ADVANCED NURSING PRACTICE AND PRESCRIPTIVE AUTHORITY: A VICTORY FOR NEW JERSEY NURSES

I. Introduction

The scope of professional nursing practice has been steadily expanding to meet the health care needs of the public.[1] Advanced education and specialty clinical training have enabled many nurses to provide primary health care services.[2] Unfortunately, statutory barriers to practice have prevented these nurses from rendering complete patient care.[3] The State of New Jersey has recently removed these barriers by amending the New Jersey

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[1] *See* Susan McGrath, *The Cost-Effectiveness of Nurse Practitioners*, 15 NURSE PRACTITIONER 40 (1990). Nurses in advanced practice roles provide cost-effective health care services. *Id.* at 40. The availability of these services not only improves health care access but also the quality of care, since nurse practitioner services emphasize disease prevention and health promotion. *Id.*

[2] *See* AMERICAN NURSES' CREDENTIALING CENTER, CERTIFICATION CATALOG (1992) [hereinafter ANA CREDENTIALING CATALOG]. Primary health care is defined as follows:

> "[A] basic level of health care, usually provided in an outpatient [or community] setting, that emphasizes a patient's general health needs." The most frequently emphasized aspects of primary health caregiving focus on "first contact care" which is accessible, comprehensive, coordinated, continuous, and accountable. The patient-oriented rather than disease-oriented focus of primary care emphasizes preventative measures, such as immunizations and health assessments, as well as the diagnosis and management of commonly occurring conditions such as acute and chronic illnesses.

Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 422 (1992) (quoting in part OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, OTA-H-434, HEALTH CARE IN RURAL AMERICA 483 (1990) and citing in part INSTITUTE OF MEDICINE, A MANPOWER POLICY FOR PRIMARY HEALTH CARE: REPORT OF A STUDY 1 (1978); U.S. DEPT. OF HEALTH & HUMAN SERVICES, SEVENTH REPORT TO THE PRESIDENT AND CONGRESS OF THE STATUS OF HEALTH PERSONNEL IN THE UNITED STATES IV-D-1 (1990)).

[3] Safriet, *supra* note 2, at 421. The author states that "our nationwide health care system imposes numerous disabilities on patients or would-be-patients seeking care, and on many of those who would care for them. Chief among these are conflicting and restrictive state provisions governing the scope of practice and prescriptive authority for [nurse practitioners]. . ." *Id.* at 440. Statutory barriers to advanced nursing practice also include insurance reimbursement for rendered services. *Id.* at 421. Nursing research has indicated that the most important facilitator effecting prescriptive authority is the opportunity to provide total patient care. Margo Arrants Griffin, An Exploratory Study of the Influencing Factors of Prescrip-

Nurse Practice Act.[4] Senate Substitute for S. 3491 [hereinafter S.S. 3491], enacted in 1992, defines advanced nursing practice and expands the tasks which may be performed by a certified nurse practitioner or clinical nurse specialist.[5] Prescriptive authority is included within this broadened scope of practice.[6]

The nursing profession has been attempting to expand the scope of nursing practice for many years.[7] New Jersey's statutory recognition of advanced practice and prescriptive authority is a significant and exciting accomplishment for the nursing community. The following legislative note will discuss the enactment of amendments to New Jersey's Nurse Practice Act within the context of the health care delivery system and the history of nursing practice.

An overview of the legal regulation and history of nursing practice will be provided in part II of the note. Part III will define advanced nursing practice and identify health care changes which have necessitated the demand for expanded nurse practitioner services. A history of prescriptive authority and the identification of various statutory methods utilized in the regulation of prescriptive practice will be discussed in part IV. Part V will address the specific provisions of the statutory amendments, including the legislative history, policy considerations and the current status of the enacted bill. The professional and legal considerations of the advanced practice amendments will be discussed in parts VI and VII, respectively. Part VIII will set forth the current status of prescriptive authority legislation in other states, and, lastly, part IX will address the impact that the advanced practice amendments will have on health care in New Jersey.

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tive Authority for Nurse Practitioners 163 (1992) (unpublished Ed.D dissertation, Seton Hall University) (on file with the *Seton Hall Legislative Bureau*).

[4] New Jersey Nurse Practice Act, L. 1947, c. 262, § 1 (codified at N.J. STAT. ANN. § 45.11 (West Supp. 1992)..

[5] S.S. 3491, 204th Leg., 2d Sess. (1991) (codified in scattered sections of N.J. STAT. ANN. § 45 (West Supp. 1992)) [hereinafter S.S. 3491]. A nurse practitioner is a registered nurse who possesses advanced nursing education and clinical training beyond the requirements of state licensure. Safriet, *supra* note 2, at 423-24.

[6] S.S. 3491, *supra* note 4. *See infra* note 93.

[7] *See* Elizabeth Harrison Hadley, *Nurses and Prescriptive Authority: Legal and Economic Analysis*, 15 AM. J.L. & MED. 245, 248-50 (1989).

II. The Legal Regulation of Nursing Practice

A. *General Overview*

The authority for the legal regulation of nursing, medical and other health care practice belongs to state governments.[8] The state legislatures have defined the practice of nursing through the enactment of nurse practice acts.[9] It is the responsibility of a state regulating body to promulgate rules and regulations pursuant to those acts.[10] In twenty-seven states the exclusive regulating body is the board of nursing and in the remaining states the regulating body is the board of medicine, board of health or a joint board of nursing and medicine.[11]

The policy reason for regulating nursing practice is to protect public health, safety and welfare.[12] The state regulating body develops and maintains standards for nursing practice which reflect the minimum requirements necessary to assure that the public is provided with safe and competent health care.[13] The state usually ensures that minimum requirements are met by restricting nursing practice to those individuals who have fulfilled certain licensing criteria.[14] Licensure is defined as follows:

> [A] process by which an agency of state government grants permission to individuals accountable for the practice of a profession to engage in the practice of that profession and prohibits all others from legally doing so. It permits use of a particular title. . . . Effective means are employed for taking action against licensees for acts of professional misconduct, in-

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8 *Id.* at 248. *See also* NAT'L COUNCIL OF STATE BOARDS OF NURSING, NATIONAL COUNCIL OF STATE BOARDS OF NURSING POSITION PAPER ON THE LICENSURE OF ADVANCED NURSING PRACTICE 2 (May 18, 1992) [hereinafter NCSBN POSITION PAPER]. The professional association retains the authority for professional regulation. Interview with Muriel M. Shore, Member, New Jersey State Board of Nursing and American Nurses' Association Board (Oct. 12, 1992). Professional regulations include standards of practice. *Id. See also Advanced Practice Nursing: A New Age in Health Care,* NURSING FACTS (Am. Nurses' Ass'n 1992) [hereinafter NURSING FACTS].

9 Hadley, *supra* note 7, at 248.

10 *Id.*

11 THE AMERICAN NURSES' ASSOCIATION, THE REGULATION OF ADVANCED NURSING PRACTICE AS PROVIDED FOR IN NURSING PRACTICE ACTS AND ADMINISTRATIVE RULES 2 (1991) [hereinafter ANA: REGULATION OF ADVANCED PRACTICE].

12 *See* NCSBN POSITION PAPER, *supra* note 8, at 2.

13 *Id. See also* Hadley, *supra* note 7, at 248.

14 Safriet, *supra* note 2, at 441.

competence, and/or negligence.[15]

The New Jersey Nurse Practice Act is located in title 45, chapter 11 of the New Jersey Statutes Annotated. The body that regulates nursing practice in New Jersey is the State Board of Nursing, a subdivision of the Department of Law and Public Safety, Division of Consumer Affairs.[16] Prior to the enactment of S.S. 3491 in 1992, licensure was the exclusive method by which the Board of Nursing ensured minimum practice requirements in New Jersey.[17] The advanced practice amendments now set forth a certification process to regulate prescriptive authority.[18]

B. *The History of Nurse Practice Acts and the Expanding Scope of Nursing Practice*

Advanced practice and prescriptive authority legislation is an outgrowth of nurse practice acts.[19] The history of nurse practice acts reflects the states' slow recognition of independent nursing services.

The history of nurse practice acts is divided into three phases.[20] Between the years 1903 and 1938, state statutes merely regulated the use of the title "registered nurse" rather than actually define the scope of nursing practice.[21] Between 1939 and 1971, states recognized the need to regulate professional practice.[22] This recognition led to the enactment of nurse practice acts which not only defined the scope of nursing practice but also

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15 THE AMERICAN NURSES' ASSOCIATION, THE STUDY OF CREDENTIALING IN NURSING: A NEW APPROACH, THE REPORT OF THE COMMITTEE 6 (1979) [hereinafter ANA: STUDY OF CREDENTIALING]. The American Nurses' Association cites that professional nurses "should be the only licensed members of the occupation." *Id.* at 7.

16 *See* THE NEW JERSEY STATE BOARD OF NURSING, GUIDELINES FOR THE PRIMARY HEALTH CARE NURSE/NURSE PRACTITIONER (May 20, 1986) [hereinafter GUIDELINES FOR PRIMARY HEALTH CARE].

17 *See* N.J. STAT. ANN. § 45:11 (West Supp. 1992).

18 N.J. STAT. ANN. § 45:11-47 (West Supp. 1992).

19 Griffin, *supra* note 3, at 42.

20 Hadley, *supra* note 7, at 248.

21 *Id.* North Carolina was the first State to pass a nurse registration act in 1903. *Id.* at 248-49. New York, New Jersey and Virginia passed similar acts in the same year, and by 1923 all the states had nurse registration acts. *Id.* at 249. At this time, any individual could work as a nurse but only those who were licensed could actually hold themselves out to be a "registered nurse." Griffin, *supra* note 3, at 42 (citing Elizabeth Harrison Hadley, *Nurses and Prescriptive Authority: Legal and Economic Analysis*, 15 AM. J.L. & MED. 245 (1989)).

22 *See* Griffin, *supra* note 3, at 42; Hadley, *supra* note 7, at 249.

prohibited the practice of nursing without a license.[23] After 1971, the expanding role of nursing practice was finally acknowledged by state legislatures and nurse practice acts were amended to qualify or repeal statutory prohibitions that had prevented nurses from engaging in diagnosis or treatment.[24]

The staggering evolution of nurse practice acts demonstrates the tension between physicians and professional nurses within the health care delivery system.[25] State medical practice acts, which were first promulgated in the 1880s, define the practice of medicine broadly and exclusively reserve the performance of medical tasks to physicians.[26] Unfortunately, most nurse practice acts define nursing to be the performance of tasks done pursuant to the supervision of a physician; hence, nursing practice has traditionally been treated as "complementary" to physician services, rather than as an "independent service."[27]

The statutory prohibition of independent nursing services became increasingly impracticable as the scope of nursing practice expanded to include tasks that were previously exclusive to the medical profession.[28] Since World War II, the scope of nursing practice has increased to meet the public's health care needs.[29] The restrictive "complementary" role of nursing has weakened as broader definitions of nursing practice, coupled with the efforts of professional nursing organizations, have enabled certain nursing services to be finally recognized as a substitute for physician services.[30] The effort to obtain prescriptive practice constitutes the latest attempt by professional nurses to serve in an independent, substitutive role within the health care

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23 *See* Hadley, *supra* note 7, at 249.

24 *Id.*

25 *Id.* at 250.

26 *Id.*

27 *Id.* Hadley states that "[i]n economic terms, the initial regulatory scheme required nurses' services to be complementary to physicians' services. Complements are products used jointly in a production process or consumed with another good or service. . . . Substitutes, in contrast, are products that perform similar functions and fulfill similar needs." Hadley, *supra* note 7, at 250-51.

28 *Id.* at 251.

29 Griffin, *supra* note 3, at 44.

30 Hadley, *supra* note 7, at 251. The efforts of professional nursing organizations to amend the definition of nursing practice to include diagnosing was the first attempt by nursing to abandon or at least modify the restrictive complementary role of nursing services. *Id.*

delivery system.[31]

III. The Emergence of Advanced Nursing Practice

Specialty nursing practice has emerged as a result of both rapid changes in the health care system and the efforts of professional nursing organizations.[32] Advanced practice is a term that commonly refers to nursing services, offered by nurse practitioners or clinical nurse specialists, who are registered nurses with formal education and training in a specialty clinical area.[33] Prescriptive authority is one type of advanced practice.[34] Since nurse practice acts only license nurses to perform general nursing tasks, advanced practice requires a statutory amendment to authorize and define the expanded services that qualified nurse practitioners may offer.[35] In 1971, Idaho became the first State to statutorily recognize advanced nursing practice.[36] Idaho amended their Nurse Practice Act to permit specialty nurses to engage in the practice of diagnosis and treatment.[37] Presently, forty states have legally recognized advanced practice via "statutes or agency rules, statutory interpretations by attorneys general and courts, or declaratory rulings by agencies."[38] New Jersey's adoption of prescriptive authority was enacted as an advanced practice amendment to the New Jersey Nurse Practice

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31 *Id.*

32 *See* Safriet, *supra* note 2.

33 *Id.* at 423-24. The additional education required constitutes either graduate or certificate programs coupled with supervised training in a clinical specialty area. *Id.* at 424. Other recognized titles of advanced practice include primary health care nurse practitioner, nurse midwife and nurse anesthetist. *See* ANA: REGULATION OF ADVANCED PRACTICE, *supra* note 11, at 54; GUIDELINES FOR PRIMARY HEALTH CARE, *supra* note 16.

34 *See* N.J. STAT. ANN. § 45:11-47 (West Supp. 1992).

35 *See* Safriet, *supra* note 2, at 456.

36 *Id.* at 445.

37 *Id.* IDAHO CODE § 54-1402(d) (1992) provides:

> Nurse practitioner means a licensed professional nurse having specialized skill, knowledge and experience, authorized by rules and regulations jointly promulgated by the Idaho board of medicine and Idaho board of nursing and implemented by the Idaho board of nursing, to perform designated acts of medical diagnosis, prescription of medical therapeutic and corrective measures and delivery of medications.

38 *Id. See also* Linda J. Pearson, *1991-92 Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice,* 17 NURSE PRAC. 14 (1992).

Act.[39]

Advanced specialty nursing practice, an alternative health care approach, developed as the direct result of legislative and economic changes affecting the health care system.[40] "The need was recognized in the 1960s in response to a national physician shortage and as a means of increasing availability and accessibility of trained, professional health care service providers."[41] Three health care problems in the United States - access to care, quality of care and cost of care - have necessitated the need for alternative health care options and advanced nursing practice.[42]

Access to health care is an identified problem because individuals cannot afford care, lack health insurance or they live in rural areas in which access to health care is reduced or non-existent.[43] Delayed access contributes to higher medical costs and increased morbidity rates.[44] Studies have shown that in rural and inner city areas, where there are greater access problems, more health care services are offered by nurse practitioners than physicians.[45]

> In 1980, 47.3% of employed [nurse practitioners] worked in inner cities and 9.4% worked in rural areas. Nurse practitioners also provide access to care in specialty areas where physician accessibility is still limited: nursing home and home health care for the elderly, ambulatory care, and care in correctional institutions, municipal teaching hospitals and for children with chronic illnesses.[46]

With regard to the quality of health care, "[r]ecent studies analyzing infant mortality and general life expectancies indicate . . . that the quality of care in the United States is lower than that in many other industrialized countries."[47] Moreover, it has been documented that Americans undergo unnecessary and inappropriate tests and treatments such as coronary bypass surgery, caesarean de-

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39 N.J. STAT. ANN. § 45:11-47 (West Supp. 1992).

40 NCSBN POSITION PAPER, *supra* note 8, at 1.

41 McGrath, *supra* note 1, at 40.

42 *See* Safriet, *supra* note 2, at 419-20.

43 *Id.* at 419.

44 *Id.*

45 *Id.* at 431.

46 McGrath, *supra* note 1, at 41. *See also* NURSING FACTS, *supra* note 8.

47 Safriet, *supra* note 2, at 420.

liveries and insertions of cardiac pacemakers.[48] Lastly, the reluctance of both the medical profession and the health insurance industry to recognize the importance of disease prevention has also contributed to inadequate health care.[49]

Nursing services, which emphasize wellness care and disease prevention, are, in some instances, appropriate substitutes for medical services. The Office of Technology Assessment released a case study in 1986 at the request of United States Senate Committee on Appropriations.[50] The study concluded that nurse practitioners render care that is equivalent to the quality of care offered by physicians.[51] With regard to prescriptive practice, a study published in the *New England Journal of Medicine* in 1974 reported "no difference between [nurse practitioners] and physicians in the "adequacy" of their prescribing practices."[52] A study conducted in the early 1980s of nurse practitioners prescribing pursuant to standard protocols suggests that nurses will not be indiscriminate drug prescribers.[53]

Furthermore, nurses in an advanced practice role not only provide equivalent health care, but their services have been identified as cost-effective.[54] The high costs of health care have necessitated the

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48 *Id.*

49 *Id.*

> Traditionally, private and governmental insurance programs have not "covered" or paid for preventive or wellness care. Coverage was, and to a large extent still is, dependent upon the actual or suspected existence of a disease or abnormality. This "illness" requirement derives both from cost considerations and from the traditional emphasis upon "medical" modalities which focus upon "curing" deviations from the physical or mental norm. Recent public policy actions indicate however, that considerations of health and preventive measures may gain importance in our policy priorities.

Id. at 420 n.5 (citing in part PUB. HEALTH SERVICE, U.S. DEP'T. OF HEALTH & HUMAN SERVICES, PUB. NO. 50212, HEALTHY PEOPLE 2000: NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES (1991)).

50 *Id.* at 426.

51 Safriet, *supra* note 2, at 426-27. The findings of the OTS study were based upon the analysis of several studies which assessed quality of care by utilizing process and outcome measures in addition to statistics reflective of physician acceptance and patient satisfaction. *Id.*

52 Diane Feeney Mahoney, *Nurse Practitioners as Prescribers: Past Research Trends and Future Study Needs*, 17 NURSE PRAC. 44, 44 (1992)(citing W. Spitzer et al., *The Burlington Randomized Trial of the Nurse Practitioner*, NEW ENG. J. MED. 251 (1974)).

53 *Id.* at 47 (citing D. Munroe et al., *Prescribing Patterns of Nurse Practitioners*, 82 AM. J. OF NURSING 1538 (1982)).

54 *See* McGrath, *supra* note 1; GUIDELINES FOR PRIMARY HEALTH CARE, *supra* note 16.

public's need for advanced nursing services.[55] Over thirty-six million Americans have no health insurance.[56]

> The proportion of the [Gross National Product] devoted to health care has grown from 5.9% in 1965 to 12.5% in 1990, increasing in dollar amounts from $42 billion to approximately $647 billion. The rate of increase for health care spending has been almost twice that of the [Gross National Product].[57]

The public's choice of accessing a nurse practitioner for treatment has had the positive effect of reducing health care spending because nurse practitioners offer equivalent physician services at a lower cost.[58] For example, estimates indicate that fifty to ninety percent of the services provided by physicians could be rendered by primary care nurse practitioners at significantly reduced annual salaries.[59]

Nurse practitioners have been cost-effective in both out- and in-patient health care settings.[60] The availability of nurse practitioner services in out-patient clinics reduces health care costs because nurse practitioners place a large emphasis on wellness care and disease prevention.[61] In addition, it has been documented that the utilization of nurse practitioners within acute care medical facilities can effectively reduce the average length of hospital stay,[62] thereby accumulating large savings not only for hospitals but also for third

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55 *See* Safriet, *supra* note 2, at 434.

56 Pearson, *supra* note 38, at 14. Even more than 36 million people are "underinsured for primary and preventive health services." *Id.*

57 Safriet, *supra* note 2, at 420 (citing in part Katherine R. Levit et al., *Health Spending and Ability to Pay: Business, Individuals and Government*, 10 HEALTH CARE FIN. REV. 1 (1989); U.S. GEN. ACCT. OFF., HRD-91-102, U.S. HEALTH CARE SPENDING TRENDS, CONTRIBUTING FACTORS AND PROPOSALS FOR REFORM (1991)).

58 *Id.* at 434. *See also* Hadley, *supra* note 7, at 250.

59 McGrath, *supra* note 1, at 41. McGrath states that the higher fees paid for physician services is a cost that taxpayers subsidize since both medical and nursing education is heavily supported by the federal government. *Id. See also* NURSING FACTS, *supra* note 8.

60 *See* McGrath, *supra* note 1.

61 *Id.* at 40. The author states that "[w]hile escaping direct measurement, substantial savings can be realized from increased accessibility and the early detection and prevention of medical problems, especially to low-income individuals who would otherwise be less likely to seek medical attention." *Id.*

62 N.J. STATE BOARD OF NURSING, TRANSCRIPT OF PROCEEDINGS, IN THE MATTER OF INFORMAL PUBLIC OUTPUT, PRESCRIPTIVE PRACTICE OF NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST 28 (May 19, 1992) [hereinafter TRANSCRIPT OF PUBLIC OUTPUT].

party payors and state and federally funded programs.[63]

Although there is an obvious need for advanced nursing practice, barriers to practice continue to be embodied in state statutes and regulations.[64] Two frequently cited legal impediments to advanced practice have been prescriptive authority and insurance reimbursement for rendered services.[65] The State of New Jersey has recently removed the barrier of prescriptive authority and at the same time statutorily defined advanced nursing practice by enacting S.S. 3491.

IV. Prescriptive Authority

A. *Background*

The history of prescriptive authority in the United States reveals that prescriptive practice has not always been within the exclusive dominion of physician services.[66] Prior to the 1900s, the public could obtain medications without a prescription.[67] Not until the early 1900s did physicians become responsible for drug prescription.[68] There are two primary reasons for this occurrence.[69] First, as the American Medical Association grew in membership and increased its financial resources, it required pharmaceutical manufacturers to reveal the contents of their drugs and to discontinue advertising to the public.[70] As a result, consumers were forced to rely on physicians when determining which drugs to purchase.[71] Secondly, pharmaceutical manufacturers targeted advertising to the medical community, recogniz-

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63 McGrath, *supra* note 1, at 41. Research conducted by the San Juan Veterans Administration studied the length of hospital stay and cost of in- and out-patient care for chronic congestive heart failure patients over a 12 month period both before and after the introduction of a nurse practitioner clinic. *Id.* The study revealed that the hospital stay of patients before the implementation of a nurse practitioner clinic was averaged at 930 days with a total cost of $158,968. *Id.* Nurse practitioner services reduced the length of hospital stay to 135 days and decreased total cost to $38,830. *Id.*

64 *See* Safriet, *supra* note 2, at 440.

65 *Id.* at 421.

66 Griffin, *supra* note 3, at 11 (citing G. Harkless, *Prescriptive Authority: Debunking Common Assumptions*, 14 NURSE PRAC. 57 (Aug. 1989)).

67 *Id.* at 9.

68 *Id.* at 9-10.

69 *Id.* at 10.

70 *Id.*

71 Griffin, *supra* note 3, at 10.

ing that physicians were instrumental in the failure or success of their drug.[72] Thus, the public's reliance on physician collaboration, coupled with the reduced availability of drug information, enabled physicians to be perceived as medication experts.[73]

Subsequently, the Pure Food and Drug Act of 1906 limited the authority to prescribe narcotic drugs only to physicians, yet all other drugs were free to be purchased without a prescription.[74] The original act remained viable for thirty-two years.[75] It was not until the 1937 Sulfanilamide disaster, which caused 107 deaths, that Congress was impelled to strengthen the original 1906 Act.[76] As a direct result, the 1938 Federal Food, Drug and Cosmetic Act[77] was signed into law.[78] A 1945 amendment to the drug labeling regulations defined the types of drugs that would require a physician prescription.[79] In 1951, the Durham-Humphrey Amendment[80] created a distinct separation of prescription drugs and over-the-counter drugs.[81] Accordingly, the public's reliance on physician pharmaceutical expertise grew.[82]

> As the pharmaceutical companies realized the increasing power the public was bestowing on the physicians, [coupled with the changing FDA regulations,] they in turn began subsidizing the physicians professional organizations, financing its journals and supporting physicians in the political arena. The prescriptive practice of physicians was slowly turning into an economic power and social privilege.[83]

Prescriptive authority has remained, until present, a statutory

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72 *Id.*

73 *Id.*

74 Law of June 12, 1906, ch. 3915, 34 Stat. 768 (current version in scattered sections of 21 U.S.C.). *See also* Terra Ziporyn, *The Food and Drug Administration: How Those Regulations Came To Be,* 254 JAMA 2037 (1985).

75 21 U.S.C. §§ 1-5, 7-14 (West 1972).

76 Ziporyn, *supra* note 74, at 2044 (citation omitted).

77 Law of June 25, 1938, ch. 675, 52 Stat. 1040 (current version at 21 U.S.C. §§ 301-92 (1992)).

78 Ziporyn, *supra* note 74, at 2044.

79 *Id.* at 2045 (citation omitted).

80 Law of Oct. 26, 1951, ch. 578, 65 Stat. 648 (current version at 21 U.S.C. § 353 (1992)).

81 Ziporyn, *supra* note 74, at 2045. "[T]his amendment recognized the responsibility of the medical profession to prescribe drugs . . ." *Id.* (quoting Wallace F. Janssen, FDA Historian).

82 Griffin, *supra* note 3, at 11.

83 *Id.*

barrier to advanced nursing practice.[84] The medical profession's exclusive domain over prescriptive practice has had "more to do with protecting the competitive position of physicians than with protecting the public health."[85] Since many states have started to amend nurse practice acts to include some type of prescriptive authority,[86] a brief overview of the various methods of regulation will be discussed.

B. *Methods of Prescriptive Authority Regulation*

States that currently recognize prescriptive authority for nurse practitioners have utilized various methods to regulate practice. For example, states have permitted nurse practitioners to prescribe in an independent/substitutive role or a dependent/complementary role.[87] The independent role allows nurses to prescribe with no physician involvement or oversight.[88] The dependent or complementary role permits prescribing only in conjunction with a physician or pursuant to pre-established joint regulatory protocols.[89] The State of New Jersey has adopted the latter approach.[90]

Furthermore, states have adopted different methods to identify and control the types of drugs that a nurse practitioner may prescribe.[91] The three most utilized approaches include the statutory designation of classes of drugs, state regulations that list categories of drugs and the development of written standard protocols that encompass drug formularies.[92] The New Jersey prescriptive practice amendment expressly prohibits the prescribing of narcotics and only permits nurses to prescribe drugs in accordance with joint protocols developed in agreement with a collaborating physician or pursuant to physician orders.[93]

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84 *See* Safriet, *supra* note 2, at 440.

85 *Id.* at 454.

86 *See generally* Pearson, *supra* note 38.

87 *See* Safriet, *supra* note 2, at 458-61. *See also* Hadley, *supra* note 7, at 247.

88 Safriet, *supra* note 2, at 459.

89 Hadley, *supra* note 7, at 247.

90 N.J. STAT. ANN. § 45:11-49(b) (West Supp. 1992).

91 Sarah Cohn, *Prescriptive Authority for Nurses*, 12 LAW, MED. & HEALTH CARE 72, 73 (1984).

92 *Id.*

93 N.J. STAT. ANN. § 45: 11-49(b) (West Supp. 1992) provides in pertinent part:

> b. A nurse practitioner/clinical nurse specialist may order medications and devices in the inpatient setting, subject to the following conditions:

States have invoked various methods to regulate prescriptive practice.[94] The four most common types of legal regulation are designation/recognition, registration, certification and licensure.[95] Designation/recognition is the least restrictive method whereby the state grants the use of special credentials that signify expertise and the ability to practice in an advanced clinical area.[96] This method of regulation does not restrict practice but merely allows the use of credentials to serve as an informational mechanism for the public.[97] Registration, the second method of legal regulation, consists of a roster, maintained by the regulatory agency, which lists the names of those nurses who may engage in advanced practice.[98] The first two methods, designation/recognition and registration, do not require a state inquiry into competency.[99] The third method, certification, is a process whereby the state board of nursing certifies advanced practice or recognizes certification that was previously obtained through a professional nursing organization.[100] It is this certification process that can create problems of title protection.[101] Because New Jersey has adopted a certification approach,[102] the issue of title protection will be discussed *infra*. The last method of legal regulation, licensure, is the most restrictive approach and permits nurses to engage legally in advanced practice only if predetermined qualifications are met.[103] A licensure method defines the specific scope of advanced practice.[104]

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(1) no controlled dangerous substances may be ordered;
(2) the order is written in accordance with standing orders or joint protocols developed in agreement between a collaborating physician and the nurse practitioner/clinical nurse specialist, or pursuant to the specific direction of a physician.

94 NCSBN POSITION PAPER, *supra* note 8, at 3.
95 *Id.*
96 *Id.*
97 *Id.*
98 *Id.*
99 NCSBN POSITION PAPER, *supra* note 8, at 3.
100 *Id.*
101 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 15-21, 40.
102 N.J. STAT. ANN. § 45:11-47 (West Supp. 1992).
103 NCSBN POSITION PAPER, *supra* note 8, at 3.
104 *Id.*

V. *The Enactment of Senate Substitute for S. 3491*

Two compelling policy considerations support New Jersey's enactment of S.S. 3491.[105] First, the advanced practice amendment will better serve the health care needs of New Jersey residents.[106] Secondly, the legislation will legitimize advanced nursing education and specialty clinical expertise by statutorily expanding the scope of nursing practice.[107] S.S. 3491 amended the already existing Nurse Practice Act. Although the bill granted prescriptive authority to nurse practitioners, it also set forth other changes in nursing regulation and practice.[108]

Namely, the bill added the definitions of nurse practitioner/clinical nurse specialist and collaborating physician to the Act.[109] S.S. 3491 required a nurse practitioner/clinical nurse specialist to be appointed to the Board of Nursing.[110] The bill then added several new sections to the Nurse Practice Act. Requirements for advanced practice certification were enunciated[111] and the scope of advanced nursing practice was defined.[112] Additionally, a grandfather clause was set forth that would be applicable to those nurse practitioners who are already certified by a professional organization and have completed a board approved pharmacology

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105 S.S. 3491, 204th Leg., 2d Sess. (1991) (codified scattered sections of N.J. STAT. ANN. § 45).

106 *See* Safriet, *supra* note 2, at 419-22.

107 *See* THE NEW JERSEY STATE NURSES' ASSOCIATION, PRIMARY HEALTH CARE NURSE PRACTITIONER (1979).

108 S.S. 3491, *supra* note 105. Senate Substitute 3491 also amended provisions of N.J. STAT. ANN. § 45:14-13 to 15 (West Supp. 1992). These amendments authorize pharmacists to dispense prescriptions written by a nurse practitioner/clinical nurse specialist. *Id.*

109 N.J. STAT. ANN. § 45:11-23 (d) - (e) (West Supp. 1992) provides:

> d. "Nurse practitioner/clinical nurse specialist" means a person who holds a certification in accordance with section 8 or 9 of P.L.1991, c. 377 (C. 45:11-47 or 45:11-48).
>
> e. "Collaborating physician" means a person licensed to practice medicine and surgery pursuant to chapter 9 of Title 45 of the Revised Statutes who agrees to work with a nurse practitioner/clinical nurse specialist.

110 N.J. STAT. ANN. § 45:11-24 (West Supp. 1992).

111 N.J. STAT. ANN. § 45:11-47 (West Supp. 1992). The "certification" process has created controversy regarding the need for title protection as well as the authority of a board of nursing to certify when it has exclusively been the responsibility of the American Nurses' Association to certify specialty practice. *See infra* note 156 and accompanying text.

112 N.J. STAT. ANN. § 45:11-49 (West Supp. 1992).

course.[113]

Specifically, the legislation defines advanced practice by identifying additional tasks beyond those named in the Nurse Practice Act.[114] These tasks include initiating laboratory and other diagnostic tests and prescribing or ordering medications and devices as authorized by the Act.[115] The legislation prohibits the prescribing of narcotic medications.[116] The statutory amendment authorizes prescribing done in collaboration with a physician or pursuant to joint protocols developed between the physician and the nurse practitioner.[117] The amendment also provides both the Board of Nursing and Board of Medical Examiners with the opportunity to advise the Director of Consumer Affairs during the adoption of standards for joint protocols.[118] The legislation grants the Board of Nursing the power to "certify" those nurse practitioners/clinical nurse specialists that are at least eighteen years old, of good moral character, possess a current New Jersey registered professional nurse license, have completed an educational program including pharmacology and have passed a written examination.[119]

Several bills setting forth the scope of advanced practice and prescriptive authority had come before the Assembly and Senate in New Jersey prior to S.S. 3491.[120] These previous bills stirred controversy amongst health care professionals.[121] Due to territorial issues, the New Jersey State Nurses' Association opposed the statutory allowance of physician assistant services in New Jersey and physicians objected to nursing prescriptive authority.[122] Once the two groups resolved differences, specific language of

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113 N.J. STAT. ANN. § 45:11-48 (West Supp. 1992).

114 N.J. STAT. ANN. § 45:11-49 (West Supp. 1992).

115 N.J. STAT. ANN. § 45:11-49(a) (West Supp. 1992).

116 N.J. STAT. ANN. § 45:11-49(b)(1) (West Supp. 1992).

117 *See supra* note 93.

118 N.J. STAT. ANN. § 45:11-51 (West Supp. 1992).

119 N.J. STAT. ANN. § 45:11-47 (West Supp. 1992).

120 *See, e.g.*, A. 4766, 204th Leg., 2d Sess. (1991), sponsored by Assemblywoman Mullen and S. 2100, 204th Leg., 1st Sess. (1990), sponsored by Senator Lipman.

121 *See* Jeri L. Bigbee, *Territoriality and Prescriptive Authority for Nurse Practitioners*, 5 NURSING & HEALTH CARE 106 (1991).

122 Prescriptive authority has raised conflict amongst health care professionals because it "fails to clearly "fit" within only one professional territorial boundary." *Id.* at 106.

the bill became an issue.[123] For example, A. 4766,[124] sponsored by Assemblywoman Mullen on April 22, 1991, proposed standards for prescriptive practice and stated that nurse practitioners could prescribe in accordance with protocols approved by the Board of Nursing.[125] The bill did not mandate prescribing pursuant to physician collaboration.[126] Assembly bill 4766 was short-lived and eventually replaced with S.S. 3491.[127]

Senate Substitute 3491 was sponsored by Senator Lipman on May 13, 1991.[128] The bill authorized the prescribing of medications pursuant to protocols approved by the New Jersey State Board of Nursing.[129] Senate Substitute 3491 was referred to the Senate Labor, Industry and Profession Committee, chaired by Senator Raymond Lesniak, on June 24, 1991.[130] A senate committee substitute for S.S. 3491 (S.C.S. for S.S. 3491) was released on December 9, 1991.[131] The committee substitute authorized prescribing pursuant to physician collaboration or joint protocols adopted by the Division of Consumer Affairs.[132] On the same day, S.C.S. for S. 3491 was sent to the floor of the Senate for a second reading.[133] At this time, S.S. 3491 was formally adopted.[134] On December 16, 1991, S.S. 3491 was passed by the Senate.[135] S.S. 3491 was referred to the Assembly Health and Human Services Committee on January 6, 1992.[136] On January 10, 1991, Assemblywoman Mullen's bill, A. 4766, was replaced by S.S. 3491 and passed by the Assembly.[137] The bill was signed

123 *See* Letter from Andrea Aughenbaugh, Deputy Director of the New Jersey State Nurses' Association, to nursing colleagues (1991) [hereinafter Aughenbaugh letter] (on file with the *Seton Hall Legislative Bureau*).

124 A. 4766, 204th Leg., 2d Sess. (1991).

125 *Id.*

126 *Id.*

127 *See* 78 N.J. LEGIS. INDEX, No. 22, at S60 (1991)[hereinafter LEG. INDEX].

128 S.S. 3491, 204th Leg., 2d Sess. (1991).

129 *Id.*

130 Telephone interview with Christie Davis, Legislative Aid to Senator Lipman (Oct. 17, 1992).

131 S.C.S. for S. 3491, 204th Leg., 2d Sess. (1991).

132 *Id.*

133 *Id.*

134 *Id.*

135 LEG. INDEX, *supra* note 127. The bill was passed by a vote of 29-5. *Id.*

136 Telephone interview with Christie Davis, Legislative Aid to Senator Lipman (Oct. 17, 1992).

137 LEG. INDEX, *supra* note 127. The bill was passed by a vote of 68-0. *Id.*

into law by Governor Florio on January 5, 1992.[138] Although the provisions for board seats became effective immediately,[139] the Board of Nursing was granted one year to develop rules and regulations for prescriptive practice and the certification of nurse practitioners.[140]

Once the bill was enacted, the Board of Nursing formed an advisory committee to assist the Board in establishing regulations that would promote and protect the public health and welfare of citizens.[141] The committee held two informal public forum meetings.[142] The meetings afforded the public its due process rights by providing an opportunity for concerns and suggestions to be expressed prior to the promulgation of the rules and regulations.[143] Issues or concerns that were identified to the Board through these meetings include title protection,[144] legal regulation versus professional regulation of specialty practice[145] and the importance of a pharmacology component.[146] The perceived benefits of prescriptive authority that were recognized include decreased health care costs and length of hospital admissions,[147] a decrease in the number of medications prescribed to gerontological patients,[148] a decrease in emergency department visits,[149] a decrease in hospital admissions[150] and an enhanced and more collaborative relationship between physicians and nurses.[151]

Since the two public forum meetings, the New Jersey State Board of Nursing has been developing regulations to implement the advanced practice legislation.[152] On January 19, 1993, the

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138 *Id.* The Nurse Practitioner/Clinical Nurse Specialist Certification Act, P.L. 1991, c. 377 (codified in scattered sections of N.J. STAT. ANN. § 45.

139 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 14.

140 *Id.* at 13-14.

141 *See* TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 3.

142 *Id.* at 2-3.

143 *Id.* at 2.

144 *Id.* at 15-21, 40.

145 *Id.*

146 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 21.

147 *Id.* at 28.

148 *Id.* at 27.

149 *Id.* at 32.

150 *Id.* at 33.

151 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 34.

152 *NP/CNS Regulations Proposed,* N.J. NURSE (N.J. STATE NURSES ASS'N), Mar. 1993, at 1.

Board of Nursing proposed regulations, however, the rules have not yet been drafted into regulatory language.[153] Once the regulations are written and approved by the Division of Consumer Affairs, the rules will be published in the *New Jersey Register*.[154] Regulations proposed by the Board of Nursing include the following:

> 1) A masters degree will be required after the initial 180 day grandfathering period to practice as a NP/CNS.
> 2) A recent (within 5 years) 3 credit pharmacology course incorporated in the advanced practice program or integrated in the clinical courses and emphasizing management of the drug regimen will be required.
> 3) If a NP/CNS does not have the above, 30 contact hours of pharmacological management, 10 of which must be pure pharmacology, will suffice. These contact hours must have been earned within the past five years.
> 4) The same pharmacology requirement (30 contact hours) will be required for biennial renewal of the NP/CNS certification.[155]

VI. Professional Implications

The most significant professional implication of S.S. 3491 is the certification process that will regulate advanced practice in New Jersey.[156] The focus of the controversy regarding certification involves the issue of title protection.[157]

Certification is a process whereby "an individual licensed to practice in a profession has met certain predetermined standards specified by that profession for specialty practice. Its purpose is to assure various publics that an individual has mastered a body of knowledge and acquired skills in a particular specialty."[158] The differentiation between state licensure and professional

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153 *Id.*

154 *Id.*

155 *Id.*

156 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 15-21, 40.

157 *Id.*

158 ANA: STUDY OF CREDENTIALING, *supra* note 15, at 8. The professional association is responsible for regulating standards of practice and certifying specialty practice whereas the state government is responsible for ensuring that minimum standards of competence are met. *Id.* at 4.

certification is not unique to nursing.[159] Legal and medical professional organizations also offer certification for specialty practice.[160]

The American Nurses' Association (ANA) has been credentialing nursing practice since 1973.[161] Upon completion of predetermined standards, the ANA certifies a practitioner to use credentials and hold her/himself out to be a specialist in a particular clinical area.[162] The ANA opposes the certification of advanced nursing practice by state boards' of nursing.[163] The ANA presently grants the title of "certified nurse practitioner."[164] Since the New Jersey State Board of Nursing will now regulate the title, the previously certified nurse practitioner that does not pursue state certification for prescriptive authority can no longer use the ANA credential in the State of New Jersey.[165] Herein lies the conflict between legal and professional regulation.[166] It should be the sole responsibility of the professional association to certify practice.[167]

The issue may be one of mere semantics, however, the serious impact of its effect raises concern amongst the professional nursing community.[168] Although the New Jersey Board of Nursing is aware of the title protection concern,[169] the language of the advanced practice legislation does expressly authorize the Board of Nursing to regulate the title of "certified nurse practitioner."[170]

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159 Griffin, *supra* note 3, at 52.

160 *Id.*

161 ANA CREDENTIALING CATALOG, *supra* note 2, at 3.

162 *Id.*

163 Letter from Virginia Trotter Betts, President of American Nurses' Association, to Carolyn Hutcherson, President of National Council of State Boards of Nursing (July 8, 1992) (on file with the *Seton Hall Legislative Bureau*).

164 *See* ANA CREDENTIALING CATALOG, *supra* note 2.

165 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 15-21.

166 Interview with Muriel M. Shore, Member, New Jersey State Board of Nursing and American Nurses' Association Board (October 12, 1992). There will probably be a future test case challenging the authority of the New Jersey Board of Nursing to supersede the authority of the professional association. *Id.*

167 *Id.* For example, the American Nurses' Association would not be opposed to the Board of Nursing granting prescriptive authority by utilizing a different title, such as "board certified" nurse practitioner. *Id.*

168 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 15-21, 40.

169 *Id.* at 40.

170 *See supra* note 89 and accompanying text.

VII. Legal Considerations

There are three possible legal implications that should be considered when addressing the New Jersey advanced practice amendments. These legal considerations include infringement on the constitutional right to pursue chosen employment,[171] possible violation of antitrust laws[172] and the legal dangers of joint protocols.[173]

The advanced practice amendments could be subject to constitutional challenge because they constitute a state action that restricts entry into practice.[174] Judicial decisions have held that a state's regulation of professional practice through licensing statutes is constitutional if rationally related to a legitimate state objective.[175] The State of New Jersey does have a legitimate state interest in safeguarding the public.[176] Statutory barriers to employment will most likely be held constitutional because restrictions on professional practice generally impose only those minimum requirements necessary to ensure public health, safety and welfare.[177] However, the "Board [of Nursing] must give attention to assuring guarantees of procedural due process, such as notice and an opportunity to be heard, to protect against charges of proceeding with arbitrary, discriminatory or unreasonable regulations."[178]

Increased regulation of nursing practice could violate federal antitrust laws if it has the effect of creating an unfair advantage in the employment market or limiting access to the field.[179] Antitrust laws were enacted to ensure fairness in the open market by restricting monopolies and setting forth trade restraints.[180]

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171 NCSBN POSITION PAPER, *supra* note 8, at 2.

172 *Id.*

173 *See* Donna M. Moniz, *The Legal Danger of Written Protocols and Standards of Practice*, 17 AM. J. OF PRIMARY HEALTH CARE 60 (1992); Paula F. Henry, *Analysis of Standardized Procedures and Protocols: A Legal Viewpoint*, NURSE PRAC. FORUM 122 (1992).

174 NCSBN POSITION PAPER, *supra* note 8, at 2.

175 *See* Ricci v. State Bd. of Law Examiners, 427 F. Supp. 611, 618 (E.D. Pa. 1977), *vacated and remanded on other grounds*, 569 F.2d 782 (3d Cir. 1978); Stuart v. Wilson, 211 F. Supp. 700, 701 (D.C. Texas 1962).

176 *See Ricci*, 427 F. Supp. at 618.

177 NCSBN POSITION PAPER, *supra* note 8, at 2.

178 *Id.* at 4.

179 *Id.*

180 *See, e.g.*, Sherman Act, 15 U.S.C.A. §§ 1-36 (West 1972).

Antitrust laws have been construed by the courts to be applicable to state restrictions on professional practice.[181] Antitrust immunity may be extended to state action, but "the challenged restraint must be one clearly articulated and affirmatively expressed as state policy, and . . . [the] policy must be actively supervised by the state itself."[182]

> In light of current judicial decisions in antitrust suits involving professions, Boards should be aware that they will be less open to challenge on antitrust grounds if the regulation of advanced nursing practice is clearly mandated by statute, and if there is active oversight of the regulatory process by the licensing authority.[183]

The enactment of S.S. 3491 should not invoke claims of antitrust violation because both prongs of the antitrust immunity test appear to be satisfied. The language of S.S. 3491 requires the promulgation of rules and regulations for advanced practice in order to protect public health and safety.[184] Moreover, the New Jersey State Board of Nursing is responsible for the oversight of nursing regulation and practice.[185]

The third legal consideration involving S.S. 3491 is the requirement that prescribing be done pursuant to joint written protocols.[186] The joint protocols are to "conform with standards adopted by the Director of Consumer Affairs . . ."[187]

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181 Patrick v. Burget, 486 U.S. 94 (1988); Kreozer v. Am. Academy of Periodonotology, 735 F.2d 1479, 1491 (D.C. Cir. 1984).

182 California Retail Liquor Dealers Assoc. v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (quoting Lafayette v. Louis. Power & Light Co., 435 U.S. 389 (1978)). *See also Patrick*, 486 U.S. at 94.

183 NCSBN POSITION PAPER, *supra* note 8, at 4.

184 N.J. STAT. ANN. § 45:11-50 (West Supp. 1992).

185 *See* N.J. STAT. ANN. § 45:11-24(d) (West Supp. 1992) which provides in pertinent part:

> The board shall have the following duties and powers: . . .(8) It shall examine applicants for a license or renewals thereof, issue, renew, revoke and suspend licenses, as hereinafter provided. (9) It shall in its discretion investigate and prosecute all violations of provisions of this act. (10) It shall keep an official record . . . of each applicant and licensee as the board shall deem advisable. . . .(18) It shall perform all other functions which are provided in this act to be performed by it or which in the judgment of the board are necessary or proper for the administration of this act. (19) It shall from time to time prescribe rules and regulations not inconsistent with this act.

186 *See supra* note 93.

187 N.J. STAT. ANN. § 45:11-49(o) (West Supp. 1992).

Since written protocols have been invoked to determine the requisite standard of care in medical malpractice litigation,[188] two important legal implications should be considered. First, standard protocols are generally developed in accordance with the typical textbook patient.[189] This is a danger because no two patients are identical and protocols do not take into consideration every clinical deviation.[190] Secondly, clinical experiences vary among different health care settings and geographic locations.[191] For example, the availability of resources and the type of client population vary greatly between an urban out-patient clinic and a suburban geriatric center.[192]

Identified guidelines that should be used to develop written standard protocols include the following:

> The protocols should be the minimum requirements for safe care and *not* the maximum for ideal care. Standards and protocols should be updated as scientific knowledge develops. The protocols or standards should be realistic in light of actual practice settings, taking into account all the various settings in which they would be applied.[193]

Nurse practitioners are advised to adhere to standard protocols without deviation[194] and carefully document compliance.[195]

VIII. Current Status of Prescriptive Authority Legislation in the United States

Forty states presently have some type of prescriptive practice legislation.[196] Another seven states are currently attempting to generate legislation for prescriptive authority.[197] Of the states with some type of prescriptive practice already in effect, only thirteen states enable nurses to prescribe independently of physicians, twenty-four states permit nurses to prescribe with some type of physician collaboration or supervision and three states

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188 Moniz, *supra* note 173, at 58, 59.
189 *Id.* at 60.
190 *Id.*
191 *Id.*
192 *Id.*
193 Moniz, *supra* note 173, at 59.
194 *Id.*
195 Henry, *supra* note 173, at 123.
196 Pearson, *supra* note 38, at 16.
197 *Id.*

allow limited, site dependent authority.[198] Approximately seventeen states permit nurse practitioners to prescribe certain controlled medications.[199]

IX. Impact of Prescriptive Authority and Advanced Nursing Practice Legislation on Health Care in New Jersey

The enactment and implementation of S.S. 3491 will have a significant impact on health care in New Jersey.[200] The three major areas of health care that will recognize the greatest improvement are access, cost and disease prevention.[201]

Although state certification of advanced practice and prescriptive authority has not yet been implemented,[202] nurse practitioners are currently working in New Jersey in a restricted role.[203] Primary care practitioners are employed in various settings including hospitals, out-patient clinics, geriatric centers, private practice, physician offices and school health clinics.[204] Primary care nurse practitioner services have a beneficial effect on both health care access and cost, however, the provision of these services has been restricted by statutory practice barriers.[205] The State's recognition of advanced practice and prescriptive authority will better serve the health care needs of New Jersey residents because nurse practitioners will now be able to provide complete patient care.[206]

The significant effect that nurse practitioner services can have on health care is evident from the following example. A 1989 report released from the Department of Pediatrics at the University of Medicine and Dentistry of New Jersey, New Jersey Medical School, indicates that most emergency room visits by pe-

198 Griffin, *supra* note 3, at 1 (citing Linda J. Pearson, *1991-92 Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice,* 17 NURSE PRAC. 14 (1992)).

199 *See* Pearson, *supra* note 38.

200 *See* Safriet, *supra* note 2, at 419-22.

201 *Id.*

202 TRANSCRIPT OF PUBLIC OUTPUT, *supra* note 62, at 13-14.

203 Leonia Kleinman, The Clinical Specialist and Primary Health Care of the Young/Old 17 (1992) (Seton Hall University College of Nursing Grant Proposal submitted to the U.S. Dept. of Health and Human Services).

204 *Id.* at 16.

205 *See* Safriet, *supra* note 2, at 421.

206 Griffin, *supra* note 3, at 163. *See also* Safriet, *supra* note 2.

diatric clients are for minor acute illness, with only twenty percent actually in need of emergency care.[207]

> The establishment of a walk-in clinic utilizing a nurse practitioner/pediatrician team at University Hospital and primary health care clinics at University Hospital and Beth Israel Medical Center, both employing pediatric nurse practitioners, are beginning to reduce the use of the emergency unit by children for non-emergency visits and increase the scope of care available.[208]

Furthermore, many nurse practitioners are presently employed in federally-designated health professional shortage areas.[209] Health professional shortage areas are defined as follows:

> [A]n area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage and which is not reasonably accessible to an adequately served area, a population group which the Secretary determines has such a shortage or a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage.[210]

Seton Hall University College of Nursing, for example, reports that approximately thirty percent of nurse practitioner graduates are employed in health professional shortage areas.[211] The availability of nurse practitioner services in underserved and poverty areas greatly improves health care access and health promotion to a needy population.[212]

Advanced health services provided by nurse practitioners would greatly contribute to the health care needs of New Jersey resi-

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207 Kleinman, *supra* note 203, at 7 (citing Report from the Department of Pediatrics, UMDNJ-NJ Medical School (1989)).

208 *Id.*

209 *See* 42 U.S.C.A. § 254e(d) (West 1991) which provides in pertinent part: "[T]he Secretary [of Health and Human Services] shall designate health professional shortage areas in the states. . ."

210 42 U.S.C.A. § 254e(a)(1) (West 1991).

211 *See* Kleinman, *supra* note 203, at 23. Underserved areas in New Jersey in which Seton Hall University College of Nursing graduates are employed include Atlantic City, Newark, Jersey City, Paterson (north side), Bridgeton, and Trenton. *Id.* at 26.

212 *Id.*

dents,[213] yet, the State's need for nurse practitioners outweighs the actual number presently employed in New Jersey.[214] In 1992, estimates calculated by the New Jersey State Nurses' Association indicate there are fewer than 400 nurse practitioners employed in the State of New Jersey.[215] "Studies conducted by the Office of Health Manpower [in 1989] determined there was an immediate need for over five hundred nurse practitioners for office-based care alone."[216] There are no statistics available that reflect nurse practitioner vacancies in New Jersey, however, employment requests received by Seton Hall University College of Nursing indicate a need for nurse practitioners in hospitals, primary care clinics, geriatric centers, home care agencies, school health clinics and state agencies.[217] In addition, programs which would like to employ additional nurse practitioners include the AIDS program at the Children's Hospital of New Jersey in Newark[218] and Healthstart, a program which provides health care to low income pregnant females and children under the age of two.[219]

It is evident that although there is a need for nurse practitioner health services in the State of New Jersey, there is a shortage of nurse practitioners actually in practice.[220] Since autonomy and increased responsibility have been identified as factors that would attract inactive nurses back into practice,[221] it is hopeful that the enactment of S.S. 3491 will encourage New Jersey nurses to pursue

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213 *See* Safriet, *supra* note 2, at 419-22.

214 *See* Kleinman, *supra* note 203, at 17.

215 *Id.*

216 *Id.* at 16.

217 *Id.* at 17.

218 *Id.*

219 Kleinman, *supra* note 203, at 7.

220 Currently Seton Hall University College of Nursing offers the only nurse practitioner program in the State of New Jersey which is accredited by the National League for Nursing, recognized by the National Organization of Nurse Practitioner Faculties [hereinafter NONPF] and listed in the National Directory of Nurse Practitioner Programs. Interview with Kathy Enge, Recruiter for Seton Hall College of Nursing (Nov. 12, 1992). Rutgers University College of Nursing does have an accredited graduate nursing program but the nurse practitioner tract is not recognized by the NONPF and not listed in the National Directory of Nurse Practitioner Programs. *Id.* The University of Medicine and Dentistry of New Jersey and Trenton State College also offer nurse practitioner programs but neither are accredited by the National League for Nursing. *Id.*

221 Muriel M. Shore, Identification of Factors Which Would Attract Inactive Registered Nurses Back Into the Hospital Setting 120 (1990) (unpublished Ed.D. dissertation, Seton Hall University).

the advanced practice role.[222]

X. *Conclusion*

The enactment of S.S. 3491 removes significant barriers to nursing practice.[223] Advanced practice definitions and prescriptive authority will enable New Jersey nurse practitioners to deliver total patient care.[224] The health care needs of New Jersey residents will be better served, specifically in the areas of health care cost, access and quality of care.[225]

New Jersey nurses have been attempting to expand the scope of nursing practice in the state through active lobbying efforts.[226] The broadening of health care services and practice amongst any health care professionals has often encountered conflict for territoriality reasons.[227] The New Jersey State Nurses' Association does not view S.S. 3491 as the bill of choice.[228] S.S. 3491 does not authorize independent prescriptive practice or the prescribing of controlled drugs, nor does it protect the title of "certified nurse practitioner."[229] Nevertheless, the statutory allowance of collaborative prescriptive authority and the expansion of tasks that may be performed by a nurse practitioner in an advanced practice role is still a significant and important victory for New Jersey nurses.

Nancy L. Shore

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222 *See* Kleinman, *supra* note 203, at 17.

223 *See* Safriet, *supra* note 2, at 421.

224 *See* Griffin, *supra* note 3, at 163.

225 *See* Safriet, *supra* note 2, at 419, 421. "With an emphasis on health promotion and disease prevention and a proven record of providing excellent primary care in diverse settings, advanced practice nurses form a critical link in the solution to America's health care crisis." NURSING FACTS, *supra* note 8.

226 *See* Aughenbaugh Letter, *supra* note 123.

227 *See* Bigbee, *supra* note 121.

228 *See* Aughenbaugh Letter, *supra* note 123.

229 N.J. STAT. ANN. §§ 45:11-47 and 11-49(b) (West Supp. 1992).