed. 1980).

8. Bullough, *The First Two Phases in Nursing Licensure*, *THE LAW AND THE EXPANDING NURSING ROLE* 23-25 (B. Bullough 2d ed. 1980). During this time period, the American Nurses' Association, founded in 1896, and the National League for Nursing, founded in 1894, were active in attempting to procure registration for nurses so that control over nursing and its educational programs could remain within nursing. See, ROBERTS, *AMERICAN NURSING: HISTORY AND INTERPRETATION* 25-26 (1954).

9. North Carolina passed the first nursing registration act in 1903. By 1923, all states in the Union, plus the District of Columbia and Hawaii, had nursing licensure acts. LESNICK & ANDERSON, *LEGAL ASPECTS OF NURSING* 314 (1947). Registration acts were later called nursing acts or nursing practice acts, and are most often identified by those terms today.

10. Bullough, *supra* note 4, at 371.

early acts only applied to those calling themselves "registered nurses," non-licensed nurses could still practice nursing as long as they did not call themselves an "R.N."<sup>11</sup> Second, the nursing boards established by these early acts were often composed of non-nurse members in addition to nurse members.<sup>12</sup> Finally, a definition of nursing was not present in any of the early acts.<sup>13</sup>

The second phase of nursing licensure, in which nursing function was defined, took place from 1938 to 1971.<sup>14</sup> This phase began with New York State passing the first mandatory licensing act.<sup>15</sup> Requiring nurses to become licensed with the state before practicing also necessitated the existence of a definition of nursing and its scope of practice to be included in the licensure statutes.<sup>16</sup> A "new" category of nurse — the licensed practical nurse — was given its birth during this era. Although requiring less education and performing services under the direction of the registered nurse, the licensed practical nurse was also under the jurisdiction of the licensure acts, and had to register in order to practice.

During the second phase, additional factors impacted on the definition and scope of nursing practice. The American Nurses' Association, although active from its inception in supporting licensure for nurses and in establishing nursing as a profession generally, adopted a model definition of nursing in 1955 which became the second prototype for states that wanted to change or modify earlier registration acts.<sup>17</sup> In addition, education require-

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11. Greenlaw, *Definition and Regulation of Nursing Practice: An Historical Survey*, 13 L. MED. AND HEALTH CARE 117, 118 (1985). This factor formed the basis for the early acts being termed "permissive" registration acts.

12. *Id.*

13. Bullough, *supra* note 4, at 317.

14. *Id.* at 366.

15. *Id.* at 371. This statute became the first prototype for other states. The New York licensure act stated: "The practice of nursing is defined as follows: A person practices nursing within the meaning of this article who for compensation or personal profit (a) performs any nursing service requiring the application of principles of nursing based on the biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, and carrying out of treatments and medications as prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health of a patient and others; or (b) performs such duties as are required in the physical care of a patient and in carrying out of medical orders as prescribed by a licensed physician, requiring an understanding of nursing but not requiring the professional service as outlined in (a)." *Id.* at 373, quoting 1938 N.Y. Laws 472, art. 52, § 1374.2 (1938).

16. Greenlaw, *supra* note 11, at 118.

17. The definition reads: "The practice of professional nursing means the performance for compensation of any act in the observation, care and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or in the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill

ments for nurses changed. At first, little, if any, education was required.<sup>18</sup> Nursing was equated with domestic service, and thus maintained a low status and those who practiced it received poor pay.<sup>19</sup> The establishment of the first school of nursing in England in 1860 by Florence Nightingale led to the development of schools of nursing affiliated with hospitals in the United States.<sup>20</sup> During the second era, the move to educate nurses in colleges and universities began and this movement set the stage for the American Nurses' Association 1965 position paper on nursing education which stated that the minimum educational preparation for the professional nurse should be a Bachelor's Degree in Nursing and an Associate Degree in Nursing should be a pre-requisite to practice technical nursing.<sup>21</sup> Despite the controversy that followed the ANA position paper, nursing began to be recognized as a profession during this phase, as it began to shed its apprenticeship form of education, its perception of being a subordinate part of medical practice, and its schools of nursing's financial dependence on hospitals.<sup>22</sup>

The third phase of nurse registration, from 1971 to the present, includes the era of expanding functions for registered nurses.<sup>23</sup> The changes that took place during the prior era began to be felt during this stage. To begin with, the debate over minimum educational requirements for nurses, although not over, resulted in the closing of most, if not all, hospital nursing programs and firmly established nursing education in two year and four

and basic knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures." *ANA Board Approves a Definition of Nursing Practice*, 55 AM. J. NURSING 1474, 1474 (1955). The American Nurses' Association has supported a later definition which is more expansive. See *infra* note 26 and accompanying text.

18. DOLAN, *NURSING IN SOCIETY: A HISTORICAL PERSPECTIVE* (14th ed. 1976); G. GRIFFIN & J. GRIFFIN, *JENSEN'S HISTORY AND TRENDS OF PROFESSIONAL NURSING* (6th ed. 1969).

19. Cooper & Brent, *The Nursing Profession and the Right to Separate Representation* 58 CHI.-[KENT. L. REV. 1053, 1054 (1982).

20. See generally DOLAN, *supra* note 18; GRIFFIN & GRIFFIN, *supra* note 18; FLANAGAN, *ONE STRONG VOICE: THE STORY OF THE AMERICAN*.

21. COMMITTEE ON NURSING EDUCATION, AMERICAN NURSES' ASSOCIATION, *EDUCATIONAL PREPARATION FOR NURSE PRACTITIONERS AND ASSISTANTS TO NURSES: POSITION PAPER 6-8* (1965). The professional/technical distinction supported in the position paper created a lengthy and still-present debate within the profession and among other health professionals and nursing. See *infra* note 24 and accompanying text. It should be noted that the term "nurse practitioners" in the title of this position paper does not have the same definition that this term has in this article. See *supra* note 3. Unfortunately, the term nurse practitioner has been used to mean many different things. In this position paper, the term means simply those who practice nursing as opposed to a specific legal and practice definition. See *supra* note 3.

22. J. ASHLEY, *HOSPITALS, PATERNALISM, AND THE ROLE OF THE NURSE*, 9, 32, 83-84 (1976).

23. Bullough, *supra* note 4, at 366.

year programs.<sup>24</sup> In addition, Master's and Doctoral Degree programs in nursing proliferated.<sup>25</sup> The American Nurses' Association supported an updated definition of nursing practice for both the registered nurse and the licensed practical nurse, and suggested it as a new model definition to be included in state nurse practice acts.<sup>26</sup> As advances in medical technology

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24. The two year program most often takes place in a community college, and the graduate is currently called an associate degree nurse. Those three year or hospital schools still in existence have affiliated with college or university programs so that the graduate from a three year program can continue his/her education to receive the baccalaureate in nursing if the graduate so chooses. Despite the fact that these different educational programs exist, all graduate nurses currently sit for the same initial licensing examination. Cooper & Brent, *supra* note 19, at 1055. If the graduates successfully pass the examination, they all receive a license as a registered nurse or, in some states, a registered professional nurse, and can use the title "R.N." after their name. This is so despite, the American Nurses' Association's and other professional groups' position that the respective graduates are educated to do different tasks when caring for patients. The graduate of a three year hospital or diploma program is prepared to function in situations that are highly structure, where supervision is available, and where routinized and standardized procedures are utilized. *Id.* at 1055 n.7, citing H. YURA, *Climate to Foster Utilization of the Nursing Process*, PROVIDING A CLIMATE FOR UTILIZATION OF NURSING PERSONNEL (1975); American Nurses' Association, *Standards for Nursing Education* (1975). Baccalaureate graduates, in contrast, are prepared to utilize the problem-solving approach or nursing process, thus allowing them to function more independently. *Id.*, citing H. YURA & M. WALSH, *THE NURSING PROCESS: ASSESSING, PLANNING, IMPLEMENTATION AND EVALUATING* 21, 22 (2nd ed. 1973); AMERICAN NURSES' ASSOCIATION, *STANDARDS FOR NURSING EDUCATION* 23 (1975). Currently, there is a move across the country, supported by the American Nurses' Association and its state affiliates, to require different licensing examinations for two proposed levels of entry into practice, those of the registered nurse (a baccalaureate graduate) and the associate nurse (an associate degree graduate). The magnitude of the implications of these proposed licensure changes is beyond the scope of this article. It is important to note, however, that they are raising much division and dissent within the profession, and it is not clear that the changes will be dealt with well in the respective states.

25. In the Master's program, a student can elect to major in a clinical specialty in nursing, such as psychiatric/mental health nursing or medical-surgical nursing, or can develop expertise in a role area of nursing, such as nursing administration or clinical specialist. Many Master's programs now allow for a combination of both. Doctoral programs offer a major in nursing or in a related field, such as psychology, public health, or sociology. Cooper & Brent *supra* note 19, at 1056. For an up-to-date analysis of current admission and enrollment trends in all types of nursing education programs, see Gothler & Rosenfeld, *Nursing Education Update: Enrollment and Admission Trends*, 7 *NURSING AND HEALTH CARE* 555 (1986).

26. The definition reads: "The practice of nursing means the performance for compensation of professional services requiring substantial specialized knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing theory as the basis for assessment, diagnosis, planning, intervention and evaluation in the promotion and maintenance of health; the case finding and management of illness, injury, or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes but is not limited to administration, teaching, counseling, supervision, delegation, and evaluation of practice and execution of the medical regimen, including the administration of medications treatments prescribed by any person authorized by state law to prescribe. Each registered nurse is directly accountable and responsible to the consumer for the quality of nursing rendered."

The practice of practical nursing means the performance for compensation of technical

proliferated, shortages of health professionals became acute, and new ways of delivering health care emerged, the registered nurse took on expanded role responsibilities that had to be incorporated legally into the practice. The incorporation of these responsibilities took on many forms in the various states, depending on the respective licensing statutes, and included, but were not limited to the promulgation of rules and regulations sanctioning expanded practice; the delegation by physicians of responsibilities to the nurse that he or she was legally able to perform; and specific statutory language in the nursing act itself that would spell out additional acts the nurse could undertake.<sup>27</sup> The American Nurses' Association did not sanction the latter approach, stating that the current nurse practice acts should be broad enough legally to provide a framework for nursing practice in general, and establishing specific guidelines and standards for specialized or advanced practice should rest with the profession.<sup>28</sup>

Regardless of the type of mechanism for the nurse to function in expanded roles, the mechanisms exist, and this current phase of development in relation to nursing licensure for registered nurses obviously held implications for nurse practitioners.

#### HISTORY OF THE NURSE PRACTITIONER MOVEMENT

Nurse practitioners emerged into the practice arena during the mid-1960's,<sup>29</sup> when the nursing profession as a whole was struggling with defining the nursing function. At first, the nurse practitioner was seen as a "physician extender," especially in view of the need to place a ceiling on the rising cost of health care, the shortage of primary health care physicians, and the move toward specialization of physicians that began in the 1960's.<sup>30</sup> In response to these problems, in 1971 President Nixon promoted the development of nurse practitioners and other health professionals by providing

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services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing procedures. These services are performed under the supervision of a registered nurse and utilize standardized procedures leading to predictable outcomes in the observation and care of the ill, injured, and inform; in the maintenance of health; in action to safeguard life and health; and in the administration of medications and treatments prescribed by any person authorized by state law to prescribe. AMERICAN NURSES' ASSOCIATION, "THE NURSING PRACTICE ACT" SUGGESTED STATE LEGISLATION 6 (1981) (hereinafter THE NURSE PRACTICE ACT).

27. Greenlaw, *supra* note 11, at 119. See also Bullough, *supra* note 4.

28. THE NURSE PRACTICE ACT, *supra* note 26, at 3.

29. Note, *The Role of the Nurse Practitioner: Threatened After Sermchief v. Gonzales*, 28 ST. LOUIS U. L.J. 493, 499 (1984). For an excellent perspective on the nurse practitioner movement, see MCGIVERN & MEZEY, NURSES, NURSE PRACTITIONERS — THE EVOLUTION OF PRIMARY CARE (1986).

30. *Id.*

federal funds for training nurse practitioners.<sup>31</sup> The first nurse practitioner program was established in 1965 at the University of Colorado Medical Center.<sup>32</sup>

Like the nursing profession in general, the nurse practitioner movement also went through developmental phases. The first, the precursive phase, from 1963-1969, focused on communicating to the public information concerning the programs and their graduates.<sup>33</sup> Initial concerns about the quality and type of education of the nurse practitioner were resolved without much controversy. The University of Colorado nurse practitioner program required applicants to possess a baccalaureate in nursing and be eligible for admission to the University's graduate program in nursing.<sup>34</sup> The course prepared pediatric nurse practitioners and took two academic semesters, composed of four months of didactic and clinical experience at the medical center and four to five months of field work in the community, and a year of clinical practice as a nurse practitioner.<sup>35</sup> Other programs and demonstration projects were established,<sup>36</sup> and studies done on the programs and graduates indicated that the nurse practitioners could function as competent primary care givers, that patients accepted them, and patients cared for by the practitioners fared well.<sup>37</sup>

During this developmental phase for nurse practitioners, the American Nurses' Association was implementing its certification program for the nursing profession in general in order to recognize excellence in the clinical

31. The first funding for nurse practitioners was the Nurse Training Act of 1971, Pub. L. No. 92-158, 85 Stat. 465 (codified as amended at 42 U.S.C. § 296n (1976 & Supp. V 1981)). A second Nurse Training Act of 1975 was passed to ensure continued funding for training. Pub. L. No. 94-63, 89 Stat. 361. Although funding for nurse practitioners is still arguably available under the Public Health Services Act, 42 U.S.C. § 206(m) (1982 & Supp. III 1985), there is a question about its true existence in light of the Gramm-Rudman-Hallings law. See *Gramm-Rudman Sets Stage for Epic Budget Battle: First Cuts Hurt Health Care Programs Most of All*, 67 AM. J. NURSING 461 (1986).

32. FORD & SILVER, *The Pediatric Nurse Practitioner at Colorado*, 67 AM. J. NURSING 1443, 1443-1444 (1967).

33. EDMUNDS-WINTERTON, EVALUATION OF NURSE PRACTITIONER EFFECTIVENESS: AN OVERVIEW OF THE LITERATURE EVALUATION AND THE HEALTH PROFESSIONS 69, 69-81 (1978).

34. Ford, *Nurse Practitioners: History of a New Idea and Predictions for the Future*, NURSING IN THE 1980'S: CRISES, OPPORTUNITIES, CHALLENGES 231, 233 (L. Aiken, ed. 1982).

35. *Id.* at 234.

36. At Yale University, for example, nurses provided care to students in the college health clinics. Public health nurses were also utilized in providing care to mothers and children by functioning in a collaborative model with physicians. *Id.* at 238.

37. See, Ford, Seacat & Silver, *The Relative Roles of Public Health Nurse and Physician in Prenatal and Infant Supervision*, 56 AM. J. PUB. HEALTH 1097 (1966); Lewis & Resnick, *Nurse Clinics and Progressive Ambulatory Patient Care*, 277 NEW ENG. J. MED. 1236 (1967); Stoeckle, Noonan, Farrisey & Sweatt, *Medical Nursing Clinic for the Chronically Ill*, AM. J. NURSING, July 1963, at 87.



practice of nursing.<sup>38</sup> In order to be certified in an area of clinical practice, the ANA required graduation from any nursing educational program, practice for a specified period of time in the clinical area in which certification was sought, and successful passage of an examination which tested knowledge and clinical expertise.<sup>39</sup> Although the American Nurses' Association certification program became the subject of much debate,<sup>40</sup> certification became an important component of the nurse practitioner's practice as can be seen during the second phase of the nurse practitioner movement.

The years from 1970 to 1974 were ones of role legitimization and definition for nurse practitioners.<sup>41</sup> During this period, nurse practitioners were involved in defining and refining their role and its scope from both a legal and practice perspective. Attention was focused on licensure issues and on defining the nurse practitioner's functions as the practice of nursing rather than medicine.

The licensure issue became as important a one for the nurse practitioner as it was for nursing in general. Although nursing practice acts had been in existence for some time, expansion of the functions of the nurse was in full swing.<sup>42</sup> At issue for the nurse practitioner was whether the existing functions or the proposed changes, by whatever route the state had selected to do so, would include their practice, especially in view of its emphasis on primary care. By this era's end, thirty-seven states eventually recognized nurse practitioners in their nurse practice acts,<sup>43</sup> either by including an "ad-

38. FLANAGAN, *supra* note 20, at 231.

39. *Id.* at 234-235.

40. The ANA had initially attempted to develop standards for certification, but decided that the task was better left to certification boards that corresponded to the five specialty areas of nursing practice — community health, maternal and child health, geriatrics, psychiatric/mental health nursing and medical surgical geriatrics, psychiatric/mental health nursing and medical surgical nursing. Note, *A Revolution in White — New Approaches in Treating Nurses as Professionals*, 30 VAND. L. REV. 839, 847-849 (1977). See also FLANAGAN, *supra* note 20. The ANA continued to certify nurses through these boards, and has expanded their certification to fifteen programs in nursing practice and two programs in nursing administration. American Nurses' Association, *Take the Extra Step . . . Become a Certified Nurse* (1983 Catalogue). Many non-nursing professional groups, such as the American Academy of Pediatrics, did not sanction the ANA certification program due to a perceived excess in the level of independent practice the certified nurse would possess. Note, *supra* at 848. In addition, some nursing groups, such as the Association of Operating Room Nurses withdrew their support from the program. *Id.* Despite this rather stormy history, certification has been generally well accepted from both within and outside the profession as a voluntary means of underscoring excellence in clinical practice. For the nurse practitioner, however, certification became an essential requisite to practice in many states. For an excellent review of certification organizations, requirements and 1984 figures, see Fickeissen, *Getting Certified*, 85 AM. J. NURSING 265 (1985).

41. EDMUNDS-WINTERSTON, *supra* note 33; See also Ford, *supra* note 34, at 237.

42. See *supra* notes 24-27 and accompanying text.

43. Kelly, *Nurse Practitioner Challenges To the Orthodox Structure of Health Care*

ditional acts" clause in the act which expanded the definition of nursing by allowing acts of medical diagnosis and treatment to be performed by specially trained nurses, by amending the act to state additional advanced practice definitions or allow the board of nursing to develop rules for such practice, or by the naming of the specific practitioner (for example, the pediatric nurse practitioner) with the expanded functions in the act.<sup>44</sup> Twenty-five of the states required some type of certification as a requirement to practice as a nurse practitioners,<sup>45</sup> twenty-eight required completion of a post-basic board-approved educational program as a requirement to practice,<sup>46</sup> and fifteen of the states mandated physician-developed protocols, guidelines and/or nurse-physician agreements<sup>47</sup> in order to attempt to defend allegations of the nurse practicing medicine without a license.

The last, and current, phase in the nurse practitioner movement, from 1975 to the present, has been named the phase of role consolidation and maturation.<sup>48</sup> The fight for "legitimization" having been won, at least for the time being, the nurse practitioner continued to impact positively on the quality of health care, health care cost and health care employment.<sup>49</sup>

Many states during this era further expanded the nurse practitioner's role to include the ability to prescribe medications and treatments.<sup>50</sup> This further expansion, plus developing "intrapersonal conflicts with medicine"

*Delivery: Regulation and Restraints on Trade*, 11 AM. J. LAW AND MED. 195, 199 (1985), citing LaBar, *The Regulation of Advanced Nursing Practice as Provided For In Nursing Practice Acts and Administrative Rules* (Am. Nurses' Assoc. 1983) (hereinafter LaBar, *Regulation*). The states are Alabama, Arizona, Arkansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Virgin Islands, Washington, and Wyoming.

44. Kelly, *supra* note 43.

45. LaBar, *Regulation*, *supra* note 43, at 105. Although the certification requirements vary from state to state, acceptable certification may be from the American Nurses' Associates (ANA), the National Association of Pediatric Nurse Associates (NAPNAP) or the Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG). *Id.*

46. *Id.*

47. *Id.*

48. EDMUNDS-WINTERTON, *supra* note 33; See also Ford, *supra* note 34, at 237.

49. EDMUNDS-WINTERTON, *supra* note 33. For a comprehensive review of research findings relating to nurse practitioners, see *Nurse Practitioners: A Review of the Literature 1965-1979* (Am. Nurses' Assoc. and Nat'l Assoc. Pediatric Nurse Assoc. and Prac. 1980) (hereinafter *Nurse practitioners: A Review*).

50. LaBar, *Prescribing Privileges for Nurses: A Review of Current Law* (Am. Nurses' Assoc. 1983). The states are Alaska, Arizona, Idaho, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, South Dakota, Tennessee, Utah, Vermont and Washington. See also Smith, *Registered Nurses Struggle for Prescriptive Authority*, . . . In Brief 3 (Am. Assoc. of Nurse Attorneys 1986).

concerning who would deliver primary care<sup>51</sup> — physicians or nurse practitioners — supported a widening division between the two groups.<sup>52</sup> This division, and its precursors, formed the backdrop of an adversarial rather than a collaborative ambiance for the current debate over nurse practitioner practice and the *Sermchief* and *Fein* decisions.

### THE *Sermchief* CASE

In Missouri, two nurse practitioners — Janice Burgess and Suzanne Solari<sup>53</sup> — were employed by the East Missouri Action Agency, a federally funded tax exempt not-for-profit corporation that had three offices in rural portions of the state. The Agency provided services to mainly lower income clients in the areas of family planning, obstetrics and gynecology. Burgess and Solari provided the following services, among others, to clients: breast and pelvic examinations; taking health histories; counseling services; community education; prescribing oral contraceptives, condoms, and other birth control methods; and laboratory testing of pap and vaginal smears, blood serology and venereal disease cultures.<sup>54</sup> All of the tasks and services performed by the nurse practitioners were done pursuant to specific physician-developed written standing orders and protocols for Burgess and Solari, which delineated what they could do themselves and when the client needed to be referred to one of the Agency's physicians.<sup>55</sup> There had been no complaints from clients concerning the care and treatment that had been provided by the nurse practitioners.<sup>56</sup>

In 1980, a complaint was filed with the Board of Registration for the Healing Arts<sup>57</sup> alleging that the nurse practitioners were practicing

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51. Ford, *supra* note 34, at 244; Kelly, *supra* note 43, at 201-202.

52. See *Nurse Practitioners: A Review*, *supra* note 49, at 9-11.

53. Both Burgess and Solari are registered nurses duly licensed in the state of Missouri. Burgess is trained and qualified as a family planning practitioner while Solari is trained and qualified as an obstetrical/gynecological nurse practitioner. Note, *supra* note 29, at 495 n.13.

54. *Sermchief*, *supra* note 1, at 684.

55. *Id.* Standing orders are orders written by a physician for the nurse concerning the administration of medications and/or treatments. They often include the ability of the nurse to make a nursing judgment as to if, and when, the medication and/or treatment should be administered. Protocols are defined as "a form that combines a data collection section with a decision logic patten to direct the practitioners in history taking, diagnosis, therapy and disposition appropriate to a particular patient." Greenfeil, Friedlan, Scifers, Rhodes, Black & Komaroff, *Protocol Management of Dysuria, Urinary Frequency and Vaginal Discharge*, 81 ANN. INTERNAL MED. 452 (1974).

56. *Id.*

57. The Board of Healing Arts, pursuant to Missouri law, was to enforce, implement and administer Chapter 334 of the Missouri Revised Statutes, dealing with physicians' and surgeons' practice. MO. ANN. STAT. § 334 (Vernon 1966 & Supp. 1987). Complaints filed with boards or agencies entrusted to investigate complaints concerning practitioners' practice, or the unauthorized practice of that profession, are afforded full confidentiality. Therefore,

medicine without a license and that the physicians who had developed the written standing orders and protocols were aiding and abetting the unauthorized practice of medicine. After investigating the complaint, the Board met in December of 1980 and decided to recommend *criminal* prosecution of Burgess and Solari for the unlawful practice of medicine and requested that the physicians show just cause why their medical licenses should not be revoked or suspended for aiding and abetting that unauthorized practice.

The nurse practitioners and physicians, after discovering that the Board was going to take action against them, retained an attorney and filed an action for declaratory and injunctive relief.<sup>58</sup> After obtaining a temporary restraining order against the Board, the nurses and physicians sought to obtain a permanent injunction prohibiting the Board from interfering with their practice.<sup>59</sup> In addition, they alleged that Section 334.010, the Missouri Medical Practice Act, was unconstitutionally vague on its face and not in conformity with the Fifth and Fourteenth Amendments to the United States Constitution;<sup>60</sup> that their freedom to practice their profession was being violated; and that their clients' right to the free choice of health care was also being violated.<sup>61</sup> The Board counterclaimed, alleging that the two nurse practitioners were not licensed to practice medicine; that as registered nurses they had been practicing beyond the scope of the definition of professional nursing as it was defined in the Missouri Nursing Practice Act;<sup>62</sup> that the physicians were aiding and abetting the unauthorized practice of medicine; and asked for declaratory and injunctive relief to enjoin the nurse practitioners and physicians from performing, aiding, and abetting activities that constituted the unauthorized practice of medicine.<sup>63</sup>

On June first and second, 1982, the trial court heard arguments for

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although not officially confirmed, it is believed that the complainant was a physician.

58. Wolff, *Court Uphold Expanded Practice Roles for Nurses*, 12 LAW, MED. AND HEALTH CARE 26, (1984).

59. Note, *supra* note 29, at 495.

60. See *infra* note 69.

61. *Id.*

62. At the time the case was filed, the following definition of professional nursing was in existence in Missouri: "Professional nursing" is the performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including but not limited to: (a) Responsibility for the teaching of health care and the prevention of illness to the patient and his family; or (b) Assessment, nursing diagnosis, nursing care and counsel of persons who are ill, injured or experiencing alterations in normal health processes; or (c) The administration of medication and treatments as prescribed by a person licensed in this state to prescribe such medications and treatments; or (d) The coordination and assistance in the delivery of a plan of health care with all members of the health team; or (e) The teaching and supervision of other persons in the performance of any of the foregoing. MO. REV. STAT. § 335.016(8) (1978 & Supp. 1987).

63. Note, *supra* note 29, at 495-96.

both sides of the issue, and held the nurses' activities constituted the unlawful practice of medicine and enjoined them from performing most of the activities done pursuant to the written orders and protocols unless a physician was on site when those activities were performed.<sup>64</sup> The court also held that the Medical Practice Act was not unconstitutionally vague or uncertain and thus gave sufficient notice to the nurse practitioners that their actions were unlawful.<sup>65</sup> Finally, the court held that the physician based orders and protocols were not insulated from the requirement that to prescribe medications and treatments, one had to be licensed in the state of Missouri to do so.<sup>66</sup>

The nurse practitioners and physicians immediately appealed the lower court's decision to the Missouri Supreme Court by challenging the validity of the Missouri Nursing Practice Act.<sup>67</sup> The court, although rejecting that specific challenge, retained jurisdiction due to the "general interest" in the case.<sup>68</sup>

The Missouri Supreme Court also had to determine if the nurse practitioners were practicing nursing as defined in the Missouri Nursing Practice Act. To do so required a comparison of that act with sections of the Medical practice Act<sup>69</sup> so that the court could interpret each statute as a matter of law.<sup>70</sup> The court began this process by looking carefully at the legislative history of the Missouri Nursing Practice Act and determined that it was favorable to an expansive definition of nursing practice.<sup>71</sup> Furthermore, the

64. Wolff, *supra* note 58, at 26.

65. Note, *supra* note 29, at 497.

66. *Id.* The physicians were also permanently enjoined from aiding and abetting the nurse practitioners.

67. *Sermchief*, 660 S.W.2d at 684.

68. *Id.*

69. The two sections at issue were: "It shall be unlawful for any person not a registered physician within the meaning of the law to practice medicine or surgery in any of its departments, or to profess to cure and attempt to treat the sick and others afflicted with bodily or mental infirmities, or engage in the practice of midwifery in this state, except as herein provided." MO. REV. STAT. § 334.010 (1978); "This chapter does not apply to dentists licensed and lawfully practicing licensed and lawfully practicing their profession within the provisions of chapter 332, RSMO; to nurses licensed and lawfully practicing their profession within the provisions of chapter 336, RSMO; . . ." MO. REV. STAT. § 334.155 (1959).

70. *Sermchief*, 660 S.W.2d at 686.

71. Prior to the definition of nursing in existence at the time of the *Sermchief* case, the definition of nursing was: "A person practices professional nursing who for compensation or personal profit performs, under the supervision and direction of a practitioner authorized to sign birth and death certificates, any professional services requiring the application of principles of the biological, physical or social sciences and nursing skills in the care of the sick, in the prevention of disease or in the conservation of health." MO. REV. STAT. § 335.010.2 (1953) (Repealed 1976). Also important was the following: "Nothing contained in this Chapter shall be construed as conferring any authority on any person to practice medicine or osteopathy or to undertake the treatment or cure of disease." MO. REV. STAT. 335.190 (1969)

court determined that the nurse practitioners, when providing services based on (physician based) standing orders and protocols, are making a nursing diagnosis, as opposed to a medical diagnosis.<sup>72</sup> The court also underscored the fact that "nurses can assume responsibilities heretofore not considered to be within the field of professional nursing so long as those responsibilities are consistent with . . . 'specialized education, judgement and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences.'" <sup>73</sup> Thus, on November 22, 1983, the Missouri Supreme Court reversed the trial court's ruling, and held that the activities of Burgess and Solari were authorized by the Missouri Nursing Practice act and were not the unauthorized practice of medicine.

#### IMPLICATIONS FOR THE FUTURE AND THE *Fein* CASE

Although seemingly a victory for the nurse practitioner, the *Sermchief* decision created new questions and left many lingering ones unanswered. To begin, nurse practitioners in Missouri can use written standing orders and protocols to function in expanded roles. The court noted that written orders and protocols had been in existence for some time when the 1975 version of the Missouri Nursing Act was passed, and stated there was "nothing in the statute purporting to limit or restrict their continued use."<sup>74</sup> Even so, the court did not mandate their use nor list situations in which they would not be appropriate.<sup>75</sup> Proponents of retaining control of the profession within the profession rather than having the legislature or the courts do so<sup>76</sup> hail this lack of direction as a victory while others see it as a gray area that might raise troublesome issues in the future. For example, if a

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(Repealed 1976). The court also discussed the fact that "[e]ven a facile reading of that section (defining nursing practice) reveals a manifest legislative desire to expand the scope of authorized nursing practice. Every witness at trial testified that the new definition of professional nursing is a broader definition than that in the former state . . . Most apparent is the elimination of the requirement that a physician directly supervise nursing functions. Equally significant is the legislature's formulation of an open-ended definition of professional nursing. . . . The 1975 Act not only describes a much broader spectrum of nursing functions (than did the earlier statute), it qualifies this description with the phrase 'including, but not limited to.' We believe this phrase evidences and intent to avoid statutory constraints on the evolution of new functions for nurses delivering health services." *Sermchief*, 660 S.W.2d at 689 (citations omitted).

72. *Sermchief*, 660 S.W.2d at 686-90.

73. *Id.* By avoiding the demarcation of "that thin and elusive line that separates the practice of medicine and the practice of professional nursing in modern day delivery of health services," the Court attempted to avoid potential future problems. *Id.* But see *infra* notes 74-111 and accompanying text.

74. *Sermchief*, 660 S.W.2d 689.

75. Wolff, *supra* note 58, at 27.

76. See *supra* notes 22-27 and accompanying text.

physician developed standing orders and protocols for a nurse practitioner to render *medical* treatments that went beyond the scope of nursing practice in Missouri — which was the original argument by the Board of Healing Arts in this case — those activities would appear to be sanctioned by the *Sermchief* decision.<sup>77</sup> Thus, exactly what additional expanded role activities Missouri nurse practitioners can do via standing orders and written protocols will remain to be seen.

A second gray area in Missouri deals with the issue of nursing diagnosis. Again, the court, although supporting nursing diagnosis,<sup>78</sup> did not specifically define or discuss it.<sup>79</sup> Nursing diagnosis is included in the definition of professional nursing in the Missouri Act<sup>80</sup> and therefore its legitimization is arguably stronger than if it were not included. Yet, exactly what nursing diagnosis includes in Missouri from a legal perspective was not helped by the *Sermchief* decision,<sup>81</sup> and at least one commentator supports the proposition that “because of the existence of the written orders and protocols used by the nurses and physicians . . . the court was able to avoid the question of nursing diagnoses and treatments in any other context.”<sup>82</sup>

A third concern for nurse practitioners in Missouri deals with the fact that the definition of professional nursing in the State Nursing act does not include nurse practitioners, as is the case in many other state nursing practice acts. Once again, proponents for retaining control of the profession from within the profession believe this is the best approach to follow. Yet, the Missouri Board of Nursing, which had the ability to define and promulgate (informal) opinions concerning the expanded role(s) of the nurse never promulgated any rules, regulations or interpretive statements concerning

77. Wolff, *supra* note 58, at 27.

78. See *supra* notes 70-75 and accompanying text. Although not defined by the court, nursing diagnosis has been defined by the American Nurses' Association as part of the nursing process, which includes data collection, diagnosis, planning, treatment and evaluation. “Diagnosis is a beginning effort to objectify a perceived difficulty or need by naming it, as a basis for understanding and taking action to resolve the concern. A nurses' conceptualization or diagnosis of a presenting condition is a way of ascribing a meaning to it, which may or may not accurately reflect the phenomenon under consideration for treatment. Both the diagnosis and its theoretical interpretation are open to revision. . . .” *Nursing: A Social Policy Statement* 11 (Am. Nurses's Assoc. 1980). For a basic understanding of the nursing diagnostic process, see GORDON, *NURSING DIAGNOSIS: PROCESS AND APPLICATION* (1982).

79. The court said: “There can be no question that a nurse undertakes only a nursing diagnosis, as opposed to a medical diagnosis, when she or he finds or fails to find symptoms described by physicians in standing orders and protocols for the purpose of administering courses of treatment prescribed by the physicians in such orders and protocols.” *Sermchief*, 660 S.W.2d at 688.

80. See *supra* note 62 and accompanying text.

81. Comment, *Interpreting Missouri's Nursing Practice Act*, 26 ST. LOUIS U. L.J. 931, 946 (1982).

82. Wolff, *supra* note 58, at 29.

nursing practice.<sup>83</sup> Thus, what the profession had hoped it would decide was relegated to the courts due to its own passivity. Other decisions of first impression concerning nursing practice may be made by the judicial system rather than by the nursing profession if inactivity remains the hallmark of the Board of Nursing.

Last, but not least, the challenge raised by the *Sermchief* case on appeal to the Missouri Supreme Court concerning the definition of nursing as it exists in the Missouri Nursing Practice Act was never dealt with by the Court.<sup>84</sup> Thus, this issue remains unchallenged judicially — at least for the present time. Yet, the questions of when it might occur, if at all, creates uncharted waters for the nurse, and the nurse practitioner, in Missouri.

The questions raised by *Sermchief* nationally were perhaps more troubling than those raised for Missouri nurses and nurse practitioners. One burning, general question is what impact does the decision have for nurses in other states. The *Sermchief* decision occurred in a state that had a supportive legislative history for the expanded role of the nurse<sup>85</sup> and had a definition of nursing which was open-ended.<sup>86</sup> Many states do not enjoy such a supportive legislative climate.<sup>87</sup> Furthermore, the court clearly stated that the decision was specific to the particular facts and issues before it.<sup>88</sup> This being the case, then, it can be argued that it is not necessarily helpful for nurse practitioners outside of Missouri to conform their primary practice to Burgess' and Solari's. Yet, absent a clear directive in their own state by the judicial system, legislature or board of nursing, it can also be argued that mirroring the expanded practice guidelines "upheld" in the *Sermchief* case may ultimately protect the nurse practitioner when, and if, similar challenges occur. Certainly the importance of knowing the limitations of

83. *Id.* The Board of Nursing in Missouri has broad statutory power to adopt rules and regulations. MO. REV. STAT. § 335.036.1(2) (1987). The only authoritative statement concerning nursing practice in Missouri was an erroneous Attorney General opinion in 1980 which stated that Missouri nurses have no authority to practice primary care that includes diagnosis and treatment. 37 OP. ATT'Y GEN. 32 (1980). The opinion was "tacitly overruled several months later." See 37 OP. ATT'Y GEN. 105 (1980).

84. Beil, *The Missouri Supreme Court Interprets The Nursing Practice Act*, 53 UMKC L. REV. 98, 105-06 (1984).

85. See *supra* note 71 and accompanying text.

86. See *supra* note 62 and accompanying text. The words "including, but not limited to" was an important phrase in upholding an expanded definition of nursing, thus allowing the activities of the nurse to change and "expand" without having to reflect each of those changes in the act.

87. Indeed, in many states, when proposed changes in nursing practice acts are contemplated and attempted, resistance from strong lobbying groups such as the American Medical Association, the American Hospital Association and others often results in minimal, if any, changes. For an excellent summary of these, and other, legislative changes affecting nursing, see LaBar, STATE NURSING LEGISLATION QUARTERLY (Am. Nurses' Assoc.).

88. *Sermchief*, 660 S.W.2d at 688.



one's practice, possessing the appropriate education, training and expertise for the care that is provided, and maintaining one's practice within the scope of practice as defined by the nursing practice act through the use of physician-based written standing orders and protocols, where needed, are sound professional practice principles, regardless of whether or not they are legally challenged.

A third concern for the nurse practitioner after *Sermchief* is the issue of professional negligence or malpractice and the appropriate standard of care that should be applied to the nurse practitioner alleged to be negligent. The *Sermchief* court, again not defining this issue directly, stated that the nurse practitioner must know the limits of his or her professional knowledge and refer the client to a physician when needed.<sup>89</sup>

This approach to the issue of professional malpractice for nurse practitioners is a sound one and consistent with accepted principles concerning accountability for one's practice. This accountability mandates that the nurse practitioner be potentially liable for her own negligence, whether she is working as an employee and member of a health team or in a more independent setting.<sup>90</sup> In addition, the employer of the nurse practitioner, if one exists, may also be vicariously liable for negligence under the doctrine of *respondeat superior*, so long as the nurse practitioner was acting within the scope of employment when the alleged negligent act occurred.<sup>91</sup> Recently, the theory of apparent authority has also been used to confer potential liability on the principle (employer) of the agent (for example, the nurse practitioner) who allegedly committed the negligence.<sup>92</sup>

Liability for the alleged negligence of one's practice is not novel. Although reported cases against nurse practitioners are few,<sup>93</sup> one case, *Fein*

89. The court specifically said: "The broadening of the field of practice of the nursing profession authorized by the legislature and here recognized by the Court carries with it the profession's responsibility for continuing high educational standards and the individual nurse's responsibility to conduct herself or himself in a professional manner. The hallmark of the professional is knowing the limits of one's professional knowledge. The nurse, either upon reaching the limit of her or his knowledge or upon reaching the limits prescribed for the nurse by the physician's standing orders and protocols, should refer the patient to the physician." *Sermchief*, 660 S.W.2d at 690.

90. Phillips, *Nurse Practitioners: Their Scope of Practice and Theories of Liability*, 6 J. LEGAL MED. 391, 401-07 (1985).

91. PROSSER, LAW OF TORTS 139-204 (1971).

92. Phillips, *supra* note 89, at 402-403. The Restatement (Second) of Agency states "One who represents that another is his servant or agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such." RESTATEMENT (SECOND) OF AGENCY § 267 (1971).

93. Hirsh & Studer, *The Nurser Practitioner in Action: Patients Friend, Physicians' Foe?*, MED. TRIAL TECHNIQUE Q 37, 64 (1984) citing Weisberger, *The Nurse Practitioner: Medicolegal Considerations*, LEGAL MED. ANN. 283, 292 (1977) and DeAngelis & Curran,

*v. Permanente Medical Group*,<sup>94</sup> did raise a novel issue, that of which standard of care should be applied to the nurse practitioner's alleged negligence which was part of the suit.<sup>95</sup>

In February of 1976, Fein, a lawyer, experienced chest pain at different times and during different levels of activity over a period of a few days. Concerned, he called his physician at Permanente Medical Group, which was affiliated with the Kaiser Health Foundation. His physician could not see Fein on that day and he was advised to call Kaiser's central appointment desk for a "short appointment."<sup>96</sup> He was given one at 4:00 P.M. that day. Fein worked the rest of that day in his office, believing that his pain was not severe enough to require immediate attention in Kaiser's emergency room.

When Fein arrived at the Foundation, he was seen by a nurse practitioner who was working under the supervision of a physician-consultant.<sup>97</sup> The nurse practitioner took a history, examined Fein and left the room to confer with physician-consultant. When she returned, she told the plaintiff that both she and the physician believed the chest pain experienced was due to muscle spasm. As a result, the doctor wrote a prescription for Valium.<sup>98</sup> Fein returned home and went to sleep, awakening at about 1:00 A.M. with severe chest pain. His wife drove him to Kaiser's emergency room, and he was examined by the emergency room physician. The doctor, after examining Fein and finding no signs of heart difficulties, ordered a chest X-ray.<sup>99</sup> On the basis of these two clinical results, the doctor also concluded that Fein was suffering from muscle spasm, gave him an injection of Demerol and a prescription for a codeine medication.

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*The Legal Implications of the Extended Roles of Professional Nurses*, NURSING CLINICS N. AMERICA 391, 391-404 (1974).

94. *Fein*, 695 P.2d 665 (Cal. 1985).

95. Prior to the *Fein* case, the standard of care most often applied to a situation in which negligence was alleged against a nurse was whether or not the conduct of the nurse in the particular situation was consistent with what the ordinary, reasonable and prudent nurse (or nurse specialist) would do in the same or similar circumstances in the same or similar community. See PROSSER, *supra* note 90. Some states, unfortunately, still apply the non-professional ordinary, reasonable and prudent *person* standard to situations allegedly involving nursing negligence.

96. *Fein*, 605 P.2d at 669.

97. *Id.* The plaintiff knew the nurse was a nurse practitioner and did not ask to see a physician. *Id.* In 1977, the California legislature adopted legislation specifically dealing with nurse practitioners, stating that a nurse practitioner must be a registered nurse and meet standards for nurse practitioners adopted by the Board of Registered Nursing. *Id.* at 674, citing CAL. BUS. AND PROF. CODE § 2834 *et. seq.* (1977). The nurse practitioner in this case, Cheryl Welch, was certified as both a registered nurse and a "family nurse practitioner." *Fein*, 695 P.2d at 674.

98. *Id.* at 669.

99. *Id.*

Upon returning home, the chest pain continued intermittently. At about noon that day, the pain became more constant and severe, so Fein returned to the emergency room where he was seen by another physician who ordered an electrocardiogram (EKG).<sup>100</sup> The EKG showed that Fein was experiencing a heart attack (acute myocardial infarction), and the physician immediately admitted him to the cardiac care unit. Fein returned to work part-time in October, 1976 after a period of hospitalization and medical treatment for his cardiac condition. He resumed full-time work in September 1977, and was not hindered in resuming full sports activities that he enjoyed prior to his heart attack.

Fein filed suit<sup>101</sup> alleging that his heart condition should have been diagnosed earlier and that treatment should have been instituted either to prevent it, or, at least, to lessen its residual effects.<sup>102</sup> The jury returned a verdict in plaintiff's favor and also returned special verdicts for lost wages during the trial, lost future wages due to the reduction in his life expectancy, for future medical expenses, and for "noneconomic damages."<sup>103</sup> The Medical Group appealed the decision.

On appeal, The Group challenged, among other things, the instructions to the trial jury that the standard of care by which the nurse practitioner's conduct should be judged should be that of a physician.<sup>104</sup> The Supreme Court of California in agreeing that the instructions were erroneous, stated that the instruction was "inconsistent with the recent legislation setting forth general guidelines for the services that may properly be performed by registered nurses in this state."<sup>105</sup> The court also pointed out that the legislative intent of the California Nursing Act, amended in 1974, was "to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and

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100. *Id.*

101. At issue was the conduct of the nurse practitioner and the two physicians involved in Fein's care prior to the EKG being taken. Their conduct was alleged to be negligent by the plaintiff. The case went to judgment only against the Permanente Medical Group, however. *Id.* at 670.

102. *Id.* at 670.

103. Creighton, *Nurse Practitioners: New Decisions*, 16 NURSING MANAGEMENT 15, (1985).

104. The jury was instructed as follows: "It is the duty of one who undertakes to perform the service of a trained or graduate nurse to have the knowledge and skill ordinarily possessed, and to exercise the care and skill ordinarily used in like cases, by trained and skilled members of the nursing profession practicing their profession in the same or similar locality and under similar circumstances. Failure to fulfill either of these duties is negligence: I instruct you that the standard care required of a nurse practitioner is that of a physician and surgeon duly licensed to practice medicine in the state of California when the nurse practitioner is examining a patient or making a diagnosis." *Fein*, 695 P.2d at 673.

105. *Id.*

registered nurses."<sup>106</sup> Further discussing the fact that the definition of nursing in the California act included the activities of "examination" and "diagnosis," the court said as a matter of law, the functions could not solely be reserved as functions of physicians.<sup>107</sup> The plaintiff was entitled, according to the court, to have the jury decide if the medical group was negligent in letting a nurse practitioner, rather than a physician, see him, and if the nurse practitioner met the standard of care of a reasonably prudent nurse practitioner in providing care, but was not entitled to the erroneous instruction.<sup>108</sup> Even so, the court concluded, the erroneous instruction did not affect the judgment in the case, and therefore did not mandate a reversal.<sup>109</sup>

At first, blush, the *Fein* case seems favorable in supporting the nurse practitioner standard as the standard to be applied to nurse practitioners when negligent care is alleged. However, upon close analysis, it becomes clear that the issue may still be unresolved. In California alone, nurse practitioners cannot be certain that a physician standard may not be applied in a situation that does not mirror the facts of *Fein*. Nurse practitioners across the country must wait for the resolution of this issue in their respective

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106. *Id.* at 673-74.

107. The practice of nursing in existence at the time was: The practice of nursing within the meaning of this chapters means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all of the following:

(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by a physician by and within the scope of licensure of a physician.

(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(d) Observations of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implements, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

*Id.*, citing Section 2725 of the CAL. BUS. AND PROF. CODE (1974). Paragraph (d) was what the court relied on in determining that examination and diagnosis could be performed by California nurses. *Id.* at 674.

108. *Id.* at 674.

109. The court compared the behavior of nurse practitioner Welch with that of the second physician Fein had seen in the emergency room and discussed the fact that *both* had failed to order EKG. Thus, the court concluded, the jury could not have found the nurse practitioner negligent without finding the physician negligent as well, especially in view of the availability of information concerning the plaintiff's first visit to the emergency room *and* the fact that the physician standard of care clearly applied to him. *Id.*

states. Had the California court been able to affirmatively state that in every instance of alleged malpractice involving a nurse practitioner, the standard to be applied should be the nurse practitioner standard, it would have certainly provided smooth sailing for California nurse practitioners and a potential safe harbor for others attempting to resolve this issue in other states.

A final concern for nurse practitioners after *Sermchief* is that of continuing to protect potential employment opportunities, especially in relation to obtaining staff privileges at medical facilities.<sup>110</sup> Had the *Sermchief* court not supported that primary care focus of the nurse practitioner, it is clear that their future would have been uncertain at best. Now, however, the nurse practitioner's ability to function in Missouri, and hopefully other states, the many unanswered questions still remaining after the decision notwithstanding, seems revitalized. As a result, nurse practitioners are beginning to fight discriminatory and other practices aimed at keeping them out of the health care delivery system.<sup>111</sup>

#### CONCLUSION

There are no easy, "cook book" solutions to the many problems that the nurse practitioner faces after *Sermchief* and *Fein*. Others not discussed here may arise as well.<sup>112</sup> Moreover, it is not clear how long it will take for solutions, once found, to be implemented so that the legitimization of the nurse practitioner's practice is no longer challenged. But, as has been the case throughout the history of the nursing profession generally, and the nurse practitioner movement specifically, the waters will continue to be explored in order to provide a better prediction for future voyages, whether smooth or rough sailing, especially in the areas of autonomous nursing practice and the provision of quality care to clients.

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110. See News: *New DC Law Clamps Tighter Limits on Nurse Specialists*, 67 AM. J. NURSING 474 (1986).

111. See, e.g., Kelly, *supra* note 43; JACOX & NORRIS ORGANIZING FOR INDEPENDENT NURSING PRACTICE (1977). As Kelly notes, not only are staff privileges an issue, so are obtaining third party-reimbursement and antitrust issues. See also *Reimbursement for Nursing Services: A Position Statement of the Commission on Economic and General Welfare* (Am. Nurses' Assoc. 1977); LaBar, *Third Party Reimbursement Legislation for Services of Nurses: A Report of Changes in State Health Insurance Laws*. (Am. Nurses' Assoc. 1983). In addition, obtaining professional liability insurance has become problematic for nurses and nurse practitioners in independent roles. Initially a problem for certified nurse midwives, the difficulty is now extending to other nurses, such as psychiatric/mental health nurses in private practice.

112. One new issue that has received minimal attention in the nursing literature is the concept of institutional licensure of nurse practitioners as a way of overcoming the "limitations" of doing so through state nurse practice acts. See Mellett, *Nurse Practitioners in New York State: A Case study in Institutional Licensure?*, 34 NURSING OUTLOOK 56 (1986).