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Michael B. Zand, *Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioner Autonomy Can Safely and Economically Meet the Growing Demand for Basic Health Care*, 24 J.L. & Health 261 (2011)
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**NURSING THE PRIMARY CARE SHORTAGE BACK
TO HEALTH: HOW EXPANDING NURSE
PRACTITIONER AUTONOMY CAN SAFELY AND
ECONOMICALLY MEET THE GROWING DEMAND
FOR BASIC HEALTH CARE**

MICHAEL B. ZAND*

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I. INTRODUCTION

The role of nurse practitioner (NP) has emerged as a profession capable of closing the gap between the declining number of primary care providers caused by the dearth of family practice physicians and the growing number of Americans in need of health care. Studies have shown that NPs are equally as competent as physicians when it comes to diagnosing and treating basic ailments. NPs cost less, spend more time with patients, and garner high satisfaction reviews from those patients.

Due to the popularity and efficiency of NPs, the medical establishment has viewed the profession as a threat to their livelihood. In the forty plus years since the first NP graduated, NPs have had to continually fight and lobby for the right to

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practice their profession, preferably independent of physicians. The result has been a state-by-state patchwork of laws and regulations governing NPs' scope of practice.

This article first discusses the history and educational requirements of the NP profession. It then discusses the policy reasons why NPs should, and do, play an important role in the country's health care delivery system. The core of the article deals with the legal issues surrounding the NP's scope of practice including the need for collaborative agreements with physicians, authority to prescribe drugs, and identification. Finally the article discusses how NPs fit into the health insurance scheme and their liability for malpractice.

II. OVERVIEW

A. History and Background

A nurse practitioner (NP)¹ is a registered nurse who has undertaken additional education in order to perform tasks more traditionally associated with the medical profession.² The American College of Nurse Practitioners provides the following definition: nurse practitioners are "registered professional nurses who are prepared, through advanced graduate education and clinical training, to provide a wide range of health care services, including the diagnosis and management of common, as well as complex, medical conditions . . ."³ NPs distinguish themselves from physicians by emphasizing that, as nurses, they are patient focused – examining the patient's history and family – while physicians are disease focused.⁴ While some NPs specialize in areas such as neonatal, geriatric, psychiatric, or acute care, the majority of NPs provide primary care.⁵

The role of NP began in the mid-1960s in response to a nationwide shortage of physicians.⁶ The first NP program began as a master's degree at the University of

¹ The literature and legislation refer to NPs using various titles. These include APRN (advanced practice registered nurse), ARPN (advanced registered nurse practitioner), APN (advanced practice nurse), and ANP (advanced nurse practitioner). Although NP and APN seem to be the most common acronyms, this article will consistently use NP, unless quoting otherwise.

² This article will not discuss physician assistants (PAs) who by definition work as physician *extenders*. See CAROLYN BUPPERT, *NURSE PRACTITIONER'S BUSINESS PRACTICE AND LEGAL GUIDE* 10 (2d ed. 2004). As will be shown in this article, NPs have striven and to some degree achieved independence from physicians.

³ AMERICAN COLLEGE OF NURSE PRACTITIONERS, *WHAT IS A NURSE PRACTITIONER* 1, http://www.acnpweb.org/files/public/What_is_a_Nurse_Practitioner.pdf (last visited Dec. 18, 2010).

⁴ See ANN B. HAMRIC ET AL., *ADVANCED PRACTICE NURSING: AN INTEGRATIVE APPROACH* 93 (3d ed. 2005); see also *Frequently Asked Questions*, COLUMBIA UNIVERSITY SCHOOL OF NURSING: CAPNA, <http://www.capna.com/faq.html> [hereinafter CAPNA *faq*] (last visited Dec. 18, 2010) ("The nursing model emphasizes prevention, community-based care, education, and management of chronic disease. NPs offer a broader range of health promotion strategies for disease prevention [compared to physicians] and have education and expertise as health educators.").

⁵ BUPPERT, *supra* note 2, at 7.

⁶ Sharon Christian et al., *Overview of Nurse Practitioners Scopes of Practice in the United States: Discussion*, CTR. FOR HEALTH PROFESSIONS, 2007, available at

Colorado School of Nursing in 1965.⁷ Other NP educational programs began springing up throughout the country.⁸ At the outset, most NPs practiced in traditional settings by associating with physician groups or hospitals.⁹ However, in 1977, the Arizona State University School of Nursing began a federally funded nurse-managed health care center,¹⁰ paving the way for NP independent practice.

By the 1990s, the number of NPs had skyrocketed¹¹ and between 1996 and 2001 the number doubled.¹² Between 1999 and 2009, the number doubled again.¹³ As of 2009 there were 157,782 NPs in the United States.¹⁴ As of 2007, there were 250 nurse-managed health care centers, mostly in medically underserved rural and urban communities.¹⁵ However, the majority of NPs practice in settings supervised by physicians.¹⁶

B. Educational Requirements

In most states, the NP profession is regulated by the state Board of Nursing (BON).¹⁷ However, in a minority of states, NPs are regulated by the BON and the Board of Medicine (BOM) or some other regulatory authority.¹⁸ In either case, the

http://futurehealth.ucsf.edu/Content/29/2007-12_Overview_of_Nurse_Practitioner_Scopes_of_Practice_In_the_United_States_Discussion.pdf, at 2.

⁷ *Id.* at 2-3.

⁸ Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift*, HEALTH LAW, Apr. 2008, at 21.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ Linda J. Pearson, *The Pearson Report: A National Overview of Nurse Practitioner Legislation and Healthcare Issues*, AM. J. NURSE PRACTS., Feb. 2010, available at <http://www.pearsonreport.com/tables-maps/category/hipdb-rates> [hereinafter *Pearson Report*] (table on HIPDB rates).

¹⁴ *Id.* In comparison, there are about 954,000 physicians in the United States. Suzanne Sataline & Shirley S. Wang, *Medical Schools Can't Keep Up: As Ranks of Insured Expand, Nation Faces Shortage of 150,000 Doctors in 15 Years*, WALL ST. J., Apr. 12, 2010, available at <http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html>.

¹⁵ Ritter & Hansen-Turton, *supra* note 8, at 21. Since 2000, NPs also practice in retail-based health clinics, discussed *infra* note 183 and accompanying text. *Id.*

¹⁶ Ginger Rough, *For Many, a Nurse Practitioner Is the Doctor*, ARIZ. REPUB., Feb. 21, 2009.

¹⁷ *Pearson Report*, *supra* note 13, at <http://www.pearsonreport.com/statebystate> [hereinafter *Pearson State-By-State*](State-by-State Legislation). There are 36 such states plus the District of Columbia. *Id.*

¹⁸ *Id.* In some of these states, such as New Jersey, the BOM only has the power to regulate in the area of drug prescribing. *Id.* In the following states, the BON is *not* the sole authority over NPs: Delaware, Florida, Georgia, Illinois, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, North Carolina, South Dakota, Tennessee, and Virginia. The

regulatory authority sets the minimal requirements needed for becoming a licensed NP.

All NPs must at least achieve the degree of a registered nurse (RN).¹⁹ Forty-two states also require a master's degree with the remaining states requiring completion of a specific course of study beyond the RN.²⁰ NP programs generally consist of courses in "advanced practice nursing philosophy, advanced health assessment, diagnosis, advanced pathophysiology, advanced pharmacology, primary care, and clinical decision making."²¹ In 43 states and the District of Columbia NPs are also required to pass a national certification examination.²² NPs can gain additional certification in a number of specialties such as neonatal, geriatric, psychiatric, acute care,²³ or midwifery.²⁴

Doctors argue that NPs' education is insufficient to allow them to practice independently. According to James King, president of the American Academy of Family Physicians, "[w]ith four years of medical school and three years of residency training, physicians' understanding of complex medical issues and clinical expertise is unequaled."²⁵ NPs counter that they have a proven track record of providing quality care²⁶ and that new technologies allow them to cost-effectively diagnose common illnesses without extensive medical education.²⁷ As for physicians' argument that NPs' lack of a comprehensive medical education will lead them to misdiagnose atypical cases,²⁸ NPs reply that as professionals, they can recognize

role of the BOM is an indicator of NP autonomy in the state, as discussed in depth *infra* sec. III.

¹⁹ BUPPERT, *supra* note 2, at 5.

²⁰ *Pearson State-By-State*, *supra* note 17; BUPPERT, *supra* note 2, at 5. The states that do not require a master's degree are Delaware, District of Columbia, Idaho, Indiana, Maryland, Massachusetts, Minnesota, New York, and Washington. *Pearson State-By-State*, *supra* note 17.

²¹ Janette A. Bertness, *Practicing Without a License*, 14 ROGER WILLIAMS U. L. REV. 215, 225-26 (2009).

²² *Pearson State-By-State*, *supra* note 17. The states that do not require passage of a national certification examination are California, Kansas, Indiana, Iowa, New York, Oregon, and Virginia. *Id.* Note that some states require national certification but do *not* require a master's degree – Delaware, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, and Washington. *Id.* Indiana and New York are the only states that do not require either a master's degree or national certification. *Id.*

²³ BUPPERT, *supra* note 2, at 6.

²⁴ This specialty is known as a Certified Nurse Midwife (CNM). See American College of Nurse-Midwives, *What is a Midwife?*, http://www.midwife.org/about_midwife_profession.cfm (last visited Dec. 18, 2010).

²⁵ Laura Landro, *The Informed Patient: Making Room for 'Dr. Nurse'*, WALL ST. J., Apr. 2, 2008, at D1.

²⁶ See *infra*, notes 52-54 and accompanying text.

²⁷ See generally Clayton M. Christensen et al., *Will Disruptive Innovations Cure Health Care?*, HARV. BUS. REV., Sept.-Oct. 2000 (discussed *infra* notes 44-51 and accompanying text).

²⁸ Bertness, *supra* note 21, at 233.

when a problem goes beyond the scope of their training and requires referral to an appropriate physician.²⁹

NPs can raise their level of education by pursuing a “doctorate of nursing practice” (DNP). Over 200 nursing schools have established or plan to establish such programs that generally require two additional years of training including a year of residency.³⁰ According to Mary Munding, Dean of the Columbia University School of Nursing, the goal of DNP programs is to produce nurses who will have “hospital admitting privileges, coordinate care among specialists, . . . and [the ability to] manage[] complex illnesses such as diabetes and heart disease.”³¹ Similarly to NPs, there is no national standard for the certification of DNPs. However, a voluntary DNP certification exam, which will be based on the exam physicians take to receive their medical license, is being developed.³² While some NP groups want to make the DNP degree the standard for all NPs,³³ there has been opposition from the medical establishment³⁴ as well as from NPs themselves.³⁵

C. Policy Arguments

There are a number of policy arguments that support the use and expansion of the NP role to provide health care. These include the inadequate number of physicians available to provide care, cost effectiveness, and patient satisfaction and quality of care.

The surge in the NP profession has coincided with and perhaps resulted from a steep decline in the number of medical students entering primary care. In 2007, less than half of the available family practice residency programs were filled³⁶ as only

²⁹ Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 451 (1992) [hereinafter Safriet, *Health Care Dollars*].

³⁰ Landro, *supra* note 25.

³¹ *Id.*

³² *Id.*

³³ *See id.* (“By 2015, [t]he American Association of Colleges of Nursing aims to make the doctoral degree the standard for all new advanced practice nurses, including nurse practitioners.”).

³⁴ *See* Edward L. Langston, *Letter to the Editor*, WALL ST. J., Apr. 11, 2008, at A15 (“[I]t’s an undeniable fact that a nurse with a graduate degree doesn’t have the same education as a physician who has completed medical school and residency training, and it’s misleading to patients for nurses to introduce themselves as a doctor.”). *See also infra* sec. III (D) (discussing limits on DNPs identifying themselves as doctors).

³⁵ While the American Academy of Nurse Practitioners supports the DNP degree, it “wants to ensure that [current NPs] won’t be marginalized or required to go back to school for a costly advanced degree.” Landro, *supra* note 25. *See also* Marylu Manning, *Letter to the Editor*, WALL ST. J., Apr. 11, 2008, at A15 (“To use the title ‘doctor’ is knowingly misleading. Why antagonize the physicians who are just now beginning to accept the nurse practitioner as a vital part of the medical team?”).

³⁶ Ritter & Hansen-Turton, *supra* note 8, at 2.

seven percent of medical school graduates chose family practice.³⁷ According to the American Academy of Family Physicians, the decline is attributable to “factors related to lifestyle and educational debt.”³⁸ This has resulted in some areas of the country not meeting the general standard of one primary care physician per 1000 – 2000 people.³⁹ As will be shown below, NPs offer an affordable and efficient way to fill this gap without compromising on the quality of patient care.

NPs provide economically efficient health care by reducing the cost of buying basic care and freeing up physicians to focus on complex illnesses. On a basic level, since the time required to become a licensed NP is significantly less than the time needed to attain a medical license, training costs for NPs are much lower.⁴⁰ NPs also provide care at a lower cost than doctors as insurance generally reimburses NPs 85% of what it would pay a physician for similar services.⁴¹ At forty to seventy dollars a visit, prices at retail health care centers,⁴² in which NPs provide service, are significantly lower than physician fees.⁴³

In a 2000 Harvard Business Review article, a professor of business administration and two physicians argue that since most patients see doctors for relatively straightforward illnesses, it is inefficient for physicians to treat such illnesses.⁴⁴ That is because making a simple diagnosis “tap[s] but a small fraction of what our medical schools have prepared physicians to do.”⁴⁵ Because new scientific technology allows NPs to easily diagnose illnesses that a generation ago could only be made by doctors after extensive observation,⁴⁶ it is a waste of resources to require such a diagnosis to be made by a physician.⁴⁷ The authors note that “[h]istory tells

³⁷ Milt Freudenheim, *Trying to Save by Increasing Doctors' Fees*, N.Y. TIMES, July 21, 2008, at A1. This represents a 25% drop from 2002. See Sataline & Wang, *supra* note 14.

³⁸ Ritter & Hansen-Turton, *supra* note 8, at 2.

³⁹ See Freudenheim, *supra* note 37. See also Safriet, *Health Care Dollars*, *supra* note 29, at 432 (“In many rural and inner-city areas, [NPs] are the only providers available.”).

⁴⁰ Safriet, *Health Care Dollars*, *supra* note 29, at 437.

⁴¹ Kate Pickert, *If a Health-Care Bill Passes, Nurse Practitioners Could Be Key*, TIME, Aug. 3, 2009.

⁴² See *infra* note 183 and accompanying text.

⁴³ See MARY KATE SCOTT, HEALTH CARE IN THE EXPRESS LANE: RETAIL CLINICS GO MAINSTREAM 5 (CAL. HEALTHCARE FOUND., 2007), available at http://www.4medsystems.com/pdf/case_studies/HealthCareInTheExpressLaneRetailClinics2007.pdf (stating that NP-run retail health clinics in Brevard County, Florida charge \$55-\$65 per visit while the average doctor office visit costs \$150-\$200). Accordingly, NP salaries are significantly lower than physician salaries. While the median income of a family doctor is around \$150,000, an NP makes only \$87,400 on average. See Freudenheim, *supra* note 37; Landro, *supra* note 25. As a result, in order to maintain their high incomes, physicians must see more patients, frequently seeing each one for only a few minutes. Christensen et al., *supra* note 27, at 108. NP-staffed retail clinics on the other hand generally spend fifteen minutes with the patient. Scott, *supra* note 43, at 5.

⁴⁴ Christensen et al., *supra* note 27, at 2.

⁴⁵ *Id.*

⁴⁶ E.g., portable blood glucose meters for diabetes detection. See *id.* at 4.

⁴⁷ *Id.* at 7.

us that major new growth markets coalesce when products, processes, and information technologies let less highly paid groups of people do things . . .”⁴⁸ The authors compare regulations requiring doctors to supervise NPs making simple diagnoses to requiring every personal home computer buyer to also purchase a mainframe computer.⁴⁹ While there will always be some businesses that require large, expensive mainframes for complex data crunching, personal computers are more than adequate for simple tasks such as e-mail and word processing.⁵⁰ Similarly, if NPs could independently diagnose and treat simple illnesses, doctors would have more time to treat more complex illnesses.⁵¹

Even if NPs are needed to fill the primary care gap and prove to be more cost effective, these arguments are moot if NPs provide inferior care. However, a number of studies have shown that NPs provide the same or better quality of care than physicians. The first such study was conducted in 1986 by the Office of Technology Assessment of the United States Congress (OTA), which found that “the quality of care provided by NPs functioning within their areas of training and expertise tends to be as good as or better than care provided by physicians.”⁵² In 2000, the Journal of the American Medical Association published a study in which 1316 primary care patients were randomly assigned to either an NP or a physician. The study, which was corroborated by a follow-up study in 2004, concluded that “patient outcomes for nurse practitioner and physician delivery of primary care do not differ.”⁵³ Studies have also shown that NPs spend more time with patients during visits than physicians and “emphasize prevention and health maintenance to a greater degree.”⁵⁴

Patients themselves have expressed strong satisfaction for NP services. A 2002 study found that nurse-managed health centers had a higher retention rate of patients than physician-managed health centers.⁵⁵ The study also found that the patients at the nurse-managed health centers expressed a high level of satisfaction with the care provided.⁵⁶ NPs also point to the significantly lower numbers of malpractice suits against NPs in comparison to the number of suits against physicians as evidence of patient satisfaction with NP service. While one out of every four physicians is sued for malpractice, only one in 166 NPs are sued.⁵⁷ Finally, despite the friction between

⁴⁸ *Id.*

⁴⁹ *Id.* at 8.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Ritter & Hansen-Turton, *supra* note 8, at 3.

⁵³ *Id.*

⁵⁴ Christensen et al., *supra* note 27, at 5.

⁵⁵ Ritter & Hansen-Turton, *supra* note 8, at 5.

⁵⁶ *Id.*

⁵⁷ *Pearson Report*, *supra* note 13. There are, however, other explanations for this disparity. Plaintiffs’ lawyers may prefer to sue physicians who have deeper pockets and more professional liability insurance. See Bertness, *supra* note 21, at 249 (“Professional liability insurance carriers may only issue malpractice policies to NPs who are employed at [physician] managed sites.”).

physicians and NPs in the legal arena,⁵⁸ most physicians who actually work with NPs have positive attitudes towards them.⁵⁹ This is extremely important since NPs and physicians often work on a team or at least consult with one another in providing patient care.⁶⁰

III. NURSE PRACTITIONER AUTONOMY

A. *Opposition from the Medical Establishment*

NPs have long been at loggerheads with the medical profession in their quest to gain professional autonomy.⁶¹ Conflicts concerning the right to practice without physician supervision and the right to prescribe have pitted state medical associations against NP organizations in a state-by-state turf war that has lasted thirty years. This has led to a regulatory environment that varies greatly from state to state.⁶²

From the outset, the medical profession had the distinct advantage in fighting against NP autonomy. Physicians were the first health care providers to secure legal licensure in the United States.⁶³ By the early 1900s, almost every state had adopted “medical practice acts” which gave physicians exclusive domain over the “practice of medicine.”⁶⁴ However, recognizing that other health care providers were competent to perform medical services, combined with the overwhelming demand for medical services, physicians lobbied state legislatures to allow them to supervise

⁵⁸ See *infra* sec. III.

⁵⁹ Ritter & Hansen-Turton, *supra* note 8, at 22. See also Christian et al., *supra* note 6, at 16 (citing a 2003 survey of physicians’ perceptions of NPs which found that physicians believe NPs “(1) possess the necessary skills and knowledge to provide primary care to patients; 2) are an asset to a physician’s practice; 3) free the physician’s time to handle more critically ill patients; and 4) increase revenue for the practice.”).

⁶⁰ See discussion *infra* sec. III(B); Michelle Andrews, *With Doctors in Short Supply, Responsibilities for Nurses May Expand*, N.Y. TIMES, Nov. 6, 2009, <http://prescriptions.blogs.nytimes.com/2009/11/06/with-doctors-in-short-supply-responsibilities-for-nurses-may-expand> (noting that approximately 25% of primary care physician practices have NPs on staff).

⁶¹ See, e.g., Safriet, *Health Care Dollars*, *supra* note 29, at 429 n. 48 (quoting a 1981 resolution of the American Medical Association House of Delegates to “work to eliminate federal funding for training of further numbers of [NPs].”).

⁶² Ritter & Hansen-Turton, *supra* note 8, at 22. For the past 22 years, Linda Pearson, a family psychiatric mental health NP, has documented the current legal framework for NPs in each of the fifty states and the District of Columbia in a publication called the “Pearson Report.” *Pearson Report*, *supra* note 13. Her 2010 data is used throughout this article. The report also includes a state-by-state guide to legislative activity regarding NP autonomy and scope of practice.

⁶³ Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers’ Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 306 (2002) [hereinafter Safriet, *Closing the Gap*].

⁶⁴ *Id.* To take an extreme example of this monopoly, until the mid- to late-1970s, only physicians were authorized to pierce ears since the piercing of tissue constituted the practice of medicine. *Id.* at 307.

and delegate certain medical procedures to non-physicians.⁶⁵ It was against this background of physician monopoly and mandatory supervision that NPs had to lobby for state legislatures to recognize their autonomy.

As the NP profession emerged, state legislatures began to deal with NP licensure and scope of practice.⁶⁶ Idaho was the first state to amend the physician monopoly on health care by allowing NP diagnosis and treatment.⁶⁷ While still theoretically granting physicians the exclusive practice of medicine, states have carved out exceptions for certain medical services by amending their nursing regulations.⁶⁸ Accordingly, NPs are still not technically allowed to “practice medicine,” although their diagnostic and prescriptive power would undoubtedly have been considered the practice of medicine as late as the 1960s. In other words, NPs have achieved their powers through the operation of legislative exceptions and, some would say, judicial fictions.

For example, Washington is a state that allows for broad NP autonomy.⁶⁹ Nevertheless, this autonomy is at best an exception, if not a contradiction, to the existing medical licensure laws. According to the Washington statute, “[n]o person may practice or represent himself or herself as practicing medicine without first having a valid license to do so.”⁷⁰ The practice of medicine is defined as one who:

- (1) Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;
- (2) Administers or prescribes drugs or medicinal preparations to be used by any other person;
- (3) Severs or penetrates the tissues of human beings . . .⁷¹

The statutory exception for NPs is buried in the following section: “Nothing in this chapter shall be construed to . . . prohibit [t]he practice of . . . nursing . . .”⁷² The actual scope of practice for NPs is found in the administrative code:

- (1) A licensed advanced registered nurse practitioner (ARNP) is a registered nurse prepared in a formal educational program to assume primary responsibility for continuous and

⁶⁵ *Id.* at 307.

⁶⁶ BUPPERT, *supra* note 2, at 7.

⁶⁷ *Id.*

⁶⁸ *See infra* notes 69-74 and accompanying text.

⁶⁹ *Pearson Report*, *supra* note 13, available at <http://www.pearsonreport.com/tables-maps/category/npdb-rates/> (receiving a grade of “A” for allowing prescriptive, diagnostic, and treatment powers without physician involvement).

⁷⁰ WASH. REV. CODE § 18.71.021 (2010).

⁷¹ WASH. REV. CODE § 18.71.011 (2010).

⁷² WASH. REV. CODE § 18.71.030(4) (2010).

- comprehensive management of a broad range of patient care, concerns and problems . . .
- (6) Performing within the scope of the ARNP's knowledge, experience and practice, the licensed ARNP may perform the following:
 - (a) Examine patients and establish diagnoses by patient history, physical examination and other methods of assessment;
 - (b) Admit, manage and discharge patients to and from health care facilities;
 - (c) Order, collect, perform and interpret diagnostic tests;
 - (d) Manage health care by identifying, developing, implementing and evaluating a plan of care and treatment for patients;
 - (e) Prescribe therapies and medical equipment;
 - (f) Prescribe medications⁷³

So even though Washington provides NPs with a broad scope of practice (“admit”, “discharge”, “interpret”), and is thus considered by NPs to be a very hospitable state in which to practice, NP authority to practice is still framed as a legal exception to physicians’ monopoly on the practice of medicine. This historical monopoly is the only way to explain the absurdity of granting NP authority in the form of an exception to the practice of medicine when so many of NPs’ and physicians’ scope of authority are clearly the same (“prescribes drugs” for physicians versus “[p]rescribe medications” for NPs).⁷⁴

In *Sermchief v. Gonzales*,⁷⁵ a seminal case for NPs,⁷⁶ the Supreme Court of Missouri cut through similarly absurd statutory anomalies⁷⁷ to clearly uphold the legality of NP practice. NPs working for a non-profit family planning clinic took the medical history of incoming patients and provided those patients with breast and pelvic examinations, PAP smears, and information about contraception.⁷⁸ The NPs’ actions were done pursuant to written orders of resident physicians.⁷⁹ Nevertheless, the Missouri State Board of Registration for the Healing Arts threatened to find the

⁷³ WASH. ADMIN. CODE § 246-840-300 (2010).

⁷⁴ WASH. REV. CODE §§ 18.71.021 and 18.71.011, *supra* notes 71 and 73 and accompanying text (quoting the Washington statute and regulations). *See Bertness, supra* note 21, at 270 (showing an example of proposed legislative language that attempts to clarify Rhode Island’s scope of practice statutes by replacing all physician and NP terms with “health care provider”).

⁷⁵ 660 S.W.2d 683 (Mo. 1983).

⁷⁶ The court noted that the case “attracted amici briefs resembling a letter writing campaign directed at a legislative body.” *Id.* at 686.

⁷⁷ The conflicting statutes restricting the practice of medicine, the exception for nurses, and the definition of NP were similar to those mentioned above for Washington. *See id.* at 687-88.

⁷⁸ *Id.* at 684.

⁷⁹ *Id.* at 684-85.

NPs guilty of the unauthorized practice of medicine.⁸⁰ The NPs sued for a declaratory judgment that their actions fit within Missouri's NP statute and therefore did not constitute the unauthorized practice of medicine.⁸¹ The Board countered that the NP statute was unconstitutionally vague in permitting practices that resembled the practice of medicine and should be nullified under the Fifth and Fourteenth amendments of the U.S. Constitution.⁸²

The court declined the invitation to "define and draw that thin and elusive line that separates the practice of medicine and the practice of professional nursing."⁸³ Nevertheless, in finding that the NPs' actions were legal, the court emphasized the state legislature's "manifest . . . desire to expand the scope of authorized nursing practices."⁸⁴ The court further stated that the statutory language intentionally allowed for the "evolution of new functions for nurses [and the] assum[ption of] responsibilities heretofore not considered to be within the field of professional nursing."⁸⁵ By rejecting the medical establishment's bid to block the development of advanced nurse practice through judicial fiat, the court allowed the state legislature to continue to expand and develop the role of NPs in order to meet their constituencies' growing health care needs.⁸⁶

In another significant NP victory, NPs sued the Oregon Workers' Compensation Department for promulgating rules that excluded provider NPs from insurance reimbursement.⁸⁷ The Department had derived its rules from the state's Workers' Compensation statute which limited eligibility to a "doctor or physician" which was defined as a "person duly licensed to practice one or more of the *healing arts*."⁸⁸ In ruling for the NPs, the court said that the "term 'healing arts' is not a static concept, capable of only one definition, now and forever."⁸⁹ Noting that NPs can provide comprehensive medical care including diagnosis and treatment, the court concluded that NPs fell within the statutory definition of "doctor or physician" since "[diagnostic and treatment] services certainly fall within the commonly understood meaning of a 'healing art.'"⁹⁰

Although the American Medical Association (AMA) endorses NP collaboration with physicians, it still opposes the provision of medical care by anyone other than a physician, unless supervised by a physician. The latest AMA House of Delegates

⁸⁰ *Id.* at 685. The physicians were also charged with aiding and abetting the NPs' unauthorized practice of medicine. *Id.* at 684 n. 1.

⁸¹ *Id.* at 684.

⁸² *Id.* at 685.

⁸³ *Id.* at 688.

⁸⁴ *Id.* at 689.

⁸⁵ *Id.*

⁸⁶ The court cited the statutes of 40 other states that had expanded nurses' roles. *Id.* at 690 & n. 6.

⁸⁷ *Cook v. Workers' Comp. Dep't*, 758 P.2d 854, 854-55 (Or. 1988).

⁸⁸ *Id.* at 856 (emphasis added).

⁸⁹ *Id.* at 858.

⁹⁰ *Id.* at 859.

adopted the following language: “Our AMA . . . continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.”⁹¹ Publicly, the AMA takes this position because it believes that NPs lack the appropriate education to properly medically supervise patients. However, financial self-interest and competition clearly play a role.⁹² In reality, the AMA has been fighting a losing battle as state legislatures increasingly offer NP autonomy. Currently, all fifty states provide some form of prescriptive authority to NPs while fourteen states and the District of Columbia allow NPs to practice completely autonomously.⁹³

B. Physician Involvement

The Pearson report⁹⁴ divides state laws regarding physician involvement in NP practice into three categories:⁹⁵ 1) states that do not require any physician involvement (twenty-two states and the District of Columbia);⁹⁶ 2) states that require physician involvement but without written documentation (four states);⁹⁷ and 3) states that require physician involvement documented in writing (twenty-four states).⁹⁸ However, since some states in the first category, such as New Jersey,⁹⁹

⁹¹ Practicing Medicine by Non-Physicians, American Medical Association, House of Delegates, H-160.949(3) (2010) available at <http://www.ama-assn.org/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-160.949.HTM>. NPs also face opposition from some state medical associations. See, e.g., *Pearson Report*, *supra* note 13, available at <http://www.pearsonreport.com/statebystate/statedetails/alabama> (“the [Alabama] Medical Association . . . has informed NPs that they will staunchly oppose any legislation that would expand NP [scope of practice].”).

⁹² Ritter & Hansen-Turton, *supra* note 8, at 22. This cynical view was adopted by one legal commentator who served five years as a public member of a state medical board:

I can’t imagine the hours I have spent listening intently to the differences between . . . the various branches of medicine and nursing. Looking back on it, few of these arguments had anything to do with competency or public safety. It was monopoly and money and not safety and skill that usually were at stake.

Safriet, *Closing the Gap*, *supra* note 63, at 316.

⁹³ Ritter & Hansen-Turton, *supra* note 8, at 24; *infra* note 102 and accompanying text.

⁹⁴ See *supra* note 62.

⁹⁵ *Pearson Report*, *supra* note 13, available at <http://www.pearsonreport.com/tables-maps/category/diagnoses>.

⁹⁶ *Id.* The states are Alaska, Arizona, Colorado, Hawaii, Idaho, Iowa, Kentucky, Maine, Michigan, Montana, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Washington, West Virginia, and Wyoming. *Id.* In Maine, NPs require physician involvement for their first two years of practice. *Id.*

⁹⁷ *Id.* The states are Connecticut, Indiana, Minnesota, and Pennsylvania. *Id.*

⁹⁸ *Id.* The states are Alabama, Arkansas, California, Delaware, Florida, Georgia, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, South Carolina, South Dakota, Texas, Vermont, Virginia, and Wisconsin. *Id.* For a survey of each state’s statute regarding physician involvement, see *Pearson State-By-State*, *supra* note 17 and BUPPERT, *supra* note 2, app. 2-B at 75.

require physician involvement for prescribing medicine,¹⁰⁰ a key component of most treatments,¹⁰¹ the actual number of states in which NPs are truly independent of physicians drops to fourteen (including the District of Columbia).¹⁰² Even in these states, NPs often collaborate and work in teams with physicians, despite the lack of a legal requirement to do so.¹⁰³

Although the majority of states require “physician involvement,” the scope of that term is ambiguous. State laws vary from physical presence to mere phone accessibility.¹⁰⁴ Some states require regular meetings and/or periodic chart reviews.¹⁰⁵ The Pennsylvania NP statute, for example, states that “[a] certified registered nurse practitioner may perform acts of medical diagnosis in collaboration with a physician and in accordance with regulations promulgated by the board.”¹⁰⁶ The regulations clearly explain the meaning of “collaboration”:

A process in which a CRNP works with one or more physicians to deliver health care services within the scope of the CRNP’s expertise. The process includes the following:

- (i) Immediate availability of a licensed physician through direct communications or by radio, telephone or telecommunications.
- (ii) A predetermined plan for emergency services.
- (iii) A physician available to a CRNP on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics and cosigning records when necessary to document accountability by both parties.¹⁰⁷

Similarly to the Pennsylvania statute, many states with physician involvement requirements mandate physician review of patient records. Although most such

⁹⁹ See *infra* note 145 and accompanying text.

¹⁰⁰ See *infra* Part (C).

¹⁰¹ Ritter & Hansen-Turton, *supra* note 8, at 24.

¹⁰² I came to this number by starting with the states in Pearson’s data that did not require physician involvement in practice (listed *supra*, note 96) and removing states which were also on Pearson’s list of states requiring physician collaboration to prescribe (*infra*, note 142). The fourteen states are Alaska, Arizona, District of Columbia, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, Rhode Island, Utah, Washington, and Wyoming.

¹⁰³ *Id.*

¹⁰⁴ Christian et al., *supra* note 6, at 11.

¹⁰⁵ *Id.*

¹⁰⁶ 63 PA. CONS. STAT. § 218.2 (2010).

¹⁰⁷ 49 PA. CODE § 21.251 (2010).

statutes are vague concerning how to implement these “chart reviews,”¹⁰⁸ five states mandate specific percentages.¹⁰⁹ For example, Texas requires that the collaborating physician review at least ten percent of all NP patient charts.¹¹⁰

Missouri imposes a geographic limit on the distance between the NP and collaborating physician. In areas federally designated as “health professional shortage areas,”¹¹¹ the NP and collaborating physician must be no further than fifty miles apart, while in all other areas the maximum distance shrinks to thirty miles.¹¹² Although most states allow for physician supervision to occur remotely, seven states actually require that the physician be onsite for a minimum amount of time.¹¹³ For example, Texas requires that the physician be at the NP’s practice site 2% of the time¹¹⁴ while Alabama has an onsite requirement of 10%.¹¹⁵

Additionally, some states that require physician involvement mandate a maximum number of NPs that one physician can supervise. New York’s requirement of a one to four ratio is typical of such states:¹¹⁶ “No physician shall enter into practice agreements with more than four nurse practitioners who are not located on the same physical premises as the collaborating physician.”¹¹⁷ However, states with such mandated ratios are in the minority.¹¹⁸

As stated above, some states require an explicit written protocol outlining the physician-NP collaboration. The legal terms for these written protocols vary widely from “integrated practice arrangement” (Nebraska) to “written guidelines”

¹⁰⁸ For example, the New York law states that “[e]ach practice agreement shall provide for patient records review by the collaborating physician in a timely fashion but in no event less often than every three months.” N.Y. EDUC. LAW § 6902(3)(c) (McKinney 2010). Although a simple reading of the statute would imply that a physician must review *every* patient record, that implication does not seem to be the case. See *Pearson Report, supra* note 13, <http://www.pearsonreport.com/statebystate/statedetails/new-york> (“[New York requires] a review of a *sample* of patient records by the collaborating physician”) (emphasis added); e-mail from Mary Munding, Founder, Columbia Advanced Practice Nurse Associates, to author (Nov. 22, 2009) (on file with author) [hereinafter Munding e-mail] (“Yu [sic] seem to think EVERY chart has to be reviewed which is not the case.”).

¹⁰⁹ Ritter & Hansen-Turton, *supra* note 8, at 25.

¹¹⁰ TEX. OCC. CODE ANN. § 157.0541(c)(2) (2010). The other states are Alabama (10%), Georgia (25%), Montana (5%), and Tennessee (20%). Ritter & Hansen-Turton, *supra* note 8, at 25.

¹¹¹ See U.S. Department of Health and Human Services, Health Resources and Services Administration, Shortage Designation: HPSAs, MUAs & MUPs, <http://bhpr.hrsa.gov/shortage> (last visited Dec. 18, 2010).

¹¹² MO. CODE REGS. ANN. tit. 20, § 2200-4.200(2)(B) (2010).

¹¹³ Ritter & Hansen-Turton, *supra* note 8, at 24. The states are Alabama, Illinois, Missouri, South Dakota, Tennessee, Texas, and Virginia. *Id.* at 25.

¹¹⁴ TEX. OCC. CODE ANN. § 157.0541(c)(1)(A) (Vernon 2010).

¹¹⁵ ALA. ADMIN. CODE r. 610-X-5-.08(4) (2010).

¹¹⁶ Ritter & Hansen-Turton, *supra* note 8, at 25.

¹¹⁷ N.Y. EDUC. § 6902 (3)(e) (McKinney 2010).

¹¹⁸ Ritter & Hansen-Turton, *supra* note 8, at 25.

(Massachusetts) and “standard care arrangement” (Ohio).¹¹⁹ The protocol “is a written instrument that guides the NP in collecting data from the patient and recommends specific action based upon the collected data. It consists of mutually agreed-upon medical guidelines between the physician and the NP that define the individual and shared responsibilities of the physician and NP.”¹²⁰

For example, the New York statute mandates that the “practice protocol” contains provisions “for the resolution of any disagreement between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment that is within the scope of practice of both.”¹²¹ The agreement must also provide for review of patient records at least every three months.¹²² Furthermore, the New York law requires that the “practice protocol” be filed with the state’s department of education within ninety days and be clearly posted in the “practice setting” of the NP.¹²³

Florida’s regulations go into more detail and require:

1. A description of the duties of the ARNP.
2. A description of the duties of the physician or dentist (which shall include consultant and supervisory arrangements in case the physician or dentist is unavailable).
3. The management areas for which the ARNP is responsible, including
 - a. The conditions for which therapies may be initiated,
 - b. The treatments that may be initiated by the ARNP, depending on patient condition and judgment of the ARNP,
 - c. The drug therapies that the ARNP may prescribe, initiate, monitor, alter, or order.
4. A provision for annual review by the parties.
5. Specific conditions and a procedure for identifying conditions that require direct evaluation or specific consultation by the physician . . .¹²⁴ Similar to New York, Florida requires that the protocol be filed with the state department of health within thirty days of the NP’s license renewal and be “kept at the site of practice of each party to the protocol.”¹²⁵

It should be noted that despite legal requirements of physician involvement, NPs are still able to achieve a significant amount of independence. For example, Columbia Advanced Practice Nurse Associates (“CAPNA”), a primary care facility

¹¹⁹ Christian et al., *supra* note 6, at 12.

¹²⁰ BUPPERT, *supra* note 2, at 45. For a sample protocol provided by the Florida Department of Health, see *ARNP Protocol*, FLORIDA DEPARTMENT OF HEALTH, <http://www.doh.state.fl.us/Mqa/nursing/ProtocolSample.htm> (last visited Dec. 18, 2010).

¹²¹ N.Y. EDUC. § 6902(3)(a) (McKinney 2010).

¹²² N.Y. EDUC. § 6902(3)(c) (McKinney 2010)..

¹²³ N.Y. EDUC. § 6902 (3)(c)-(d) (McKinney 2010)..

¹²⁴ FLA. ADMIN. CODE ANN. r. 64B9-4.010(2)(b) (2010).

¹²⁵ FLA. ADMIN. CODE ANN. r. 64B9-4.010(3) (2010).

in New York City associated with the Columbia University School of Nursing, treats over 3,000 patients.¹²⁶ CAPNA is fully staffed by NPs¹²⁷ and “provides comprehensive primary care by advanced practice nurses who diagnose and treat illnesses, perform physical examinations, order diagnostic tests and refer to specialists as needed.”¹²⁸ CAPNA emphasizes that its NPs are capable and certified by insurance companies to be a patient’s primary care provider.¹²⁹ However in accordance with New York’s collaborative requirements, CAPNA’s NPs “work in partnership with the more than 2,000 physicians at New York-Presbyterian Hospital.”¹³⁰

Removing legal requirements of physician involvement tops the agenda for many state NP lobbying programs. For example, in New York, the Nurse Practitioner Association has introduced legislation to eliminate the statutory requirement of collaboration.¹³¹ In 2005, the Oregon legislature accepted the changes of “a team of 38 NPs who reviewed more than 750 statutes” with the goal of identifying physician-specific statutes which could be made NP inclusive.¹³²

C. Prescriptive Authority

Despite opposition from the medical establishment, NPs have gained the legal right to prescribe medicine in all fifty states, with Georgia being the final state to approve in 2006.¹³³ State laws require that NPs demonstrate proficiency in pharmacology. For example, Rhode Island requires completion of thirty hours of pharmacological education.¹³⁴

¹²⁶ Mundinger e-mail, *supra* note 108. CAPNA opened in 1998. See CAPNA faq, *supra* note 4.

¹²⁷ The founder of CAPNA, Mary Mundinger, is the Dean of the Columbia University School of Nursing. The four other NP providers are all faculty members at the nursing school. See *CAPNA Practitioners*, COLUMBIA UNIVERSITY SCHOOL OF NURSING: CAPNA, <http://www.capna.com/practitioners.html> (last visited Dec. 18, 2010).

¹²⁸ *About CAPNA*, COLUMBIA UNIVERSITY SCHOOL OF NURSING: CAPNA, <http://www.capna.com/about.html> (last visited Dec. 18, 2010).

¹²⁹ CAPNA faq, *supra* note 4.

¹³⁰ *About CAPNA*, *supra* note 128. See also Tina Kelley, *Like a Doctor's Office, With a Little More Time*, N.Y. TIMES, Apr. 25, 2000, at F7 (interviewing an NP and patient at CAPNA in which the NP referred the patient to a cardiologist). However, when asked about how CAPNA implements the New York requirements of chart review and physician collaboration given CAPNA’s large number of patients, Dean Mundinger was evasive. She characterized the New York law as “consultative” rather than “supervisory” and stated that NPs were the ones who initiated the consultations. Mundinger e-mail, *supra* note 108.

¹³¹ See Pearson, *supra* note 13, at <http://www.pearsonreport.com/statebystate/statedetails/new-york> (last visited Mar. 6, 2011); *S00324 Summary*, NEW YORK STATE ASSEMBLY, available at <http://assembly.state.ny.us/leg/?bn=S00324&term=2011> (last visited Mar. 4, 2011).

¹³² See Pearson, *supra* note 13, at <http://www.pearsonreport.com/statebystate/statedetails/oregon> (last visited Mar. 6, 2011).

¹³³ Ritter & Hansen-Turton, *supra* note 8, at 24.

¹³⁴ R.I. GEN. LAWS § 5-34-39(b) (2010).

Physicians had argued that NPs lacked the required medical training to properly diagnose and prescribe the correct medicines.¹³⁵ They further argued that only they were competent to identify the symptoms of adverse drug events (ADEs)¹³⁶ and neutralize such problems.¹³⁷ However, even critics agreed that NPs were better at taking comprehensive medical histories¹³⁸ thereby avoiding potential ADEs such as prescribing penicillin for a patient with a penicillin allergy. Subsequent studies have shown that clinical offices in diverse settings create the same number of ADEs independent of the number of NPs who work in the clinics.¹³⁹

Although all states permit some form of prescriptive authority for NPs, the scope of that authority varies from state to state in two key aspects: physician supervision and prescribing of controlled substances. Fourteen states and the District of Columbia have “no requirement for any physician involvement” in NP prescribing.¹⁴⁰ New Hampshire, for example, contains a very clear and concise statute authorizing NP prescriptive power: “[a]n APRN shall have plenary authority to possess, compound, prescribe, administer, and dispense and distribute to clients controlled and non-controlled drugs within the scope of the APRN’s practice . . .”¹⁴¹ Thirty-six states impose a requirement of physician involvement.¹⁴² The statutes requiring physician involvement vary in language including: collaboration, supervision, direction, authorization, or delegation.¹⁴³ For example, in sixteen states

¹³⁵ Phyllis Coleman & Ronald A. Shellow, *Extending Physician’s Standard of Care to Non-Physician Prescribers: The Rx for Protecting Patients*, 35 IDAHO L. REV. 37, 50 (1998).

¹³⁶ ADEs are “injuries caused by medicine that jeopardize the health and lives of people.” *Id.* at 39. “An example of a preventable ADE is an amoxicillin-associated rash in a patient who was inadvertently prescribed amoxicillin despite a known allergy.” Kaushal et al., *7 Adverse Drug Events in Pediatric Outpatients*, AMBULATORY PEDIATRICS 383, 384 (Sept.-Oct. 2007).

¹³⁷ Coleman & Shellow, *supra* note 135, at 50-51. “[E]ven ordinarily benign drugs have side effects which may affect individuals in unusual ways.” *Id.* at 57.

¹³⁸ *See id.* at 61 (citing a study that NPs “were far more likely than physicians to seek further patient history before deciding on a treatment plan”).

¹³⁹ *See* Kaushal et al., *supra* note 136, at 386 (showing ADE study of six medical offices in which the number of NPs ranged from 0% to 27% and found that the number of ADEs were similar between the offices). It should be noted that it was not the purpose of the study to compare NPs’ and physicians’ relative rates of ADEs and that such conclusions are the author’s.

¹⁴⁰ *See* Pearson, *supra* note 13, at <http://www.pearsonreport.com/tables-maps/category/prescribing>. The fourteen states without any physician requirement are Alaska, Arizona, Colorado, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, Rhode Island, Utah, Washington, and Wyoming. Colorado requires a “one-time signed articulated plan” while Maine only permits NPs to prescribe after two years of practice. *Id.* at <http://www.pearsonreport.com/statebystate/statedetails/colorado>.

¹⁴¹ N.H. REV. STAT. ANN. § 326-B:11(III) (2010).

¹⁴² Pearson, *supra* note 13, at <http://www.pearsonreport.com/tables-maps/category/prescribing>. Utah only requires collaboration for schedules II-III drugs (*see infra* notes 147-152 and accompanying text). *Id.*

¹⁴³ *See* Pearson, *supra* note 17.

the law requires that the NP's prescription pad contain the collaborating physician's name.¹⁴⁴ New Jersey's law clearly delineates the requirements of physician collaboration for an NP to prescribe drugs:

- (1) the collaborating physician and advanced practice nurse shall address in the joint protocols whether prior consultation with the collaborating physician is required to initiate a prescription for a controlled dangerous substance;
- (2) the prescription is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the advanced practice nurse, or pursuant to the specific direction of a physician; . . .
- (3) the prescription is dated and includes the name of the patient and the name, address and telephone number of the collaborating physician;
- (4) the physician is present or readily available through electronic communications;
- (5) the charts and records of the patients treated by the advanced practice nurse are periodically reviewed by the collaborating physician and the advanced practice nurse;
- (6) the joint protocols developed by the collaborating physician and the advanced practice nurse are reviewed, updated and signed at least annually by both parties¹⁴⁵

Additionally some of these states specify the maximum number of prescribing NPs that a physician can supervise.¹⁴⁶

Even when the NP follows the state's proper procedure for prescribing, he or she may be limited in the types of drugs that he or she can prescribe. The Drug Enforcement Agency classifies certain drugs that are prone to abuse as controlled substances.¹⁴⁷ These controlled drugs are further classified into five schedules.¹⁴⁸ Schedule I drugs, which have no medical use (such as heroin),¹⁴⁹ may not be prescribed by anyone, including physicians.¹⁵⁰ Schedule II includes drugs with high abuse potential (such as morphine) while schedules III through V include drugs such

¹⁴⁴ *Id.* See also BUPPERT, *supra* note 2, at 185 (showing that conflicting data was resolved in favor of Pearson, which is more recent). The states are Alabama, Georgia, Hawaii, Illinois, Kansas, Louisiana, Massachusetts, Michigan, Missouri, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Texas.

¹⁴⁵ N.J. STAT. ANN. § 45:11-49(c) (West 2010). For a survey of each state's statute regarding NP prescriptive authority, see Pearson, *supra* note 17; BUPPERT, *supra* note 2, app. 5-A at 188.

¹⁴⁶ See, e.g., 18 VA. ADMIN. CODE § 90-40-100(A) (2010); N.Y. EDUC. § 6902 (3)(e) (McKinney 2010) (both stating a physician cannot supervise more than four prescribing NPs at one time).

¹⁴⁷ 21 U.S.C. § 812 (2010).

¹⁴⁸ *Id.*

¹⁴⁹ See *id.*

¹⁵⁰ See 21 U.S.C. § 829 (2010).

as stimulants and depressants.¹⁵¹ While physicians can universally prescribe for schedules II through V,¹⁵² state laws vary regarding NPs. Alabama and Florida are the only states in which NPs are not allowed to prescribe any controlled substances.¹⁵³ In Georgia, Michigan, Missouri, Oklahoma, South Carolina, Texas, and West Virginia, NPs are partially or completely prohibited from prescribing schedule II drugs.¹⁵⁴ In all other states, including the District of Columbia, NPs can prescribe (subject in some states to physician involvement) for schedules II through V.¹⁵⁵

D. Identification

As mentioned above, NPs can attain the degree of “Doctor of Nurse Practitioner” (DNP).¹⁵⁶ As part of their opposition to the DNP degree,¹⁵⁷ physicians have lobbied state legislatures to impose limitations on how DNPs identify themselves. Six states statutorily prohibit DNPs from being addressed as “Doctor NP.”¹⁵⁸ Nine other states allow DNPs to be addressed as “doctor” only if the DNP clarifies that he or she is actually an NP.¹⁵⁹ Additionally, some states even require non-doctorate NPs “to wear some form of identification that visibly and unambiguously identifies them.”¹⁶⁰

IV. MEDICAL REIMBURSEMENT

On the federal level, NPs achieved Medicare provider status in 1997 with the passage of the Balanced Budget Act.¹⁶¹ Provider status allowed NPs to receive direct

¹⁵¹ 21 U.S.C. § 812 (2010).

¹⁵² See 21 U.S.C. § 829 (2010).

¹⁵³ See Pearson, *supra* note 17; Hannah Wolfson, *Alabama’s Nurse Practitioners Want More Independence*, BIRMINGHAM NEWS (Nov. 7, 2010), available at http://blog.al.com/spotnews/2010/11/alabamas_nurse_practitioners_w.html (noting the failure of NP advocates to change the law in Alabama).

¹⁵⁴ See Pearson, *supra* note 17.

¹⁵⁵ See *id.* See also BUPPERT, *supra* note 2, at 185.

¹⁵⁶ See *supra* notes 30-35 and accompanying text.

¹⁵⁷ See Landston, note 34 and accompanying text.

¹⁵⁸ Pearson, *supra* note 13, at <http://www.pearsonreport.com/summary>. The six states are Arkansas, Connecticut, Georgia, Maine, Mississippi, and South Dakota. *Id.* Oregon removed this restriction in 2009. See Pearson, *supra* note 13, at <http://www.pearsonreport.com/statebystate/statedetails/oregon>.

¹⁵⁹ *Id.* at <http://www.pearsonreport.com/summary>. These states are Arizona, Illinois, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, and Virginia.

¹⁶⁰ Bertness, *supra* note 21, at 251-52. See, e.g., GA. CODE ANN. § 43-26-6(c) (2010):

Any person who is licensed as a[n advanced practice nurse] . . . shall identify that he or she is so licensed by displaying . . . the title “advanced practice registered nurse,” or the abbreviation “A.P.R.N.” on a name tag or other similar form of identification during times when such person is providing direct patient care.

¹⁶¹ John Michael O’Brien, *How Nurse Practitioners Obtained Provider Status: Lessons for Pharmacists*, 60 AM. J. HEALTH-SYS. PHARMACY 2301, 2303 (2003) (citing Balanced Budget Act of 1997, Pub. L. No. 105-33).

reimbursement, albeit at a rate of 85% of the physician fee schedule.¹⁶² Direct reimbursement benefits NPs because it allows them to generate more revenue based on more procedures performed.¹⁶³ Achieving Medicare provider status was a landmark for the NP profession in that it established NPs as “legitimate independent providers of primary and specialty care.”¹⁶⁴

While the federal legislation was important symbolically, most insurance regulation occurs on the state level. Compensation of NPs by managed care organizations (MCOs) can take the form of either salary arrangements or direct reimbursement.¹⁶⁵ While “[t]wenty-four states and the District of Columbia have enacted legislation” that allows for “some level of inclusion” of NPs in managed care payment schemes,¹⁶⁶ most state insurance regulatory schemes do not mandate direct reimbursement of NPs.¹⁶⁷

Some states, such as New York¹⁶⁸ and Arkansas,¹⁶⁹ allow NPs to be included as “primary care gatekeepers” for managed care.¹⁷⁰ Other states mandate “any willing provider” rules that require MCOs to credential any provider who meets the terms of the MCO’s provider agreement.¹⁷¹ These laws are designed to protect against non-physician discrimination in the health insurance market.¹⁷² Despite such legislative enactments, MCOs themselves are not always willing to credential NPs as primary care providers. In a 2007 study, researchers found that only 53% of MCOs allowed

¹⁶² BUPPERT, *supra* note 2, at 270. However if the NP provides his or her services “incident to” a physician working on site, he or she is entitled to 100% reimbursement. *Id.* at 271. However, such monies would go to the physician with the NP receiving a set salary. Obviously, NPs desire to bill independently.

¹⁶³ *Id.* at 270.

¹⁶⁴ Eileen M. Sullivan-Marx & David Keepnews, *Systems of Payment for Advanced Practice Nurses*, NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE 391, 391 (2003).

¹⁶⁵ *Id.* at 396.

¹⁶⁶ *Id.*

¹⁶⁷ Christian et al., *supra* note 6, at 15.

¹⁶⁸ N.Y. COMP. CODES R. & REGS. tit. 10, § 98-1.2(hh) (2010).

¹⁶⁹ ARK. CODE ANN. § 23-99-203(d) (2010).

¹⁷⁰ Sullivan-Marx & Keepnews, *supra* note 164, at 396. *See also About CAPNA*, *supra* note 128 (stating that CAPNA NPs are recognized as “primary care provider[s] by major insurance companies”).

¹⁷¹ Tine Hansen-Turton et al., *Insurer’s Contracting Policies on Nurse Practitioners as Primary Care Providers*, 9 POL’Y, POL., & NURSING PRAC. 241, 244 (Nov. 2008).

¹⁷² *See, e.g.*, ARK. CODE ANN. § 17-87-311(b) (2010) (stating “[t]he agency administering the state Medicaid program shall not discriminate against practitioners providing covered services within the scope of their practice based on the type of practitioner”); ARK. CODE ANN. § 23-99-204(a)(3)(2010) (stating “[a] health care insurer shall not, directly or indirectly . . . [p]rohibit or limit a health care provider that is qualified under § 23-99-203(d) [which includes NPs] and is willing to accept the health benefit plan’s operating terms and conditions, schedule of fees . . . from the opportunity to participate in that plan”).

for credentialing of NPs.¹⁷³ Among these MCOs, only 56% reimbursed the NPs at the same rate as primary care physicians.¹⁷⁴ Furthermore, the study found that the rate of NP credentialing and reimbursement was unaffected by the state's laws requiring equal insurance treatment of non-physicians.¹⁷⁵ Even among MCOs that participated in Medicaid, a federal program administered by the states, only 73% credentialed NPs.¹⁷⁶ This figure is startling if not illicit considering that federal regulation prohibits provider discrimination by MCOs participating in the Medicaid program.¹⁷⁷

The study also found a strong correlation between MCO credentialing of NPs and state laws requiring physician involvement for NPs to prescribe.¹⁷⁸ In states that did not require physician involvement, MCO credentialing of NPs rose to 71%.¹⁷⁹ That figure dropped to 50% in states that required some form of physician involvement for NPs to prescribe.¹⁸⁰ This suggests that state policies directly affecting NP autonomy have a greater effect on the private insurance market than state mandates that aim to prevent insurance discrimination by insurers. This correlation is not surprising given that insurers will be more willing to credential NPs who can provide services at a cost effective rate because they are not required by law to collaborate with a (costly) physician.¹⁸¹

This means that NP autonomy is essential if health care costs are to be lowered through the use of NP-run clinics. Adequate reimbursement by insurers is essential for the economic viability of these clinics as indicated by the statistic that 39% of nurse-managed health centers that received federal funding between 1993 and 2001 have since closed.¹⁸² Retail health care clinics, which provide low cost basic health

¹⁷³ Hansen-Turton et al., *supra* note 171, at 243.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 244.

¹⁷⁶ *Id.* at 245.

¹⁷⁷ See 42 C.F.R. § 438.12(a)(1) (2010) (stating “[a]n MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification”).

¹⁷⁸ Hansen-Turton et al., *supra* note 171, at 246.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ Physicians have also tried to preclude NPs from primary care physician status by trying to deny NPs hospital privileges. See BUPPERT, *supra* note 2, at 227. However, state legislatures have not taken up their cause, as only two states, Ohio and Maine, have significant statutory hurdles for an NP to gain hospital privileges. See Pearson, *supra* note 17. The reason seems to be that hospitals want to grant privileges to as many people as possible in order to be profitable. See BUPPERT, *supra* note 2, at 227. *But see* Bertness, *supra* note 21, at 249 (stating “[p]resently, no Rhode Island hospitals grant NPs admitting privileges.”).

¹⁸² Hansen-Turton et al., *supra* note 171, at 242.

services in drug, grocery, and mass merchandise retailers,¹⁸³ depend on employing NPs to be profitable.¹⁸⁴ If NPs are not directly reimbursed by insurers, let alone credentialed, these clinics find it difficult to do business.¹⁸⁵

V. MALPRACTICE

As professionals, NPs are subject to malpractice suits.¹⁸⁶ Generally the standard of care for an NP is that of a reasonably prudent NP, not of a physician.¹⁸⁷ Such a standard would probably be applied when the NP fails to recognize that a diagnosis or treatment is outside of the NP's abilities and fails to refer the patient to an appropriate physician. However, jurisdictions are split on whether an NP can be held to a physician's standard of care when performing services that overlap a physician's scope of practice, such as diagnosis or drug prescribing.¹⁸⁸

California follows the majority view¹⁸⁹ that an NP is held to the standard of a reasonably prudent NP. In *Fein v. Permanente Medical Group*, the plaintiff claimed that his NP misdiagnosed his heart attack as a mere muscle spasm.¹⁹⁰ The defendant insurer appealed the trial judge's jury instruction that "the standard of care required of a nurse practitioner is that of a physician and surgeon . . . when the nurse practitioner is examining a patient or making a diagnosis."¹⁹¹ The court agreed that the trial judge had erred, and the plaintiff was "entitled to have the jury determine whether . . . [the nurse] met the standard of care of a reasonably prudent nurse practitioner."¹⁹² According to the majority rule, NPs would be the most qualified to serve as expert witnesses on the issue of an NP's standard of care.¹⁹³

Since NPs in some states must collaborate with physicians, the question arises whether a physician can be held liable for the NP's negligence. In *State ex rel.*

¹⁸³ Scott, *supra* note 43, at 6. The retail clinic concept took off in 2006 with the opening of 220 new clinics. As of 2007, there were about 500 such clinics in thirty-six states with 2500 to 6000 expected by the end of 2012. *Id.*

¹⁸⁴ *Id.* at 22.

¹⁸⁵ *Id.*

¹⁸⁶ BUPPERT, *supra* note 2, at 236.

¹⁸⁷ *Id.* at 237.

¹⁸⁸ Bertness, *supra* note 21, at 245; BUPPERT, *supra* note 2, at 237.

¹⁸⁹ Coleman & Shellow, *supra* note 135, at 77.

¹⁹⁰ *Fein v. Permanente Med. Group*, 695 P.2d 665, 669 (Cal. 1985); Coleman & Shellow, *supra* note 135, at 75-79.

¹⁹¹ *Fein*, 695 P.2d at 673.

¹⁹² *Id.* at 674. *Accord* *Simonson v. Keppard*, 225 S.W.3d 868, 873 (Tex. Civ. App. 2007) (holding "[e]ven when making a diagnosis, an advanced practice nurse remains accountable for advanced practice nursing care not a physician's care.") *But see* Coleman & Shellow, *supra* note 135, at 83, 78 (arguing in favor of the minority view that physicians and NPs should be held "to the same standard of care when they perform the same task" because applying the majority rule "lower[s] the bar" of quality of care provided by NPs). Coleman and Shellow also note the irony that NPs, who generally fight for equality with physicians, support the lower standard of care. *Id.* at 78.

¹⁹³ Coleman & Shellow, *supra* note 135, at 81.

Howenstine v. Roper, the plaintiff claimed that a drug prescribed by an NP destroyed his liver.¹⁹⁴ The plaintiff argued that since the NP had a collaborative agreement with Dr. Howenstine, as required by Missouri law, Dr. Howenstine should be held vicariously liable for the NP's malpractice.¹⁹⁵ The Missouri Supreme Court rejected this argument stating "[t]he treatment provided by the [NP] to [the plaintiff] was under independent statutory authority, not under Dr. Howenstine's medical license."¹⁹⁶ In other words, even though Missouri law requires NPs to have a written protocol with a physician, their actions are autonomous and cannot be attributed to the collaborating physician.¹⁹⁷ Although the courts have held that a physician cannot be held vicariously liable for an NP's negligence, he or she can be sued for negligently hiring the NP or failing to properly supervise the NP.¹⁹⁸

VI. CONCLUSION

As cost-effective and qualified providers, NPs can play an important role in alleviating the health care crisis. The key to affordable health care is quick and affordable access to primary care providers who can provide preventative care, detect illnesses before they balloon into medical crises, and educate patients about healthy living.¹⁹⁹ Unfortunately, the number of medical school graduates entering the field of primary care is declining, mainly due to the high cost of education and the low financial return of family practice when compared to the specialties.²⁰⁰ However, a simple solution already exists: NPs. NPs have become an increasingly visible presence in the primary care arena as new modes of health care delivery, such as NP-run retail clinics, have emerged.²⁰¹ While the federal government can incentivize the use of NPs,²⁰² it will ultimately be up to the states to expand NP

¹⁹⁴ *State ex rel. Howenstine v. Roper*, 155 S.W.3d 747, 749 (Mo. 2005).

¹⁹⁵ *Id.* at 751, 753.

¹⁹⁶ *Id.* at 754.

¹⁹⁷ *Accord Monahan v. Obici Med. Mgmt. Servs.*, 59 Va. Cir. 307, 308, 311 (Va. Cir. Ct. 2002) (holding that the plaintiff, claiming misdiagnosis by an NP, cannot sue an NP's collaborating physician who never saw the plaintiff. The collaborative agreement between an NP and a physician does not *ipso facto* create a consensual relationship between the patient and the physician).

¹⁹⁸ See BUPPERT, *supra* note 2, at 245; Bertness, *supra* note 21, at 247; Howenstine, 155 S.W.3d at 754 (considering the possibility that Dr. Howenstine breached a duty to supervise the NPs in his clinic but ultimately dismissing the claim because of Dr. Howenstine's public immunity). *But see Monahan*, 59 Va. Cir. at 312 (stating, "[t]his new species of medical malpractice claim, based entirely on supervisory liability, is wholly unknown in the common law").

¹⁹⁹ See *supra* notes 44-51 and accompanying text.

²⁰⁰ See *supra* notes 36-39 and accompanying text.

²⁰¹ See Scott, *supra* note 183 and accompanying text.

²⁰² The 2010 health care reform legislation includes a number of important provisions relating to NPs. See Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 296j-1 (2010) (creating training programs for NPs to serve as primary care providers in federally qualified health centers and nurse-managed health clinics) and *Health Care Reform: Key Provisions Related to Nursing*, AMERICAN NURSES ASSOCIATION,

practice. To fully utilize NP expertise, states should remove barriers to NP practice such as highly restrictive physician collaborative agreements that only serve to increase the cost of health care.²⁰³ NPs will be able to provide quick and affordable access to primary care, allowing more highly trained physicians to concentrate on more acute illnesses.²⁰⁴

http://www.nursingworld.org/MainMenu_Categories/HealthcareandPolicyIssues/HealthSystemReform/Key-Provisions-Related-to-Nurses.aspx (last visited Mar. 4, 2011) (providing \$50 million in grants towards graduate level nursing schools); *id.* (including NPs as authorized providers in the new Medicare “independence at home” pilot program). The act clarifies that it is not usurping the states’ powers to regulate NPs. *See id.* § 1395cc-5(b)(2)(B) (“stating [the NP] is acting consistent with State law”). *See also H.R. 3200 Frequently Asked Questions*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama1/pub/upload/mm/399/hsr-hr3200-faqs.pdf> (last visited Dec. 18, 2010) (asserting AMA opposition to NP participation in the Medicare pilot program). *See generally Patient Protection and Affordable Care Act: Nursing Education and Practice Provisions*, AMERICAN ASSOCIATION OF COLLEGES OF NURSING, <http://www.aacn.nche.edu/government/pdf/HCRreview.pdf> (last visited Dec. 18, 2010).

²⁰³ *See supra* sec. III.

²⁰⁴ *See supra* notes 44-51 and accompanying text.