

University of Missouri School of Law Scholarship Repository

Faculty Publications

Summer 1995

Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses

Mary M. Beck

University of Missouri School of Law, beckm@missouri.edu

Follow this and additional works at: <http://scholarship.law.missouri.edu/facpubs>

 Part of the [Health Law and Policy Commons](#)

Recommended Citation

Mary Beck, Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses, 29 U.S.F. L. Rev. 951 (1995)

This Article is brought to you for free and open access by University of Missouri School of Law Scholarship Repository. It has been accepted for inclusion in Faculty Publications by an authorized administrator of University of Missouri School of Law Scholarship Repository.

Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses

By MARY BECK*

NURSING and organized medicine are engaged in a heated and emotional debate over independent prescriptive privileges for advanced practice nurses.¹ Uncontroverted data demonstrates that nurse practitioners provide high quality health care at a reduced cost, while increasing access to health care for under-served populations.² It is apparent that advanced practice nurses could improve the delivery of American health care. However, organized medicine is opposed to autonomous advanced nursing practice and lobbies powerfully against it. Currently, the majority of state laws and regulations pertaining to advanced practice nursing do not promote a sound public health policy, do not contemplate liability issues and do not forestall fruitless litigation.

Part I of this Article describes the background of expanded nursing practice and regulation. Part II examines the policy considerations of advanced practice nurses ("APNs") prescribing treatment. Part III reviews applicable liability issues and evaluates varying theories of state regulation. Part IV analyzes the political and statutory obstacles to nurses' prescribing medications. This Article concludes by recommending legislation and regulation authorizing autonomous prescriptive privileges for advanced practice nurses.³

* Associate Professor of Clinical Law, University of Missouri-Columbia, School of Law. J.D., University of Missouri-Columbia, School of Law, 1988; M.S.N., St. Louis University, 1971. Professor Beck currently directs the Family Violence Clinic at the University of Missouri-Columbia, School of Law. She is also a Registered Nurse, a Cardiovascular Clinical Nurse Specialist, a Family Nurse Practitioner, and an Adoption Attorney.

1. See *infra* Appendix, Table A for a definition of "advanced practice nurses."

2. See *infra* part II.A.

3. See P.H. DeLeon et al., *Prescription Privileges: Psychology's Next Frontier?*, 46 AM. PSYCHOLOGIST 384, 384-92 (1991). Expanded prescription practices for other non-physicians, such as psychologists, is beyond the scope of this paper.

The Appendix defines health care terms and characteristics of practice as they are used in this Article.⁴

I. Nursing Practice: The Background

Physicians and nurses in the United States are directly regulated by state licensing schemes codified as a class of statutes called the State Practice Acts.⁵ The Tenth Amendment to the United States Constitution delegates the function of professional regulation to the states pursuant to their police powers.⁶ These police powers exist to protect the health, safety and welfare of citizens and not the professions regulated.⁷

State Practice Acts typically define the practice of the individual profession regulated, establish a state board of examiners, delegate regulatory functions to this state board, and prohibit others from unauthorized practices of the defined profession.⁸ State boards are administrative agencies which promulgate and enforce rules and regulations governing the licensing scheme and practice in the particular profession. This scheme generally applies to medicine, nursing, pharmacy and other professions.

A. Federal Influence in the Regulation of APNs

To date, the federal government has not directly regulated the APN profession. Nonetheless, the federal government has exercised considerable influence. For instance, the Armed Forces employs various health professionals and operates federal hospitals. In this capacity, the Armed Forces, with the Surgeon General's approval, has utilized nurses in expanded practice since the 1960's. Subject to written policies, nurses in the Armed Forces write prescriptions.⁹ Federal hospitals are not required to follow

4. See also Gibson & Schwartz, *Physicians and Lawyers: Science, Art, and Conflict*, 6 AM. J.L. & MED. 173 (1981) (discussing the professional friction caused by physicians and attorneys ascribing different meanings to like terms); accord, BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 1224-27 (2d ed. 1991).

5. GINNY W. GUIDO, LEGAL ISSUES IN NURSING 123-24 (1988).

6. Elizabeth H. Hadley, *Prescriptive Authority for Nurses and Its Relationship to Professional Autonomy, Physician Substitution, Competition and Cost-Effective Health Services*, in NURSES AND PRESCRIPTIVE AUTHORITY: SPECIALTY NURSING FORUM, CLEMSON UNIVERSITY COLLEGE OF NURSING, NATIONAL CONFERENCE PROCEEDINGS 1, 1 (1990).

7. *Id.*

8. See MO. REV. STAT. §§ 334, 335 (1991). Some states may delegate more authority to one licensing board over another. Section 334 is Missouri's Medical Practice Act which creates the Missouri Board of The Healing Arts. Under section 334, the Board is authorized to subpoena witnesses. Section 335 is Missouri's Nursing Practice Act which creates the Missouri Board of Nursing. The Nursing Board is not granted subpoena power.

9. Ira P. Gunn, *Nurses and Prescriptive Authority: What is it? Who Needs It?*, in NURSES AND PRESCRIPTIVE AUTHORITY: SPECIALTY NURSING FORUM, CLEMSON UNIVERSITY COLLEGE OF NURSING, NATIONAL CONFERENCE PROCEEDINGS 11, 12 (1990).

state laws concerning professional practice and the Armed Forces' use of APNs forged an early model of advanced nursing practice which the states have followed.

Some federal legislation, primarily legislation providing third party reimbursement, has also strongly impacted advanced nursing practice.¹⁰ For example, the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS") regards all APNs as autonomous and reimburses them directly for their services.¹¹ Meanwhile Medicaid directly reimburses certified nurse midwives¹² and APNs¹³ for services to patients in states where such advanced practice nursing is authorized. Currently, 49 states allow APNs to receive Medicaid reimbursement for their services, including 39 that reimburse an APN at 80 to 100% of physicians' rates of pay.¹⁴ Medicare reimburses nurses directly but only for care provided in rural areas or in nursing homes.¹⁵ Such direct reimbursement sustains the economic viability of advanced nursing practice.¹⁶

This reimbursement legislation, as well as the Armed Forces' policies on APN practice, has had significant enabling effects on advanced practice nursing. It also reflects the federal government's positive, but nonintrusive, attitude toward the states' regulation of expanded nursing practice.

While the federal government's approach has traditionally been indirect, the policy promoted by the Clinton Administration is much more aggressive and would invade the traditional province of the states in regulating advanced nursing practice. Specifically, the Clinton Administration's health care reform plan proposes a federal override of restrictive state licensing laws and would prohibit the states from narrowing the practice of any class of health professionals beyond that which is justified by the skills and training of such professionals.¹⁷ Foreseeably, such legislation would precipitate the dismantling of existing statutory and political barriers to advanced nursing practice. The result would be more cost effective modes of

10. See *infra* part IV.A. (discussing third party reimbursement).

11. Daniel K. Inouye, *Thoughts on Nursing Autonomy*, PEDIATRIC NURSING, Sept.-Oct. 1984, at 319, 319-20, 364.

12. 42 U.S.C. §§ 1395x(gg)(2), 1396d(a)(17) (Supp. V 1993).

13. 42 U.S.C. § 1396d(a)(21) (Supp. V 1993).

14. Linda J. Pearson, *Annual Update of How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice*, 19 NURSE PRAC. 11, 17 (1994) [hereinafter *Pearson, 1994 Annual Update*].

15. Pamela C. Mittelstadt, *Federal Reimbursement of Advanced Practice Nurses' Services Empowers the Profession*, 18 NURSE PRAC. 43, 47 (1993).

16. *Id.* at 49.

17. American Health Security Act, H.R. 1200, 103 Cong., 1st Sess. § 1161 (1993).

diagnosis and treatment via non-physician providers.¹⁸ The critical practice parameters affected by such federal intervention are the authorization of independent prescriptive practice for APNs and the removal of required physician supervision of APNs.¹⁹

The Physician Payment Review Commission's ("PPRC") 1994 Annual Report to Congress is as intrusive to the states' power as the Clinton Administration's health care policy. It recommended that Model State Practice Acts be developed for non-physician health care providers.²⁰ It further recommended that states be given a time limit for bringing their practice acts into compliance after which the models would be imposed. The Commission's plan allowed states to enact a broader scope of practice for APNs than the minimum provided by model acts.²¹

The Clinton Administration's proposal and the PPRC recommendations advance policy which comports with data demonstrating the competency and cost effectiveness of advanced practice nurses.²² A large and growing number of states are authorizing prescription by advanced practice nurses, reflecting this data.²³ Currently, 48 states legally authorize some form of prescription by advanced practice nurses.²⁴ Of those 48 states, 11 permit independent prescription by nurses (including controlled substances), 22 authorize dependent prescription (including controlled substances), and 15 authorize dependent prescription (excluding controlled substances).²⁵ In states which do not authorize prescription by APNs, APNs may nonetheless prescribe via standing orders, written protocols jointly developed by advanced practice nurses and physicians, blank prescription pads signed by a physician, individual requests to a physician for

18. James F. Blumenstein, *The Clinton Administration Health Care Reform Plan: Some Preliminary Thoughts*, 19 J. HEALTH POL. POL'Y & L. 201, 204 (1994).

19. Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 202 (1992).

20. 1994 PHYSICIAN PAYMENT REVIEW COMMISSION ANNUAL REPORT TO CONGRESS 265, 265 (1994).

21. *Id.*

22. See Larry W. Koch et al., *The First 20 Years of Nurse Practitioner Literature: An Evolution of Joint Practice Issues*, 17 NURSE PRAC. 62, 62-71 (1992).

23. See Pearson, *1994 Annual Update*, *supra* note 14, at 17; Linda J. Pearson, *1991-92 Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice*, 17 NURSE PRAC. 14, 14-23 (1992) [hereinafter Pearson, *1991-92 Annual Update*]; Linda J. Pearson, *1990-91 Update: How Each State Stands on Legislative Issues Affecting Nursing Practice*, 15 NURSE PRAC. 11, 12-18 (1991) [hereinafter Pearson, *1990-91 Annual Update*].

24. Linda J. Pearson, *1995 Annual Update of How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice*, 20 NURSE PRAC. 13, 51 (1995) [hereinafter Pearson, *1995 Annual Update*]. This tally may vary with interpretation of state nursing, medical and pharmacy practice acts and accompanying administrative rules and regulations. Hadley, *supra* note 6, at 6. This tally includes Washington D.C. as a state.

25. Pearson, *1995 Annual Update*, *supra* note 24, at 16, 51.

scripts, or phone-in the prescription to a pharmacy under a cooperating physician's name.²⁶

B. Opposition Towards the Expansion of APNs' Functions

Organized medicine has long opposed the trend towards APN prescription, just as it has historically opposed any expansion of nursing functions into areas traditionally reserved for medicine.²⁷ Central to this resistance was the struggle over nurses' authority to "diagnose."²⁸ Diagnosis, a functional prerequisite to prescription, was once reserved for medicine.²⁹ In fact, the word "diagnosis" was not included in early Nurse Practice Acts. However, beginning in the 1970s, this trend was reversed.³⁰ Now it is customary for APNs to diagnose in dependent situations—through a physician's standing order, through the utilization of a physician-approved health care treatment protocol, or under the direct supervision of a physician. Essentially, there is no functional difference between nursing and medical diagnoses. The only difference is the qualifications of the persons making the diagnoses.³¹ Meanwhile, independent prescription by APNs signals a significant trend toward autonomous diagnosis by nurses. As one commentator has noted: "Nursing's efforts to obtain the legal authority to prescribe may be seen as the second chapter in the struggle over the use of the word 'diagnosing' in Nurse Practice Acts."³²

II. Policy Considerations Relating to Authorizing Independent Prescriptive Privileges for APNs

The Clinton Administration's emphasis on health care reform has moved the state of American health care to the forefront of public concern, partly due to its well-publicized shortcomings:

It is difficult, if not impossible, to pick up a magazine, journal or newspaper without reading about America's health care crisis. Although this country is spending significantly more on health care, its citizens are not

26. Pearson, *1990-91 Annual Update*, *supra* note 23, at 11, 18.

27. Lauren S. Aaronson, *A Challenge for Nursing: Re-Viewing a Historic Competition*, 37 *NURSING OUTLOOK* 274, 278 (1989).

28. See B. BULLOUGH, *THE LAW AND THE EXPANDING NURSING ROLE* 157-68 (1975); Robin S. Phillips, *Nurse Practitioners: Their Scope of Practice and Theories of Liability*, 6 *J. LEGAL MED.* 391, 391-414 (1985).

29. Elizabeth H. Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 *AM. J.L. & MED.* 245, 291 (1989).

30. See *id.* at 249-61. For example, Connecticut included the words "nursing diagnosis" in its 1975 NPA amendment. See *id.* at 258.

31. But see PATRICIA A. POTTER, *BASIC NURSING THEORY AND PRACTICE* 11-112 (2d ed. 1991), for a different viewpoint of "medical" versus "nursing" diagnosis.

32. Hadley, *supra* note 29, at 263.

getting healthier. In the last five years, U.S. health care costs have risen 42 percent more than the cost of food, housing, and transportation. Health care represents 11.5 percent of the Gross National Product Yet, despite all of this spending, the U.S. ranks 12th in life expectancy, 21st in child mortality, 22nd in infant mortality and 24th in low infant birth weight.³³

A. American Health Care and APNs

In response to public concerns, a central thrust of the Clinton health care policy focuses on universal access to health care, cost effective delivery of health services and quality. A number of studies have demonstrated that APNs improve access while reducing costs and maintaining quality.³⁴ Three reports by the Office of Technological Assistance ("OTA"), the research arm of the U.S. Congress, analyzed data and concluded:

the weight of the evidence indicates that NPs, PAs (Physician's Assistants), and CNMs (Certified Nurse Midwives) have positive influences on quality and access, that they could increase productivity and save costs, and that they have been accepted in a wide range of settings, and under many different payment systems.³⁵

In terms of quality of care, NPs appear to provide care that is of as high quality as that of physicians There is some evidence that NPs working according to protocols may provide services of even better quality than those provided by some physicians.³⁶

NPs, PAs (Physicians' Assistants), and CNMs have become important medical care providers in rural areas and are the only licensed providers of primary health care in some areas with no physicians . . . these professionals are most likely to be found in States with mid-level practitioner schools and in States that permit more independent practice.³⁷

More recent data demonstrates the comparative propensity of APNs over MDs to work in Health Professional Shortage Areas ("HPSAs") and to serve Medicaid beneficiaries and low income populations:

Nearly 19% of CNMs [Certified Nurse Midwives] provide care in high-poverty areas, compared with 10% of obstetrician-gynecologists About 14% of primary care NPs [nurse practitioners] serve in poverty areas, compared with more than 9% of physicians . . . 44% of NPs estimated that more than one-quarter of their patients were Medicaid beneficiaries, and 28% estimated that more than half were Medicaid

33. Bobbie Evans, *Current Status/Current Problems: Community Health Nurses*, in *NURSES AND PRESCRIPTIVE AUTHORITY: SPECIALTY NURSING FORUM CLEMSON UNIVERSITY COLLEGE NURSING NATIONAL CONFERENCE PROCEEDINGS* 35, 36 (1990).

34. Susan McGrath, *The Cost-Effectiveness of Nurse Practitioners*, 15 *NURSE PRAC.* 40, 40-42 (1990); Koch et al., *supra* note 22, at 62-66.

35. *Abstracts of Case Studies in the Health Technology Case Study Series*, 1986 OFFICE OF TECHNOLOGY ASSESSMENT REP. 55.

36. *Abstracts of Case Studies in the Costs and Effectiveness of Nurse Practitioners*, 1990 OFFICE OF TECHNOLOGY ASSESSMENT REP. 26 [hereinafter *Abstracts*].

37. *Health Care in Rural America*, 1990 OFFICE OF TECHNOLOGY ASSESSMENT REP. 14.

beneficiaries. Approximately 89% of the CNMs said they serve low-income women; about 80% reported serving uninsured women . . . 21% indicated that at least 90% of their patients lived in inner-city or low-income areas; 13% said their entire patient population lived in such areas.³⁸

This data supports earlier reports that APNs increase the underserved's access to cost effective, high quality primary health care.

The policy advantages of utilizing APNs are underscored by the interplay of numerous factors associated with American health care and with the relative characteristics of medicine and nursing. These factors include the shortage of primary health care services, the availability of APNs and of nurses to be trained as APNs, and the reduced costs associated with training and fielding health care with APNs.

There is a marked shortage of American health services in the area of primary care.³⁹ The breadth of primary care services that APNs can offer has been described as a percentile of delegable medical tasks. Sources indicate that somewhere between 60 to 90% of routine adult and pediatric primary care visits are safely provided by APNs.⁴⁰ These figures demonstrate the great potential of APNs to meet America's need for primary care services.

Primary care routinely entails prescription by the caregiver. For example, some 75% of office visits to internists result in prescription of medication.⁴¹ APNs need the same capability to prescribe treatment in order to effectively deliver primary care. This need for prescriptive authority is reflected in the data indicating that fewer APNs practice in the rural areas of states with no prescriptive authority (7%) than APNs practicing in states with prescriptive authority (17%).⁴²

Studies isolating data on the actual prescribing practices of APNs have been conducted with results supporting the safety and reliability of APNs prescribing treatment. One study reviewed 2,081 prescriptions written by APNs in an adult primary care setting and found that only 50 prescriptions

38. 1994 PHYSICIAN PAYMENT REVIEW COMMISSION ANNUAL REPORT TO CONGRESS, *supra* note 20, at 277.

39. Hadley, *supra* note 29, at 261-63.

40. Koch et al., *supra* note 22, at 66 (quoting Alfred Yankauer & Judith Sullivan, *The New Health Professionals: Three Examples*, 1982 ANN. REV. PUB. HEALTH 249-76). This study states 80-90% are delegable to APNs; see also AMERICAN NURSES ASS'N, PRIMARY HEALTH CARE, NURSING FACTS 1 (1993). This paper states 60-80% are delegable to APNs.

41. David A. Woodwell, *Office Visits to Internists, 1989*, ADVANCE DATA, Apr. 1992, at 1. The three most commonly prescribed drugs in this study were amoxicillin, hydrochlorothiazide, and furosemide. *Id.* at 6.

42. 1994 PHYSICIAN PAYMENT REVIEW COMMISSION ANNUAL REPORT TO CONGRESS, *supra* note 20, at 281.

were changed after consultation with a physician.⁴³ Of these 50 prescriptions, 48 medications were changed to a different drug within the same class (e.g. from one antibiotic to another), and only 2 drugs (0.04%) were changed to a different drug category. Another study reviewed 1,000 prescriptions written by APNs in a primary care setting.⁴⁴ Of the 1,000 prescriptions, 98% were indicated according to evidence in the record. The remaining 2% were inadequately documented but consistent with treatment protocols. One hundred percent of the medications were adjudged safe, and no complications arose from any of the prescriptions.⁴⁵ The study also noted that the number of prescriptions written by APNs reflected a low use of medications as compared to physicians.

One APN training program in Colorado singlehandedly launched the movement to expand nursing in 1965.⁴⁶ By 1992, there were 242 nurse practitioner programs including Adult, Community Health, Family, Ontological, Mental Health, Neonatal, Anesthesiology, Ob/Gyn, Occupational Health, Oncology, Pediatric, School Health, and Women's Health Programs.⁴⁷ In addition, there were 29 Certified Nurse Midwifery Programs and 90 Certified Registered Nurse Anesthetists Programs.⁴⁸ These educational programs, typically providing an advanced degree beyond basic nursing education, are well-established and guided by nearly 30 years of research. The cost of an APN education is approximately one-fifth that of a medical education.⁴⁹

Unquestionably, the pool of potential APNs is large. Registered Nurses ("RNs") comprise the most numerous category of health care professionals and the number of nurses grows steadily. In 1988, there were 1,627,035 RNs and 585,597 physicians in America or 2.78 nurses per physician.⁵⁰ By 1992, there were four registered nurses for every physician in America.⁵¹

43. Linda J. LaPlante & Freda V. O'Bannon, *NP Prescribing Recommendations*, 12 *NURSE PRAC.* 52, 52-58 (1987).

44. Donna Munroe et al., *Prescribing Patterns of Nurse Practitioners*, *AM. J. NURSING*, Oct. 1982, at 1538-42.

45. *Id.* at 1542.

46. Koch et al., *supra* note 22, at 62.

47. NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACILITIES, *NAT'L DIRECTORY OF NURSE PRAC. PROGRAMS* (5th ed. 1992).

48. See AMERICAN COLLEGE OF NURSE MIDWIVES, *BASIC QUESTIONS AND ANSWERS ABOUT CERTIFIED NURSE MIDWIFERY* (1991); see also AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, *QUESTIONS AND ANSWERS ABOUT A CAREER IN NURSE ANESTHESIA* (1992).

49. Barbara Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 *YALE J. ON REG.* 417, 437 (1992).

50. *Health Care in Rural America*, *supra* note 37, at 216, 219.

51. Mary Mallison, *Dear Mr. President . . .*, *AM. J. NURSING*, Nov. 1992, at 7.

Tallying the number of primary care providers alone, there are 100,000 APNs and 206,000 primary health care physicians currently in the United States.⁵² With the large number of established APN educational programs, a large number of RNs to fill them and the relatively low cost of advanced practice training, the nation's training dollars for primary care providers are well-spent in nursing.

Another advantage to fielding primary health care with APNs is apparent in the comparative salaries of APNs and MDs. In 1992, the average net income for physicians was \$170,600. The average salary of an APN was \$43,600.⁵³ Twelve years ago, the State of California translated this salary differential into health care costs when it commissioned a study of non-physician prescribing. The study reported that permitting non-physician health care providers to prescribe and dispense drugs would produce a cost savings to California of *at least* \$2 million per year.⁵⁴ Based on those results, the study recommended statutory authority for APNs, physicians assistants and pharmacists to prescribe treatment. In 1992, the California legislature granted APNs that authority.⁵⁵

Synthesizing the information discussed above, substantial data has accumulated demonstrating the following: (1) America has a need for primary health care; (2) APNs have a proclivity to work in health care shortage areas; (3) APNs have the demonstrated ability to deliver quality primary care; (4) primary care routinely entails prescription of medication; (5) APN prescription is both safe and consistent with standard medical practice; and, (6) care provided by APNs costs less. Meanwhile, no data exists indicating that the use of APNs leads to any adverse effects upon patient mortality or morbidity. The nursing profession has the present capacity to inexpensively train and field large numbers of primary care providers with the demonstrated ability and need to prescribe. The crisis in American health care needs remedies now, and the nursing profession is poised to respond. American health policy is advanced where state nurse practice acts authorize independent prescriptive authority for APNs.

B. The Nursing Profession and Its Regulation

A profession is distinguished from other occupations by its high social status, service ideal, possession of specialized knowledge obtained through lengthy education and clinical training, and relative autonomy in controlling

52. *American Nurses Association Expresses Disappointment Over AMA Opposition to APN Autonomy*, AM. NURSE, Jan. 1994, at 1, 3.

53. *Id.* at 3.

54. See DeLeon et al., *supra* note 3, at 388.

55. See CAL. BUS. & PROF. CODE §§ 2746.51, 2836.1 (West Supp. 1995).

training and performance of work.⁵⁶ Consequently, the nursing profession has an interest in a federal policy permitting independent prescriptive practices for APNs for a number of reasons. First, as discussed above, health care can be improved by APN practice. Second, APNs complete additional training beyond their basic education in order to offer primary health care. Finally, *without* independent prescriptive privileges, the utility of advanced nursing practice is reduced and the autonomy and status of the profession is diminished.

For example, a toddler visits a university-based nursing center, and an APN diagnoses him with acute otitis media (an ear infection). The parents are provided with information concerning the ailment but must be referred elsewhere to get a simple antibiotic prescription from a physician:

The same is true with a client with a strep throat after we have run a strep test. At the very best, this means that the client incurs a cost for a visit to us and a cost for a visit to the physician. At the worst, it means that we can't treat the client. And the physician won't treat the client if there is an outstanding bill.⁵⁷

These examples demonstrate the unnecessary diminution of quality and access to health care where APNs lack the autonomous legal authority to prescribe for conditions they are equipped to diagnose. Additionally, the profession of nursing is belittled where the legal requirement for MD supervision exists, because it suggests to the public that APNs lack knowledge to prescribe treatments for conditions they have diagnosed. No data exists to support such a conclusion.

Mandated supervision by individual physicians constitutes a delegation by the state, to any individual MD, of authority to set the parameters of advanced nursing practice. Such an arrangement is flawed. It is the state legislature's constitutional obligation to define and regulate professional practices as provided by the federal constitution.⁵⁸ Delegating this function to individual physicians may be unconstitutional and necessarily results in as wide a variety of APN practice parameters as there are supervising physicians. Such idiosyncratic nonuniformity necessarily confounds state nursing boards and professional associations in their duties to regulate the practice and set standards. Furthermore, physicians lack the requisite education to determine the nursing profession's proper practice. Medical schools do not focus their courses on management, nursing, or regulation. Physicians are prepared to deliver health care, and it is ill-advised to distract

56. Aaronson, *supra* note 27, at 274.

57. Sara E. Barger, *Current Status/Current Problems: Community Nursing Centers*, in *NURSES AND PRESCRIPTIVE AUTHORITY: SPECIALTY NURSING FORUM CLEMSON UNIVERSITY COLLEGE OF NURSING NATIONAL CONFERENCE PROCEEDINGS* 39, 40 (1990).

58. Hadley, *supra* note 6, at 1.

them from that end at a time when America has a critical need for their services. Another important consideration is organized medicine's anticompetitive policy toward advanced nursing practice which sets the stage for a genuine conflict of interest where physician supervision is mandated by state law.⁵⁹

Organized nursing has demonstrated its interest in controlling the standards of nursing practice, including independent prescriptive privileges, in a policy statement and model prescriptive practices legislation.⁶⁰ State legislatures have a constitutional obligation to set the parameters of professional practice. The professional organizations are best suited to set standards for their own practices, and the state licensing boards are best situated to regulate their own individual practitioners. This nationwide scheme is best served and implemented by statutory authorization of autonomous advanced nursing practice and independent prescriptive privileges.

III. APNs and Liability Issues

An analysis of liability issues attaching to prescription by APNs is revealing and forms a basis for this article's regulatory recommendations for autonomous APN prescriptive privileges. Liability concerns surrounding APN prescriptive authority exist for APNs and MDs alike. They include: (1) causes of action in malpractice and (2) potential violations of individual state Medical and/or Nursing Practice Acts. Certain liability problems exist partially because the widespread practice of APNs prescribing has preceded the clear autonomous grant of legal authority.

A. Malpractice Liability

The elements of malpractice and the theories of liability described below have dual relevancy to a discussion of APNs prescribing treatment. First, negligence by APNs functioning in a dependent role foists liability upon collaborative MDs. Second, nurses were not traditionally liable in malpractice actions. Now, nursing liability is a reality. The discussion below sets forth the elements of a negligence cause of action, addresses four theories under which MDs and hospitals are held liable for the actions of an APN, and contends with the modern reality of direct liability for nurses.

The health care purchaser has the right to sue his health care provider for negligence whether that provider is an MD, APN, hospital or other health organization. In a medical malpractice trial, the plaintiff must prove

59. See *infra* notes 109-13 and accompanying text.

60. See American Nurses Ass'n, *Nursing a Social Statement* (1980); AMERICAN NURSES ASS'N, *SUGGESTED STATE LEGISLATION* (1990) [hereinafter ANA SUGGESTED LEGISLATION].

negligence to survive a defense motion for directed verdict and to submit his case to a jury. The four elements of a negligence claim are duty, breach of that duty, causation and damages.⁶¹

"Duty" is based upon the defendant nurse, hospital or MD having a legal requirement to undertake care of the plaintiff. A plaintiff must sue those health care providers who entered into some form of express or implied agreement to provide care and who undertook to evaluate and/or treat the plaintiff, usually for compensation.⁶² The concept of duty has been enlarged by the courts through the use of certain legal doctrines which shift and expand liability beyond the professional directly responsible for treatment of the plaintiff.

"Breach" refers to the breach of medical duty in a malpractice action. Referred to as "medical negligence," this standard represents a departure from an established standard of care and has been variously defined in case law.⁶³ The standard of care used to judge delivery of medical services is typically established by the expert testimony of a medical practitioner at trial.⁶⁴ Thus, the medical profession itself sets the standards of practice applied by the courts.

"Causation" and "damages" refer to injuries suffered by the plaintiff that are causally related to the defendant's medical negligence. Personal injury damages may be labeled "economic" or "special" (such as past or future medical bills and lost wages), or "noneconomic" or "general" (such as pain and suffering or loss of companionship).⁶⁵

Theoretically, it is the negligent health care provider who assumes a duty of care and is held personally accountable for damages to an injured plaintiff in a malpractice action. However, courts have long entertained differing theories of legal accountability in order to find an adequate insurance pool to compensate plaintiffs. Thus, liability has been vicariously imposed

61. WILLIAM L. PROSSER ET AL., *CASES AND MATERIALS ON TORTS* 144 (7th ed. 1982).

62. See Furrow et al., *supra* note 4, at 283-86.

63. See *Hall v. Hilbun*, 466 So. 2d 856 (Miss. 1985). One such definition which considers not only the skill of the practitioner but resources available is as follows:

given the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment and options.

Id. at 873.

64. FURROW ET AL., *supra* note 4, at 131.

65. PROSSER ET AL., *supra* note 61, at 541.

upon the party with the "deep pocket," meaning the party with the greatest resources with which to compensate plaintiff.⁶⁶

Respondeat superior, a basic agency rule, is one such theory. Under respondeat superior principles, liability is shifted onto the employer, master or principal for the negligent acts of his employee, servant or agent when those acts arise in the course and scope of their employment, service or agency.⁶⁷ Applying this theory to an APN, the employer physician or hospital answers for the negligent acts of an employee APN performed during the course of duty.

A relative of the respondeat superior doctrine, and a second theory to finding deep pockets, is the borrowed servant doctrine:

Under the borrowed servant doctrine, a nurse employed by a hospital may be considered the temporary employee of a physician where the nurse's services have been borrowed for a period of time. The application of the doctrine depends upon whether the MD had the right to direct and control the conduct of the nurse at the time of the negligent act.⁶⁸

Thus, the borrowed servant doctrine could find application in prescriptive errors by APNs employed by hospitals or clinics but working under the direction of an MD or possibly just utilizing physician developed protocols. The borrowed servant doctrine draws physicians into negligence lawsuits filed against nurses where the physician had a purely supervisory role. In states mandating that APNs function in a dependent role, the state has, in effect, foisted liability for the APN upon anyone who agrees to collaborate, whether or not that individual ever examined the patient plaintiff or consulted on the particular care provided.

A third theory of liability, apparent authority, is another theory shifting legal accountability from a medical or nursing practitioner onto a hospital. Apparent authority is defined as follows:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.⁶⁹

Thus, hospitals and other health care facilities may be held liable for the actions of independently contracting health care providers as long as a pa-

66. Phillips, *supra* note 28, at 404.

67. Lynn D. Lisk, *Physician's Respondeat Superior Liability for the Negligent Acts of Other Medical Professionals-When the Captain Goes Down Without the Ship*, 13 U. ARK. LITTLE ROCK L.J. 183, 183 (1991).

68. Phillips, *supra* note 28, at 401; see *Ramon v. Mani*, 535 S.W.2d 654 (Tex. Ct. App. 1976), *aff'd*, 550 S.W.2d 270 (Tex. 1977) (applying the borrowed servant doctrine).

69. RESTATEMENT (SECOND) OF TORTS § 429 (1965).

tient reasonably believes that an agency relationship existed between the two.⁷⁰ This liability results when the patient looks to the institution, rather than the individual practitioner, for care; and, it results when the hospital holds out the health care provider as its employee.⁷¹

A final theory of liability is the doctrine of corporate liability. Similar to apparent authority, corporate authority is another theory drawing hospitals into malpractice suits involving an independently contracting health care provider. Under the doctrine of corporate liability, a contracting agency or hospital can be held liable if it negligently selected and/or hired the provider to whom privileges were granted.⁷² The hospital is held liable for credentialing an allegedly unfit provider where it had reason to know that the provider's ability was questionable.

Liability shifted under corporate negligence and apparent authority theories is a concern for hospitals and physicians today and potentially for APNs. However, liability shifted under these two theories is not related to restrictive state practice acts mandating dependent APN roles. Instead, they are incidents of practice and of the complex health care system. On the other hand, APN liability shifted onto supervisory MDs under the doctrines of respondeat superior and borrowed servant is exacerbated by state laws mandating a dependent APN practice. In those states, health care providers and patients cannot enjoy the demonstrated benefits of advanced nursing practice without exposing MDs to automatic expanded liability. As a result, physicians have no incentive to assume additional exposure to liability resulting from supervision of APNs unless they are adequately compensated for their risk. Unfortunately, it is economically unsound for patients receiving APN care to pay a surcharge to compensate MDs for assuming greater risk. The best solution is legislating autonomous advanced nursing practice and prescription. This action would relieve physicians of the burden of supervision and the resultant liability and reduce the cost of health care.

Traditionally, nurses were not considered to be susceptible to medical malpractice negligence suits because they did not practice medicine and therefore could be liable only for ordinary nonmedical negligence.⁷³ Ordi-

70. See, e.g., *Jackson v. Power*, 743 P.2d 1376 (Alaska 1987).

71. FURROW ET AL., *supra* note 4, at 228.

72. See, e.g., *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156 (Cal. Ct. App. 1982). See generally Susan E. Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325 (1992).

73. *Morris v. Children's Hosp. Medical Ctr.*, 597 N.E.2d 1100 (Ohio Ct. App. 1991); *Neilsen v. Barberton Citizens Hosp.*, 446 N.E.2d 209 (Ohio Ct. App. 1982). Both cases retain the theory that a nurse may only be liable in ordinary negligence. *Neilsen* holds that a nurse may give expert testimony against a physician in a medical malpractice action involving respondeat superior.

nary negligence typically enjoyed a longer statute of limitation than medical negligence thus giving the plaintiff a longer period of time in which to bring a lawsuit against a nurse and a hospital. Recent trends suggest a change in this situation such that definitions of negligence have evolved in both traditional and expanded nursing practices. Malpractice theory has been specifically applied to APNs and is increasingly reflected in case law definitions of standards of care tailored to APNs.⁷⁴ The appropriate experts to establish the APN standard of care in litigation should be other APNs.⁷⁵

California adopted a specific APN standard of care in *Fein v. Permanente Medical Group*.⁷⁶ In *Fein*, an APN, and subsequently an MD, failed to diagnose Fein's myocardial infarction (heart attack). The California Supreme Court held that the legislature intended to create a scope of practice for some nurses whose functions overlapped a variety of physician functions. The court also held that the standard of care to be applied by a jury measuring the APN's treatment of Fein is that of a reasonably prudent APN. This decision overturned a lower court opinion which had made the standard of care for APNs the same as that for physicians.⁷⁷

The burden of liability for advanced practice nursing is best placed upon the individual APN utilizing an APN standard of care rather than on a supervisory MD.⁷⁸ The standard of care by which a court should measure advanced nursing practice should be that degree of skill and learning commonly exercised by a prudent and reasonable member of the APN profession. Health policy is disadvantaged when liability is shifted upon an MD, because the deterrence goal of malpractice is hindered where liability is shifted away from the wrongdoer and the incentive to avoid malpractice removed.

One commentator, Robin S. Phillips, recommends application of malpractice theory to APNs by placing accountability directly upon the APN practicing independently or dependently.⁷⁹ While this position supports meritorious health policy by placing accountability upon the wrongdoer, it is questionable whether the judiciary, absent legislative direction, could constitutionally carve out an exception for supervising MDs that inhibits the plaintiff's right to sue in tort. It is also questionable whether legislatures, in

74. *Gugino v. Harvard Community Health Plan*, 403 N.E.2d 1166 (Mass. 1980); *Whitney v. Day*, 300 N.W.2d 380 (Mich. Ct. App. 1980) (adopting a Certified Registered Nurse Anesthetist Standard of Care); *Webb v. Jorns* 473 S.W.2d 328 (Tex. Ct. App. 1971).

75. *Baker*, *supra* note 72, at 354.

76. 695 P.2d 665 (Cal. 1985).

77. See Kenneth F. Moss, *California Supreme Court Defines Standard of Care for NPs*, *NURSE PRAC.*, May 1985, at 39-42.

78. Phillips, *supra* note 28, at 405.

79. *Id.* at 404-05.

states mandating a dependent APN practice, would or could insulate supervisory MDs from liability for an APN's negligence.⁸⁰ To effectuate malpractice theory for advanced practice nursing, independent authority of APNs to diagnose and prescribe must be legislated. Where such autonomous practice is authorized, professional liability would lie with the APN. Thus, the opportunity to shift liability in a case of APN negligence would be similar to the opportunity to shift liability in the case of MD negligence.

Critics argue that adding APNs to the list of medical malpractice defendants will increase the "medical malpractice crisis." Advocates counter that APNs enjoy a much lower rate of malpractice,⁸¹ and the National Practitioner Data Bank indicates that there are 70 malpractice claims per 1,000 MDs compared to less than 1 claim per 1,000 registered nurses.⁸² They attribute this lower claim rate to the fact that APNs spend more time with patients and enjoy better communication with patients and families, suggesting that patients are less likely to sue for a poor treatment outcome involving a nurse.⁸³ As a result, the low level of liability from advanced nursing practice is not likely to increase the malpractice crisis.

In summary, malpractice liability bears upon prescriptive authority for nurses. The deterrence goal of malpractice litigation is best served where APNs are independently liable to their patients in professional malpractice, according to an advanced nursing standard of care. Where APNs are limited to prescription in a dependent role (e.g. where states mandate that a physician "supervise" APNs, co-write treatment protocols, or otherwise collaborate in the prescription writing of an APN), states foist liability for APN negligence onto supervisory MDs via doctrines of shifting liability.

In contrast, where APNs are given clear legislative authority for independent practice and prescription, no legal justification would exist to support the inclusion of an MD defendant in an APN malpractice suit unless an MD takes an active role in the patient care by consulting on individual cases or employing APNs. Under such arrangements, the MD elects to share directly in the financial benefits as well as the liabilities of the particular patient or of the APN practice.

80. The 1993 Illinois legislature defeated House Bill 2048 which required APNs to collaborate with MDs but insulated MDs from liability for the APNs. See *Illinois Attorney General's Opinion is Victory for Consumers and Advanced Practice Nurses*, NP News, Mar.-Apr. 1994, at 5.

81. See Mallison, *supra* note 51, at 7. "Less than 1% of nurse practitioners and less than 6% of nurse-midwives are sued for malpractice. Compare that to one-third of all physicians and four-fifths of all obstetricians." *Id.*

82. Virginia T. Betts, *M.D.S. Must Give Nurses Expanded Role in Primary Care to Achieve National Health Reform Goals*, 11 HEALTH SPAN 10, 10 (1994).

83. *Regulatory Theory and Prospective Risk Assessment in the Limitation of Scope of Practice*, 4 J. LEGAL MED. 447 (1983); see also *Abstracts*, *supra* note 36, at 26.

For both APNs and MDs, a major consideration in granting prescriptive privileges to APNs is the increased accountability for the prescribing APN. Where APNs deliver primary care, public policy demands that they carry substantial professional liability insurance with which to compensate injured patients. In those states where physicians are mandated to carry such insurance, it would serve public policy to extend the mandate to other providers authorized to independently deliver health care and prescribe. With APNs already prescribing in some 90% of the states, APNs need the clear independent legal authority to prescribe and MDs need clear delineation of who bears the malpractice liability for negligence in those states which retain mandatory collaboration.

B. Liability for the Unauthorized Practice of Medicine and for Practice Outside the Scope of the Nurse Practice Act

The lack of clear legislation defining nursing practice gives rise to liability for disciplinary actions by the board of nursing and/or criminal complaints by the board of medicine. This liability is highlighted where nurses are held liable in medical malpractice for failing to provide the same care which would give rise to liability for the unauthorized practice of medicine or practice outside the legitimate scope of nursing. A review of applicable case law indicates that this dilemma is not uncommon. For example, hospital nurses have been held liable for failure to assess hospitalized patients and to timely notify physicians of changing patient signs and symptoms.⁸⁴ Further, they have been held liable for failure to perform acts within their authority to protect the health of patients where a physician's care substantially departs from accepted medical standards,⁸⁵ and for failure to adequately assess, admit and initiate proper treatment to a new hospital patient in a hospital emergency room.⁸⁶ These cases show that courts hold hospital nurses liable for proper diagnosis, knowledge of pharmacology and patient treatment. Nonetheless, APNs face professional discipline and criminal liability in cases where they *have* competently diagnosed, prescribed and treated patients.

Professional discipline and criminal liability typically arise where the nursing or medicine boards respectively allege that the nursing practice exceeded statutory limitations defined in the Nurse Practice Act or encroached on a physician's duties defined under a Medical Practice Act. Liabilities for

84. *Goff v. Doctors Gen. Hosp. of San Jose*, 333 P.2d 29 (Cal. Ct. App. 1958). See also Bobbie J. Moon, *Prescriptive Authority and Nurse Midwives*, 35 J. NURSE MIDWIFERY 50, 50-52 (1990).

85. *Poor Sisters of St. Francis v. Catron*, 435 N.E.2d 305 (Ind. 1982).

86. *Valdez v. Lyman-Roberts Hosp.*, 638 S.W.2d 111 (Tex. 1982).

APNs and/or MDs include: (1) criminal charges filed against APNs by the state board of medicine for practicing medicine without a license (also called the unauthorized practice of medicine); (2) professional discipline undertaken by the state board of nursing against APNs for practicing outside the scope of the Nurse Practice Act (such discipline may include cancelling the license to practice); (3) criminal charges filed against collaborating or supervising physicians for aiding and abetting APNs in the unauthorized practice of medicine; and, (4) professional discipline undertaken against MDs by the state board of medicine for assisting in the unauthorized practice of medicine.

In *Ethridge v. Arizona State Board of Nursing*,⁸⁷ a hospital nurse received discipline from her state nursing board for "unprofessional conduct" because she administered medications to burn unit patients without a physician's order. The appropriateness of the prescription was not an issue. Rather, physicians had failed to sign a preprinted standing order form routinely and customarily used for patients admitted to that unit. Unit physicians testified that experienced nurses followed this practice of administering medications without first obtaining a signature on the forms while new nurses customarily obtained a verbal order first. Though acting in a routine manner, the nurse was disciplined.

That the Arizona Board of Medicine did not discipline the physicians for aiding and abetting the nurses for practicing medicine without a license suggests the utility to patients and MDs of nurses functioning in a substitute prescriptive role in the hospital—particularly in intensive care units where need for patient assessment is constant and critical.

In *Montgomery v. Department of Registration and Education*,⁸⁸ a nurse appealed a decision by the Department's Committee on Nursing revoking her nursing license for prescribing medications. A doctor who regularly consulted at a Children's Rehabilitation Center left for a four-week vacation without arranging for a replacement physician. Instead, he arranged that the Director of Nursing provide care and medications during his absence. The doctor promptly countersigned all the nurse's medication orders upon his return. However, complaints were filed with the Department of Registration and Education that the doctor had left the children without medical attention. No complaints were filed alleging that the care provided or the medications ordered by the nurse were substandard. Following filing of the complaints, the parameters of the four-week doctor/nurse arrangement for continuing care and medications were disputed with respect to

87. 796 P.2d 899 (Ariz. Ct. App. 1989).

88. 496 N.E.2d 1100 (Ill. App. Ct. 1986).

whether or not the doctor directed the nurse to consult with another MD before prescribing or administering medications. Ultimately, complaints were filed against the nurse for the unauthorized practice of medicine and the doctor testified against her.⁸⁹

Many state Medical Practice Acts include a disclaimer exempting nurses practicing within the Nurse Practice Act from criminal prosecution under the unauthorized practice of medicine provision in the Medical Practice Act.⁹⁰ Where the Medical Practice Act contains this disclaimer, the legal issue shifts from whether the nursing comprised the unauthorized practice of medicine to whether the advanced nursing practice is outside the scope of the Nurse Practice Act. If the practice falls outside the Nurse Practice Act, the APN is *not* exempted from criminal prosecution under the Medical Practice Act for the unauthorized practice of medicine. Where the Nurse Practice Act broadly defines nursing, a court, or a jury, may be called upon to determine this issue.

In *Sermchief v. Gonzales*,⁹¹ the Missouri Board of Healing Arts threatened to file complaints against family planning APNs and their collaborating physicians, respectively, for the unauthorized practice of medicine and for aiding and abetting the unauthorized practice of medicine. The APNs were providing family planning services to women and prescribing under protocols jointly developed with physicians. The APNs and MDs sought a declaratory judgment with the circuit court to determine whether the nurses' practice was within the scope of the state's Nurse Practice Act.⁹² The Missouri Supreme Court decided in the plaintiffs' favor, holding that the nursing activities, including prescription, were within the definition of nursing in the Nurse Practice Act. Pursuant to that case law, APNs continued to prescribe under protocols in Missouri until mid-1993, when the state legislation passed a collaborative practice law.⁹³

In the meantime, the Board of Healing seemed to be on a mission to halt the collaborative prescriptive practices of the APNs and MDs. Subsequent to the *Sermchief* decision and prior to the 1993 law, the Missouri

89. Subsequently, complaints against the doctor were dropped. The nurse's license was revoked, and she appealed based upon the defendant Department's refusal to provide discovery materials from their files. Plaintiff argued that she needed the files to adequately prepare for the hearing concerning revocation of her license. She won the right to discovery. The administrative appeal was not reported. *Id.* at 1103.

90. *See, e.g.*, MO. REV. STAT. § 334.010 (1939).

91. 660 S.W.2d 683 (Mo. 1983).

92. *Id.* Declaratory judgment is a "remedy for the determination of a . . . controversy where the plaintiff is in doubt as to his legal rights." BLACK'S LAW DICTIONARY 283 (abridged 6th ed. 1991). A binding determination of the rights and status of the litigants is awarded by the court, even though no consequential relief is given. *Id.*

93. *See* MO. REV. STAT. § 334.104 (1994).

Board of Healing Arts took the position that a 1987 amendment to the Medical Practice Act required direct supervision of APNs and superseded *Sermchief*.⁹⁴ Thus, the Board of Healing Arts was investigating collaborative MD/APN prescriptive practices in Missouri and threatening to file complaints against APNs for the unauthorized practice of medicine and against MDs for aiding and abetting the unauthorized practice of medicine.

Missouri physicians and APNs who engaged in collaborative practice attempted to resolve this intimidating situation in *Group Health Plan, Inc. v. State Board of Registration for the Healing Arts*.⁹⁵ There, the Health Maintenance Organization ("HMO") had an arrangement whereby APNs examined patients and prescribed routine medications by filling out blank prescription pads pre-signed by HMO physicians. The Missouri Board of Healing Arts threatened actions against HMO physicians, for aiding and abetting the unauthorized practice of medicine, and the APNs, for the unauthorized practice of medicine. Consequently, the HMO, MDs, pharmacists and APNs involved filed a declaratory action with the circuit court. Ultimately, it settled on the eve of trial with some of the MDs receiving mild discipline.⁹⁶ Thus, the legality of the Board's position was not tested in court and their investigations continued until 1993, when Missouri enacted H.B. 564 which clarified the practice of APNs.

Significantly, the appropriateness and quality of prescriptions written by the HMO APNs was not at issue in *Group Health Plan, Inc.* Nevertheless the case generated a long and checkered history, was batted about between court and agency, endured extraordinary writs and lengthy discovery, was plagued by changes in staff at the Missouri Board of Healing Arts, was prolonged by the Board's refusal to comply with discovery requests, and suffered with conflicts of interest among state counsel for different state agencies.

A similar situation occurred in *Barry v. State Medical Board*,⁹⁷ where an RN, who completed training as a physician's assistant, became employed by an MD. The RN conducted the clinical practice of an APN, diagnosing and treating patients under jointly developed protocols. The Ohio State Board of Medicine refused to register the RN as a physician's assistant and prepared to revoke the MD's license for aiding and abetting the RN's unauthorized practice of medicine. The RN brought suit and the court

94. Leslie Champlin, *Nurse Practitioners in the Cross Hairs*, HEALTH CARE TIMES, Oct. 26, 1992, at 1, 8.

95. 787 S.W.2d 745 (Mo. Ct. App. 1990).

96. Interview with Richard D. Watters, plaintiff's counsel, of Lashly, Baer & Hamel, in St. Louis, Mo. (Dec. 6, 1994).

97. No. 89AP-689, 1990 Ohio App. LEXIS 3874 (Ohio Ct. App. 1990).

held that his practice was within the scope of the Nurse Practice Act and that the MD's license could not be disciplined.

The preceding cases illustrate lawsuits in which state licensing bodies are challenging APNs and MDs concerning the unauthorized practice of medicine or practice outside the scope of nursing defined in Nurse Practice Acts in situations where the patient care practices were competently performed, beneficial to the patient, and customary. Such suits are long, expensive, intimidating and a valid concern to every practitioner.

Besides licensing board sanctions and criminal proceedings, the appropriate scope of a nurse's practice is litigated in a number of other settings. In *Abbott Northwestern Hospital, Inc. v. Commissioner of Jobs and Training*,⁹⁸ a nurse challenged a denial of unemployment benefits where he had been discharged for conduct allegedly beyond the scope of his nursing license. His conduct included initiating an iced lavage of an endotracheal tube and ignoring the directions of a resident MD regarding an x-ray. The court held that the evidence supported a finding of misconduct and that benefits were appropriately denied. In *Professional Health Care, Inc. v. Bigsby*,⁹⁹ the seller of a clinic brought an action against a buyer for breach of contract. Among other defenses, the buyer alleged that the contract was void because the practice of a clinic APN constituted the illegal practice of medicine. The court disagreed, holding that the APN's practice, physician collaboration and use of protocols were within the Nurse Practice Act. In *Hoffson v. Orentreich*,¹⁰⁰ a patient brought a medical malpractice action against an MD and a negligence action against a nurse for permanent facial scars allegedly caused by the nurse's draining of acne cysts. The court held that it was not error to permit the jury to decide whether the nurse acted within the legal scope of nursing or practiced medicine without a license.¹⁰¹

In summary, state boards of medicine and nursing are in a position to take legal action against MDs and APNs in collaborative or supervised prescriptive practices where there is an absence of specific legislation or administrative rules and regulations defining autonomous advanced nursing practice, particularly prescriptive authority. Where MD and APN job descriptions require the acts later challenged, vague legal parameters put clini-

98. 448 N.W.2d 519 (Minn. 1989).

99. 709 P.2d 86 (Colo. Ct. App. 1985).

100. 562 N.Y.S.2d 479 (N.Y. App. Div. 1990).

101. Another situation occurs where malpractice insurers attempt to use vague state practice acts to squirm out of covering an APN sued in malpractice because the nurse was allegedly practicing medicine. See, e.g., *Argonaut Ins. Co. v. Continental Ins. Co.*, 406 N.Y.S.2d 96 (N.Y. App. Div. 1978) (declaratory judgment action for ruling on whether insurer had to cover a Certified Registered Nurse Anesthetist's practice. The court held that that determination would have to be made during the tort action in chief).

cians in an impossible dilemma and cripple the planning and delivery of health care. Equally impossible is the patient care predicament where the court may hold a nurse liable in malpractice for *not* performing the same acts over which the professional boards will file criminal complaints or base disciplinary actions.

It is neither advisable nor possible to tightly define in legal terms any professional practice because all practices are dynamic and changing. Legal definitions must accommodate for that evolution. Nonetheless, the clear statutory definition of advanced nursing practice coupled with both the grant of independent prescriptive privileges in Nurse Practice Acts and the eradication of unauthorized practice provisions in Medical Practice Acts would alleviate the related criminal, malpractice and disciplinary dilemmas that MDs and APNs face.

Any proposed legislation and regulation in the area of expanded nursing practice, including authorization of dependent or independent prescriptive privileges, should address all liability issues: malpractice liability, criminal liability for the unauthorized practice of medicine or for aiding and abetting the unauthorized practice of medicine, and professional disciplinary liability. Legislative authorization of independent nursing practice and prescription would advance the deterrence goals of malpractice, obviate vexatious litigation over turf and stop the filing of criminal and disciplinary complaints for customary MD/APN collaboration.

IV. Barriers to Prescriptive Authority for APNs

The barriers to APNs prescribing are formidable. Some barriers are broadbased and impede the expansion of advanced nursing practice in general, while others are unique to APN prescriptive practices. General barriers include exclusive reimbursement patterns, anticompetitive practices and lack of public awareness. Specific legal barriers include state regulation and practice acts, Drug Enforcement Agency registration and lack of constitutional protection.

A. General Barriers

1. Exclusive Reimbursement Patterns

Health care is largely financed through third party reimbursement from private insurance companies and federal health insurance programs. Direct third-party reimbursement to APNs for their services promotes the development of advanced nursing practices.¹⁰² While some states do not permit

102. Mittelstadt, *supra* note 15, at 43, 49.

direct reimbursement, other states, by mandating dependent advanced nursing practice, transfer control of direct nursing reimbursement to supervisory MDs.

Medicare permits direct reimbursement of APN services in nursing homes and rural areas.¹⁰³ Medicaid also permits direct reimbursement of certified nurse midwives, pediatric nurse practitioners and family nurse practitioners.¹⁰⁴ Determining which states permit APNs to directly receive third-party reimbursement depends on interpreting interactive statutes and administrative rules. Pearson indicates that 35 states allow third-party reimbursement of APNs and 49 states permit some degree of APN Medicaid reimbursement.¹⁰⁵ The reimbursement authorized may be categorically restrictive (such as Medicare's reimbursement of only those APNs serving patients in rural areas or nursing homes), limited by state provisions reimbursing APNs at a reduced percentage of the customary medical charge, or by other geographic or patient-based reimbursement restrictions. Where the state mandates a dependent practice, the APN may not practice without a cooperating physician who may condition his/her collaboration upon channelling reimbursement through his/her practice. This vitiates any state's authorization for direct reimbursement.

Where APNs are not directly reimbursed, or reimbursement is restricted, limited or reduced, the flexible evolution of advanced practice nursing is compromised.¹⁰⁶ Indirect reimbursement interposes the administrative mechanisms of physicians or health care facilities between APNs and their patients. This arrangement places the MD or facility in position to control the APN practice. One manifestation of this control is putting the APN on straight salary and pocketing the unlimited remainder of the reimbursement, thus limiting APNs' earning power and acting as a disincentive to those considering entering the profession.¹⁰⁷

103. *Id.* at 47. See also Marjorie Vanderbilt, *Senate Committee Votes Yes on Amendment Providing Medicare Reimbursement to RNs*, AM. NURSE, July-Aug. 1994, at 2. The U.S. Senate Finance Committee on July 1, 1994 unanimously voted in favor of the Grassley Conrad Amendment which would expand direct Medicare reimbursement to APNs in all outpatient settings. *Id.*

104. 42 U.S.C. § 1396d(a)(17), (21) (Supp. V 1993).

105. Pearson, *1994 Annual Update*, *supra* note 14, at 17.

106. Karla Kelly, *Nurse Practitioners: Regulation and Restraints*, 11 AM. J.L. & MED. 195, 207 (1985).

107. See generally *Arkansas State Nurses Ass'n v. Arkansas State Medical Bd.*, 677 S.W.2d 293 (Ark. 1984). Invalidating legislation that discourages RNs from becoming APNs is a policy concern that has been expressed by this court. In this case, plaintiff Nurses Association brought an action for declaratory relief seeking to invalidate Board of Medicine rules adversely affecting APNs. The rules forbade MDs from collaborating with more than two APNs at any one time, and defined violation of the rules as "malpractice." The Court invalidated the rules, holding that they were arbitrary and noting that the Board of Medicine had no authority to define malpractice. The

Indirect reimbursement is associated with three other economically unsound features.¹⁰⁸ First, a physician may add a supervision charge to the APN fee for service as an additional expense to the patient or third-party payor. Second, physicians may charge their own fees for functions performed by the APN rather than the reimbursement level assigned for APNs. Third, forcing public health care consumers to purchase the more expensive of two interchangeable services interferes with free market trade, resulting in inflated health care costs.

In summary, some states mandate indirect reimbursement. Other states mandate dependent practice—the effect of which is that APNs must work for or with MDs. Where APNs are statutorily required to work for or with MDs in order to practice, the MDs may mandate indirect reimbursement even if the state does not. Where the physician practice administers the reimbursement for APN services, the total practice income is increased by the unlimited amount of the reimbursement and decreased by the amount of the APN's salary. Keeping in mind that MDs assuming supervisory roles are liable for APN malpractice, and that MDs have no reason to assume additional liability without compensation, health care costs are likely to be inflated.

Indirect reimbursement also extinguishes the APN's control of his/her own practice and jeopardizes quality by placing power in the hands of MDs who are removed from the patients served, yet motivated by profits. This diminishes the qualities which make APN care effective, such as time spent and amount of communication. A hospital or physician practice administering APN reimbursement can increase its revenue by requiring an employee APN to increase patient load even where the APN would choose fewer patients with more time allotted to each. Aside from quitting the profession altogether, the APN in a state which mandates dependent practice or dependent reimbursement will likely lack the power to modify the situation.

2. Anticompetitive Practices

The resistance of organized medicine to APNs delivering traditionally physician-provided patient care services is another general barrier to APN's prescribing. It is noteworthy that organized medicine's opposition to competition with advanced practice nursing does not necessarily reflect the attitudes of all physicians.

Historically, organized medicine has attempted to deal with competition from nurses by suppressing it. Efforts to keep nurses in dependent

opinion enunciated the policy concern that the state needed health care providers and that the effect of the rule would be to discourage RNs from becoming APNs. *Id.* at 283.

108. Hadley, *supra* note 29, at 250-53.

roles surfaced as early as 1906.¹⁰⁹ While the female dominated nursing profession has been uncomfortable acknowledging the competition between itself and medicine, the male-dominated medical profession has not.¹¹⁰ The relative postures of medicine and nursing were framed, in part, by their respective responses to significant national reports assessing their professions, such as the 1910 Flexner Report for medicine and the 1923 Goldmark Report for nursing.¹¹¹ While implementing the Flexner recommendations, medicine took full legal control of its educational facilities, practice, and practitioners. As a result, medicine advanced in social status and in its control of health care. In contrast, nursing did not fully implement the Goldmark recommendations. Subsequently, nursing became a highly stratified and hierarchical profession. The heterogeneity hindered its professional advancement.

The American Medical Association's ("AMA") policies and model state legislation demonstrate its current negative posture towards competition from APNs. Table C in the AMA's *Policy Compendium* lists the resolutions which are nonsupportive of APNs.¹¹² The AMA's Model State Act is consistent with its above stated policies.¹¹³ The Act would also establish direct physician supervision of APNs with the physician limiting the drugs APNs are permitted to prescribe and controlling which patients APNs are permitted to serve.¹¹⁴

A recently released report to its Board of Trustees also reflects the AMA's negative view of APNs prescribing independently or receiving direct reimbursement for services.¹¹⁵ Its addendum, "Talking Points," lists

109. Aaronson, *supra* note 27, at 275 (citing *Nurses' Schools and Illegal Practice of Medicine*, 47 JAMA 1835 (1906)).

110. *Id.* at 276.

111. *Id.* at 276-78.

112. AMERICAN MEDICAL ASS'N, AMA POLICY COMPENDIUM, 31, 61, 63, 118, 209, 229 (1990). Resolution 38.032 verbalizes supports for competition in medical services as long as the nations' access to high quality medical care is safeguarded. *Id.* at 118. Resolution 83.001 opposes legislation authorizing the independent practice of medicine by nurse practitioners. *Id.* at 229. Resolution 7.005 recommends the elimination of federal funding for the training of mid-level practitioners (mid-level practitioners is a term often applied to describe APNs); and resolution 7.007 recommends that reimbursement for allied health personnel should be paid directly to a physician and that such personnel should be under the physician's supervision. *Id.* at 31. Resolution 73.006 "alerts" state medical associations to initiatives that would replace physician services to the elderly, the poor and the chronically ill with nurse centered programs. *Id.* at 209. Resolutions 23.006 and 23.023 oppose psychologists prescribing and pharmacists providing alternative medications. *Id.* at 61, 63.

113. See NURSE PRACTITIONER PRESCRIPTION PRACTICE ACT (Am. Medical Ass'n 1991).

114. *Id.* § 4.

115. AMERICAN MEDICAL ASSOCIATION, ECONOMIC AND QUALITY OF CARE ISSUES WITH IMPLICATIONS ON SCOPES OF PRACTICE—PHYSICIANS AND NURSES, REPORT 35 OF THE BOARD OF TRUSTEES (1993). The 17-page report does not document its statements with footnotes and con-

six questions pertaining to APNs and provides responses against independent nursing practice.¹¹⁶

Organized medicine's anticompetitive policies are further reflected in the legislative stances adopted by some state medical associations. California exemplifies the inherent inconsistency in this position:

The California legislature enacted special legislation which authorized the practice of nurse-midwifery in a demonstration project in one county. During the three-year life of the project, both the prematurity rate and the neonatal mortality rate declined 50% in the county. Opposition by the California Medical Association to a permanent legalization of nurse-midwifery practice resulted in the legislature's termination of the pilot program's authority. Following the termination, the county's prematurity rate increased 50% to pre-project levels, and the neonatal mortality rate almost tripled.¹¹⁷

It is inconsistent for state medical associations to maintain a position that quality health care is their objective when they oppose authorization of advanced practice nursing in disregard of data demonstrating the positive impact of APNs on health care.

Medicine's anticompetitive efforts also take the form of blocked access to facilities.¹¹⁸ In order to provide health care, a health care provider needs access to hospitals, long term care facilities and clinical laboratories. Presently, only 11% of APNs hold hospital privileges.¹¹⁹ It is a substantial impediment to practice when an APN is denied staff privileges because the APN is then unable to admit patients to that facility and/or utilize its patient care services.¹²⁰ Physicians have generally resisted allowing privileges for

tains only 14 bibliography citations. It summarily discredits data supportive of APNs, fails to fully explore issues, and ignores the work of major commentators. For example, the report compares physician and nursing education. While critical of the non-uniformity in nursing education and certification, the report fails to acknowledge the same non-uniformity within medicine (six-year medical school programs, medical school admission of students without undergraduate degrees, licensure of foreign medical graduates, differing residency requirements, and voluntariness of board certification).

116. The six questions are: (1) Are nurses qualified to practice independently? (2) Do nurses provide quality services independent of physicians? (3) Do nurses provide independent primary care at lower cost? (4) Should nurses increase access to care by providing independent services in underserved areas, rural and/or inner cities? (5) Are nursing services accepted by the public in place of physician services? (6) Does collaboration of physicians and nurses deliver effective care? *Id.* at 18-26.

117. Safriet, *supra* note 49, at 432 n.63.

118. See A.K. Dolan, *Antitrust Law and Physicians Dominance of Other Health Practitioners*, 4 J. HEALTH POL. POL'Y & L. 675, 675-90 (1980).

119. *Report Shows Overview of NP and CNS Populations*, NP News, July-Aug. 1994, at 7 (citing a 1992 Study by the Bureau of Health Professionals, Health Resources and Services Administration Document #PB94-158169).

120. *Wicker v. Union County Gen. Hosp.*, 556 So. 2d 297 (Miss. 1989) (holding that a CRNA had no right to practice in a hospital without staff privileges which were limited in bylaws to physicians and dentists).

APNs, and hospitals and clinical laboratories typically accommodate the inclinations of physicians for economic reasons.¹²¹ The combined resistance of the physicians and the hospitals reduces the APN's access to facilities and increases the need to refer patients to physicians for admission, clinical pathology and other procedures. As a result, the APN is forced into a dependent role and health care costs increase.

Another anticompetitive effort is seen where individual state boards of medicine and state medical associations attempt to curtail APN practice through use of litigation. These forms of litigation include: (1) challenges to the delegatory authority of the state board of nursing in order to invalidate administrative rules for APN practice; (2) prosecution of APNs for the unauthorized practice of medicine; and, (3) discipline of collaborative physicians for aiding and abetting the APNs. The court's responses have varied.

Numerous anticompetitive efforts were demonstrated in *Nurse Midwifery Associates v. Hibbett*.¹²² Its lengthy facts were reproduced in the district court opinion as follows:

Plaintiffs Susan Sizemore and Victoria Henderson are certified nurse midwives and principal partners of plaintiff Nurse Midwifery Associates, (NMA), a professional partnership for the provision of nurse midwifery services. Plaintiff Darrell Martin, M.D., a licensed obstetrician, entered into an agreement with plaintiffs in January, 1980 for the purpose of establishing a family-centered maternity practice. According to the agreement, NMA would be a financially independent nurse midwifery practice for which Dr. Martin and his associates would provide medical supervision and services. Pursuant to the contractual arrangement, plaintiff nurse midwives sought admitting privileges at defendant hospitals, and Dr. Martin sought renewal of his medical malpractice insurance policy from defendant SVMIC. [SVMIC was a physician owned and operated malpractice insurance company.]

The crux of the complaint is that the defendant physicians, in order to protect their lucrative obstetrics practices in Nashville, Tennessee, sought to prevent the nurse midwives from competing with them. The defendant physicians allegedly entered into a conspiracy for the purpose of preventing plaintiffs from operating a family-centered maternity practice or offering nurse midwifery services at hospitals in the Nashville area. In furtherance of that objective the defendant physicians (pediatricians and obstetricians) determined to bar plaintiff nurse midwives from

121. Kelly, *supra* note 106, at 209. "Because hospital administrators cannot afford to alienate staff physicians, who generate revenues, medical staff decisions on hospital privileges are rarely challenged. Similarly, clinical laboratories, which might be willing to cooperate with non-physician providers, are unlikely to do so if they fear physician reprisal." *Id.* (citing Dolan, *supra* note 118, at 676).

122. 918 F.2d 605 (6th Cir. 1990), *reh'g granted and modified*, 927 F.2d 904 (6th Cir.), *cert. denied sub nom.* Nurse Midwifery Assocs. v. Hendersonville Community Hosp., 502 U.S. 952 (1991).

obtaining hospital privileges at defendant hospitals The complaint alleges that in order to offer the type of maternity practice plaintiffs contemplated, a qualified obstetrician must be responsible for the medical care provided by nurse midwives Defendant Dr. Hibbett and other physician co-conspirators, including members of the Underwriting Committee of SVMIC, "determined to boycott, intimidate and coerce plaintiff (Dr.) Martin through the concerted action of cancelling his malpractice insurance policy with SVMIC because of his contract with plaintiffs Henderson and Sizemore."¹²³

The Federal Court of Appeals ultimately held: (1) that plaintiffs could bring an antitrust suit against the physician owned insurance company; (2) that plaintiffs could bring an antitrust suit against hospital committee obstetricians because they were in competition with the midwives; (3) that plaintiffs could *not* bring an antitrust action against hospital committee pediatricians because they were not in competition with the midwives; and, (4) that the absence of conspiracy, a prerequisite to an antitrust action, barred portions of the claims even in the presence of anticompetitive boycotts.¹²⁴ This case indicates that some federal circuits will apply antitrust principles to some hospital privilege and insurance cases, but that illegal boycotts will go untouched if the court cannot find conspiracy.

Midwifery spanned nine years of complex antitrust litigation. The application of antitrust law to situations like *Midwifery* is increasing for two reasons: (1) advanced practice nursing is encroaching on what was traditionally medicine's territory and (2) the parameters of lawful competition are relatively unexplored in health care.

The anticompetitive efforts of organized medicine is also demonstrated in *State Medical Society v. State Board of Nursing*.¹²⁵ In this case, the Louisiana State Medical Society filed a suit for declaratory judgment to invalidate a Louisiana Board of Nursing rule creating a position titled Primary Nurse Associate (another title for APNs), or in the alternative, to challenge the constitutionality of the Board of Nursing's right to make the rule. Plaintiff's allegations, reproduced in the opinion, included:

12. The practice of medicine by registered nurses . . . is antithetical to the public policy of this state . . . and represents a direct, immediate and substantial danger to the health, safety and welfare of the citizens of this State . . . In addition, (it) has interfered with . . . the relationship between physicians and their patients

123. *Nurse Midwifery Assocs. v. Hibbett*, 549 F. Supp. 1185, 1187 (M.D. Tenn. 1982), *subsequent proceeding*, 689 F. Supp. 799 (M.D. Tenn. 1988), *aff'd in part and rev'd in part*, 918 F.2d 605 (6th Cir. 1990), *reh'g granted and modified*, 927 F.2d 904 (6th Cir.), *cert. denied sub nom.* *Nurse Midwifery Assocs v. Hendersonville Community Hosp.*, 502 U.S. 952 (1991).

124. 918 F.2d at 617.

125. 552 So. 2d 1008 (La. Ct. App. 1989). The Louisiana State Nurses Association intervened in the suit on behalf of the Nursing Board.

. . . .
15. The Society . . . is aggrieved by the Rules of the Nursing Board, which authorize registered nurses to engage in the independent practice of medicine, have interfered . . . with the physician-patient relationship . . . and will unlawfully infringe upon and impede a physician's prerogative to employ a registered nurse, under the physician's direction and supervision to perform functions which the physician deems such registered nurse qualified and capable to perform.¹²⁶

The court held that the plaintiff Medical Society lacked standing to sue because it did not make the requisite showing of irreparable injury. In dicta, the court noted that despite allegations of immediate danger to the public, the rule had been in effect for two years and no complaints or disciplinary proceedings had been leveled against any APN. In so noting, the Court looked past the professional, policy and legal issues, commenting that there was no empirical data to support allegations that care provided by APNs was unsafe. Because the plaintiff lacked standing, the constitutional challenge to the board's authority to make the rules was not reached.

A constitutional challenge was addressed in a similar case, *Bellegie v. Texas Board of Nurse Examiners*,¹²⁷ which was decided in favor of the Board of Nursing. Plaintiff physicians and medical societies there had also challenged a Board of Nursing rule defining APNs. The court held: (1) that the Board had the statutory authority to make the rule; (2) that the rule was reasonably related to the Nurse Practice Act; (3) that the rule did not enlarge the scope of nursing beyond that set forth in the Board's enabling legislation; and, (4) that the rule was reasonably related to legislative intent to distinguish nurses based upon education.

These cases demonstrate that the nursing interests prevailed in lawsuits arising out of anticompetitive behavior. Nonetheless, such challenges compose a substantial barrier for APNs who wish to prescribe because lawsuits are risky, time consuming, intimidating and expensive. A major objective of legislation and regulation of APNs should be a clear grant of authority to practice in order to eliminate the ambiguities out of which such lawsuits grow.

In summary, the American Medical Association, some State Boards of Medicine and some State Medical Associations attempt to suppress competition from advanced practice nurses. The resulting litigation does not advance health care and, in fact, poses a threat to competent physicians and nurses. It is disparaging to the professions of nursing and medicine to engage in counterproductive turf battles, particularly at a time when America

126. *Id.* at 1010.

127. 685 S.W.2d 431 (Tex. Ct. App. 1985).

critically needs its health care professionals to take the lead in forging a system that serves all Americans.

3. Lack of Public Awareness

Another general barrier to the expansion of nursing practice is the public's lack of awareness.¹²⁸ Many Americans do not know what APNs do or the breadth and cost effectiveness of the health care they offer. A 1992 study of APNs concluded that a lack of knowledge by the general public about the nurse practitioner and clinical nurse specialist roles was the most frequently cited barrier to APN practice.¹²⁹

Conversely, the attributes of APN practice are known to health care researchers and legislators dedicated to effective health care reform. That health care groups are aware of the expanded practice of nursing was made evident by the large number of amicus briefs filed in the well known Missouri case *Sermchief v. Gonzales*.¹³⁰ In *Sermchief*, APNs were challenged for delivering contraceptive care in a Family Planning Clinic utilizing protocols developed jointly by participating MDs and APNs. Judge Welliver made specific note that the large number of amicus briefs which were filed with the court resembled a letter writing campaign directed at a legislative body.¹³¹ Some 35 health related associations and 80 medical school faculty members from 30 different schools filed briefs urging their perspectives upon the court. In a comment on *Sermchief*, the American Medical Association also made note of the large number of amicus briefs filed.¹³²

In summary, health care providers and analysts understand the potential role of APNs and the advantages they can offer American health care. However, the public does not fully understand advanced practice nursing. Consequently, the public underutilizes APNs, does not complain when direct reimbursement of nursing services is unavailable and may not actively support authorizing expanded nursing practice.¹³³ This lack of public understanding undermines the progress of advanced practice nursing.

128. Joyce Fitzpatrick, *Positioning Nursing to Meet Its Destiny*, in NURSES AND PRESCRIPTIVE AUTHORITY: SPECIALTY NURSING FORUM CLEMSON UNIVERSITY COLLEGE OF NURSING NATIONAL CONFERENCE PROCEEDINGS 179, 179-84 (1991).

129. *Report Shows Overview of NP and CNS Populations*, *supra* note 119, at 7.

130. 660 S.W.2d 683, 686-87 (Mo. 1983).

131. *Id.* at 686. Many were returned unread comporting with the Court's obligation to construe statutes as a matter of law and to disregard public influence and sentiment.

132. *Missouri Supreme Court Decision on Nursing Practice*, 48 JAMA 471 (1984).

133. Mittelstadt, *supra* note 15, at 47.

B. Specific Barriers to APN Prescriptions

Legal barriers to APNs prescribing are framed within the context of State Practice Acts and regulation, the Drug Enforcement Administration rules, and the lack of constitutional protection for the APN's right to prescribe.

1. State Regulation and Nursing Practice Acts

Nursing practice acts, medical practice acts and pharmacy practice acts may all contain information governing who may prescribe drugs in a given state. In addition, state administrative agencies (e.g. boards of medicine, nursing or pharmacy) control professional licensure and typically promulgate rules and regulations which also govern prescription of medications. The labyrinth of interactive practice acts and agency rules makes the identification of legitimate prescriptive practice a formidable task. Additionally, professional licensing acts are imprecise and controversial. Written by state legislators with limited knowledge about professional practice, these statutes are a product of compromise and politics.¹³⁴

The states are given the power to license professionals by the Tenth Amendment to the U.S. Constitution.¹³⁵ States have this power for the purpose of protecting the health and welfare of their citizens—not for the purpose of protecting the regulated profession from competition.¹³⁶ Nonetheless, many medical and nursing practice acts do protect professional turfs by way of unauthorized practice prohibitions. The use of unauthorized practice provisions to thwart competition is demonstrated by the cases discussed earlier in this article where unauthorized practice challenges were leveled against nurses, but no allegations were made or substantiated that the practice of or the medications prescribed by the APNs actually jeopardized the health or welfare of the public.¹³⁷

The state boards, sometimes called licensing agencies, have received critical review for many years.

Economists argue that licensing stifles competition and increases health care costs. Manpower specialists contend that statutory scopes of prac-

134. DeLeon et al., *supra* note 3, at 385.

135. The Tenth Amendment states: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the states respectively, or to the people." U.S. CONST. amend. X.

136. Hadley, *supra* note 29, at 248.

137. *Ethridge v. Arizona State Bd. of Nursing*, 796 P.2d 899 (Ariz. Ct. App. 1989); *Montgomery v. Department of Registration and Educ.*, 496 N.E.2d 1100 (Ill. App. Ct. 1986); *Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983); *Group Health Plan, Inc. v. State Bd. of Registration for the Healing Arts*, 787 S.W.2d 745 (Mo. Ct. App. 1990); *Barry v. State Medical Bd.*, No. 89AP-689, 1990 Ohio App. LEXIS 3874 (Ohio Ct. App. 1990).

tice create arbitrary barriers to both geographic and career mobility, and contribute to the reduced utilization of new emergent categories of health personnel.¹³⁸

Licensing boards are predominantly composed of members of the regulated profession. Therein lies a conflict of interest: board members are establishing rules which will affect their own livelihoods. Additionally, the composition of the boards may not be broad enough to adequately represent the entire profession. For example, where a board of nursing does not contain an APN, the board lacks expertise in the drafting of rules for advanced practice nursing.

In summary, professional regulation has been under attack for years. Imprecise professional definition, misused unauthorized practice prohibitions and ill-composed boards with built-in conflicts of interest devise statutory and administrative legal barriers for APNs who desire prescriptive authority.

2. Drug Enforcement Agency Registration

Historically, another specific barrier to APN prescription was the policies and rules of the Drug Enforcement Administration ("DEA"). Currently, health insurance reimbursement practices related to DEA registration numbers impair the prescriptive practices of APNs.

The DEA was established in 1973 to keep legitimately manufactured controlled substances in legal channels. Those Americans who wish to prescribe controlled substances (e.g. narcotics, sedatives, etc.) must obtain DEA registration numbers. Historically, states authorized only traditional medical practitioners (e.g. physicians, dentists) the broadest rights to prescribe, and the DEA registered only those practitioners.

In 1991, the DEA proposed an "affiliated practitioner" rule to deal with the growing numbers of new health care providers who were prescribing.¹³⁹ At that time, the DEA took the position that the only APNs to be permitted their own DEA registration numbers were those in states which gave them independent prescriptive privileges (plenary authority) for controlled substances. The DEA proposed that all others use the DEA numbers assigned to their collaborating physicians.¹⁴⁰ That proposal, which defined

138. H.S. Cohen, *On Professional Power and Conflict of Interest: State Licensing Boards on Trial*, 5 J. HEALTH POL. POL'Y & L. 291, 291 (1980).

139. Definition and Exemption of Affiliated Practitioners, 56 Fed. Reg. 4181 (1991) (to be codified at 21 C.F.R. pts. 1301, 1304).

140. Uncapher reported that the actual impetus for the proposed legislation was the confusion produced by the diverse state laws on the authority of NPs and PAs to handle controlled substances. J. John Uncapher, *DEA Requirements for DEA Numbers*, in NURSES AND PRESCRIPTIVE

and stratified the independent versus the affiliated practitioner, received so much criticism that it was withdrawn in 1992.¹⁴¹

That same year, the DEA proposed to amend its regulations by creating a new category of prescribers called mid-level practitioners.¹⁴² This rule, finalized in 1993, permits APNs to obtain their own DEA numbers whether they prescribe independently or dependently.¹⁴³ To date, 5,702 nurse practitioners have registered with the DEA.¹⁴⁴ The public reaction regarding the initial publication of this regulation included criticism for demeaning APNs by referring to them as mid-level practitioners and for assigning a number format different from traditional practitioners (mid-level practitioner numbers begin with the letter M rather than the letters A or B which appear in numbers of traditional practitioners).¹⁴⁵ Additional responses criticized the requirement for maintaining protocols for DEA inspection. The "Supplementary Information" section to this regulation clarified that maintenance of protocols is required only if state law requires such maintenance.

In total, the DEA mid-level practitioner regulation allows APNs to prescribe controlled substances to the extent authorized by the applicable state. It is unfortunate that the term "mid-level practitioner" was used. However, the regulation does not impair the independent or dependent prescriptive nursing practice nor does it make any requirements beyond those of traditional practitioners, except those required by state law.¹⁴⁶

AUTHORITY, SPECIALTY NURSING FORUM CLEMSON UNIVERSITY COLLEGE OF NURSING NATIONAL CONFERENCE PROCEEDINGS 69, 71 (1990).

141. Definition and Exemption of Affiliated Practitioners, 57 Fed. Reg. 15037 (1992) (to be codified at 21 C.F.R. pts. 1301, 1304).

142. Definitions and Exemptions of Affiliated Practitioners, 57 Fed. Reg. 33465 (1992) (to be codified at 21 C.F.R. pts. 1301, 1304).

143. DEA Records and Reports of Registrants, Gen. Info., 21 C.F.R. § 1304.02(f) (1993). This section defines mid-level practitioner as including, but not limited to nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and physician assistants who are authorized to dispense controlled substances by the state in which they practice. Section 1304.03(e) requires MLPs to maintain certain documents required by the state of practice for inspection by the DEA; examples listed include protocols, practice guidelines or practice agreements. Section 1301.24(b) indicates that MLPs who administer and/or dispense, but *not* prescribe, as agents or employees of another practitioner, may do so under that practitioner's registration number in lieu of obtaining a separate number. Section 1301.24(c) indicates that interns, residents, MLPs & foreign physicians may administer, dispense, *and prescribe* when authorized by a hospital or institution which assigns them a specific internal code number under its own registration.

144. Interview with Sharon Davies, Supervisory Registration Specialist, Drug Enforcement Agency, in Washington, D.C. (Dec. 5, 1994).

145. Definition and Exemption of Affiliated Practitioners, 58 Fed. Reg. 31171 (1993) (to be codified at 21 C.F.R. pts. 1301, 1304).

146. The DEA has published an official Mid-Level Practitioner's Manual which provides practical information on the Controlled Substances Act of 1970. U.S. DEPARTMENT OF JUSTICE

Of more concern are certain insurance reimbursement policies related to DEA registration numbers. Some insurance companies require a prescriber's DEA registration number for reimbursement of all prescription medications not just controlled substances. Thus, where this practice prevails, patients of APNs cannot obtain reimbursement for any medications prescribed by APNs who do not have a DEA number. Further, in those states not authorizing APNs to prescribe controlled substances, the APNs do not have DEA numbers. The DEA objects to this insurance company practice not only because it poses a reimbursement problem for mid-level practitioners, but also because it is an inappropriate use of DEA numbers.¹⁴⁷ Such use of DEA numbers increases public exposure to these numbers such that unauthorized persons could use the numbers to phone in fraudulent prescriptions. Consequently, this insurance practice exposes both physicians and APNs to misuse of their DEA numbers. However, it disadvantages only patients of APNs in obtaining reimbursement. While physicians in all states are authorized with controlled substances privileges, only twenty-seven states accord APNs controlled substance privileges.¹⁴⁸ Patients of APNs in the remaining states are ineligible to obtain reimbursement for all prescription medications where this insurance practice prevails. Such elimination of third party reimbursement for medication impairs the practice of APNs by limiting their ability to effectively treat patients.

3. Lack of Constitutional Protection

Another specific barrier to APNs prescribing is the absence of protection extended by state or federal constitutions to the right of APNs to pre-

DRUG ENFORCEMENT ADMINISTRATION, MID-LEVEL PRACTITIONER'S MANUAL, AN INFORMATION OUTLINE OF THE CONTROLLED SUBSTANCES ACT OF 1970 (1st ed. 1993).

147. Interview with Andrew McFaul, Program Analyst in the Policy Unit of Department of Drug Enforcement, Office of Diversion Control, in Washington, D.C. (Dec. 5, 1994). Mr. McFaul described a solution to this inappropriate use of DEA numbers in the Standardized Provider Identification Number program planned by the Department of Health and Human Services ("DHHS"), Health Care Financing Administration ("HCFA").

Interview with Gerald Wright, staff member of the HCFA Bureau of Operations, in Washington, D.C. (Dec. 7, 1994). HCFA intends to develop a numbering system for all health care providers in the United States. HCFA's current numbering system is known as UPIN (Uniform Provider Identification Numbers) and was developed pursuant to Consolidated Omnibus Budget Reconciliation Act ("COBRA"), 42 U.S.C. §1395ww (Supp. V 1993). This section directs DHHS to uniquely identify every physician who renders services for which Medicare pays. UPIN was developed for physicians in 1988. It was extended to nonphysician Medicare providers in 1994 and includes those certified nurses who are eligible for medicare reimbursement. Because Medicare only reimburses certain APNs, including certified registered nurse anesthetists ("CRNAs"), certified nurse midwives ("CNMs"), and those nurse practitioners who practice in rural areas, few APNs received UPINs.

148. Pearson, 1994 Annual Update, *supra* note 14, at 17.

scribe. Statutory amendments regulating advanced nursing practice are subject to constitutional challenge where they constitute a state action that restricts entry into practice.¹⁴⁹

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. 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."¹⁵⁰

Constitutional challenges generally include improper regulatory delegation by the legislature to the licensing board, violations of procedural and substantive due process, and denial of equal protection. The following case demonstrates a situation where constitutional protection was unavailable.

In *Ethridge v. Arizona State Board of Nursing*,¹⁵¹ a hospital burn unit nurse administered medicine under a preprinted but unsigned standing order. The Board of Nursing disciplined the nurse under a regulation titled "Unprofessional Conduct." Unprofessional conduct was statutorily defined as failure to maintain minimum standards of nursing practice. The facts indicated that the procedure used by the nurse was routine and that the standard order form was signed by the patient's physician the day after the nurse administered the drug. The physician who signed off on the order indicated his belief that the drug administration was proper, thus there was no complaint regarding the appropriateness of the medication. The regulation of the board of nursing and the disciplinary action levied against the nurse survived constitutional challenges.

The *Ethridge* court held that the administrative agency did not overstep its delegated legislative authority because the nurse practice act contained an intelligible principle to guide the agency's exercise of the delegated activity. The test was whether the regulations adopted by the board could be reasonably implied from the statutory scheme so as to carry out the intent of the legislature.¹⁵² Thus, the test was satisfied when the Board specified grounds for discipline.¹⁵³

The procedural due process challenge in *Ethridge* was denied because the Board used adequate procedural safeguards. Specifically, it gave nurses

149. Nancy L. Shore, *Advanced Nursing Practice and Prescriptive Authority: A Victory for New Jersey Nurses*, 17 SETON HALL LEGIS. J. 576, 595 (1993).

150. *Id.* (quoting National Council of State Boards of Nursing, National Council of State Boards Position Paper on the Licensure of Advanced Nursing Practice 2, at 2 (May 18, 1992) (on file with author)).

151. 796 P.2d 899 (Ariz. Ct. App. 1989).

152. *Id.* at 907.

153. *Id.*

adequate notice of the charges, conducted open meetings to deliberate over the charges, conducted a proper investigation of the charges and was not unfairly biased against the nurse.¹⁵⁴

The most important constitutional challenge to the Board of Nursing in *Ethridge* was the allegation that substantive due process was violated. "A statute denies an individual due process if it forbids or requires the doing of an act in language that is so vague that persons of common intelligence must necessarily guess as to its meaning and will differ as to its application."¹⁵⁵ The court held that the phrases "unprofessional conduct" and "minimum standards of acceptable and prevailing nursing practice" were sufficient to avoid arbitrariness and discrimination.¹⁵⁶ Thus, the substantive due process claim was denied.¹⁵⁷

Constitutional challenges to state practice acts prohibiting APNs from prescribing are also unlikely to succeed when based upon the Equal Protection Clause of the 14th Amendment.¹⁵⁸ The two tests applied to a statute alleged to deny equal protection are the "strict scrutiny" test which is reserved for fundamental interests, and the "rational basis" test which is applied to ordinary interests. It is more difficult for state statutes and regulations to survive a strict scrutiny test than a rational basis test. However, no fundamental interest such as race, religion, or sex is implicated where the right to professional practice is at issue, thus the rational basis test has been applied to constitutional challenges of practice acts.¹⁵⁹ Therefore, equal protection challenges offer APNs little assistance to overturn practice acts or rules which prevent them from prescribing.

The *Ethridge* case demonstrates that broadly written regulations enforced by nursing boards to restrict customary and beneficial nursing prescriptive practices can survive constitutional attacks for improper delegation and both procedural and substantive due process violations. Constitutional challenges to professional regulation will be bound by inter-

154. See also *Leigh v. Board of Registration in Nursing*, 506 N.W.2d 91 (Mass. 1987) (affirming decision to suspend license of an RN, not a CNM, for practicing midwifery without proper authorization in assisting in home births).

155. 796 P.2d at 907.

156. *Id.* at 908.

157. *Id.*

158. U.S. CONST. amend. XIV, § 1. This section provides:

No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Id.

159. *Paravecchio v. Memorial Hosp. of Laramie County*, 742 P.2d 1276 (Wyo. 1987), cert. denied, 485 U.S. 915 (1988).

pretations of regulatory and statutory language that may not be arbitrary as a matter of law, but may be arbitrary as a matter of fact.

V. Regulatory Theories Authorizing APN Prescriptive Privileges

Legal mechanisms to authorize prescription by APNs have been proposed by many knowledgeable theorists as well as by the American Nurses Association. Robin S. Phillips was a third-year law student when she wrote an article on the authorization of expanded nursing practice. Her analysis has some application to APN prescriptive authority, particularly her focus on shifting malpractice liability.¹⁶⁰ Barbara Safriet was an Associate Dean and Lecturer of Law at Yale Law School when she recommended a comprehensive four point legislative plan which establishes prescriptive privileges for APNs.¹⁶¹ Elizabeth H. Hadley was the Attorney Advisor for the Office of Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services when she recommended a two-part legislative proposal for prescription reform. Her proposed measures include independent prescriber statutes which would apply to *all* prescribers and elimination of both practice definitions and unauthorized practice provisions in state regulation of health care professionals.¹⁶² Finally, the American Nurses Association has published a Model Prescriptive Authority Act and a Model Nurse Practice Act.¹⁶³

Phillips analyzes the four basic avenues used by the states to authorize expanded nursing practice. First, with the "administrative approach" (the most common approach taken by the states), the state nursing board promulgates rules and regulations concerning APNs. However, where the boards are composed of RNs not knowledgeable in advanced practice, Phillips points out the board lacks representative membership to develop appropriate APN rules and consequently may avoid or abdicate its responsibility.

There are two variations in the second, "statutory patterns," approach. In the first variation, nurse practice acts authorize certain APNs to administer undefined "additional acts" beyond ordinary nursing. This approach may give the board discretion in developing such rules defining additional acts; nothing, however, requires the nursing board to do this. In Illinois, the Board refused to promulgate corresponding rules and regulations to further define the "additional acts" authorized by their Nurse Practice Act and an

160. Phillips, *supra* note 28, at 391.

161. Safriet, *supra* note 49, at 417.

162. Hadley, *supra* note 29, at 245.

163. ANA SUGGESTED LEGISLATION, *supra* note 60, at 2.

opinion from the Illinois Attorney General was elicited.¹⁶⁴ The phrase "additional acts" is so indeterminate that it may be subjected to interpretations that offer little protection to APNs from prosecution by boards of medicine for the unauthorized practice of medicine. Phillips advocates the second statutory pattern variation, whereby the nurse practice act defines a new title such as "Advanced Registered Nurse Practitioner." She believes this title should require specialty certification in order to stratify nursing and recognize a higher level of function.

Under the third approach, the "elimination of disclaimers approach," "disclaimers" in Nurse Practice Acts, which prohibited diagnosis and treatment by nurses, are limited or eliminated. "Nursing diagnosis" may be substituted. The disclaimer elimination approach does not, however, clarify the function of APNs and offers little reduction in litigation.

In the fourth approach, the "medical practice act" approach, MDs are authorized to delegate diagnosis and prescription to APNs. Such delegation benefits physicians' assistants rather than APNs, whose more advanced education and broader scope of practice are suited to autonomy. Additionally, delegation foists malpractice liability on MDs.

Phillips favors definition of APNs in state Nurse Practice Acts, mandatory certification of APNs and the promulgation of rules and regulations by nursing boards.¹⁶⁵ Her recommendations would have the effect of reducing litigation by placing the definition of and the authority for advanced practice in the statutes.¹⁶⁶ Phillips does identify the instances where nursing boards are ill-suited to manage the task of rule making for APNs, but she falls short of recommending APN advisory committees to the board.

Safriet's four-point plan forms a comprehensive regulatory scheme for APNs.¹⁶⁷ First, she vests sole authority over APNs in the nursing board so as to avoid any conflicting APN regulations. This would eliminate physician control. Safriet also discusses the formation of an advisory committee to counsel the nursing board on its APN regulation. Second, she recommends amending nurse practice acts to include an acknowledgement of advanced practice nursing and a single basic definition for all APNs such as:

a registered nurse licensed to practice in this state who, because of specialized education and experience, is authorized (certified) to perform acts of prevention, (medical) diagnosis and the prescription of (medical), therapeutic, or corrective measures under regulations adopted by the BON.¹⁶⁸

164. Phillips, *supra* note 28, at 411.

165. *Id.* at 414.

166. *Id.*

167. Safriet, *supra* note 49, at 478.

168. *Id.* at 479.

Safriet recommends using the word "medical" to describe functions of the APN in order to prevent prosecution for the unauthorized practice of medicine. Her third recommendation is for the modification of practice definitions in nurse practice acts to include any acts of APNs authorized by the nursing board, and to specifically empower the nursing board to promulgate APN regulations. Such definitions and delegatory specifications in Nurse Practice Acts would have the effect of preventing constitutional challenges to the rule-making and delegatory power of nursing boards. Her fourth recommendation calls for the purging of any statutory requirement for APN/MD collaboration or supervision. This would eliminate what Safriet calls the intolerable "privatizing (of) the state licensing function by conditioning an APN's scope of practice upon the dictates of one physician."¹⁶⁹ Safriet's system would reduce litigation and enable independent APN practice. In so doing, it would delineate malpractice liability and thus ultimately facilitate MD/APN collaborative practice.

Safriet indicates that her plan would enable states to place prescriptive authority in statutes or in administrative regulations.¹⁷⁰ However, in either case, it would empower APNs with independent authority to prescribe and enable them to obtain DEA numbers.¹⁷¹

The American Nurses Association has suggested pertinent model legislation with the stated goals of protecting public safety and providing access to a full range of health services for America's citizens.¹⁷² In accompanying comments, the American Nurses Association states:

Functions within nursing practice continue to overlap with those of other health care providers, raising questions about whether regulation of advanced practice ought to be a function of the state or of the profession. ANA continues to hold that the scope of nursing practice is defined by nursing through statements issued by the nursing profession.¹⁷³

The American Nurses Association's purpose in developing suggested legislation is to assist state nurses associations, which are organized to promote and secure enactment of laws regulating nursing practice.¹⁷⁴ The ANA advocates mandatory state licensure of registered nurses rather than simple registration, but supports voluntary specialty certification of APNs.¹⁷⁵ The ANA supports one broad statutory definition for all Regis-

169. *Id.* at 480.

170. *Id.* at 480-81.

171. *Id.* at 480.

172. ANA SUGGESTED LEGISLATION, *supra* note 60, at 35-37.

173. *Id.* at 2.

174. *Id.* at 5.

175. Phillips, *supra* note 28, at 408, 409. The term "Registered Nurse" is left over from the earliest state regulation of nurses, circa 1900, when registration was voluntary. Nurses could practice at that time without registration, but could not use the advantageous term "Registered

tered Nurses as opposed to defining APNs in the statute to minimize governmental regulation. This comports with its philosophy that a profession should regulate itself via standards, codes and peer review processes.

The ANA has drafted a Prescriptive Authority Act to be enacted in addition to the nurse practice act.¹⁷⁶ It declares legislative intent, lists perti-

Nurse" without meeting state registration requirements. Beginning in the late 1930's, states began to adopt mandatory licensure, and nurses could not practice without registering with the state and holding state licenses. At this time, states began to define nursing practice within their statutes.

176. ANA SUGGESTED LEGISLATION, *supra* note 60, at 35-37. The suggested language is as follows:

ARTICLE I

Section 101. *Legislative Intent*

The legislature of the state of (*state*) hereby declares that it is the policy of this state to regulate the authority of nurses licensed to practice professional nursing to prescribe. Any person licensed to practice professional nursing who prescribes without qualifying under the provisions of this act endangers the public health thereby. Nothing in this act shall be construed to limit functions and procedures already authorized by law, or which have common acceptance and usage.

ARTICLE II

Section 201. *Definitions*

As used in this act:

- (a) "board" means the (*state*) board of nursing as created in (*cite state statute*);
- (b) "prescriptive authority" means:
 - (1) to assess the need for drugs, immunizing agents, treatments, devices, and/or diagnostic tests;
 - (2) to implement Section 201(b)(1) of this act by administering, authorizing another nurse to administer, or writing prescriptions; and
- (c) "advisory committee" means a committee appointed by the board to carry out such duties as are described herein.

ARTICLE III

Section 301. *Advisory Committees*

(a) Membership.

(1) The committee will be composed of five (5) "_____" nurses appointed to the committee by the board.

(2) All nurse committee members shall be currently licensed as "_____" nurses in the state of (*state*).

(b) Terms. The board shall appoint committee members for a term of the board's discretion, but for no longer than four (4) years. The board may stagger the terms of the initial members appointed. No member shall serve more than two consecutive terms. Any committee member initially appointed for less than a full term shall be eligible to serve for one additional consecutive full term. The member shall serve until a successor is appointed.

(c) Compensation. Members of the committee shall serve without pay, but shall be reimbursed for the expenses incurred in the discharge of their duties at a rate determined by the state of (*state*).

(d) Officers. The board shall appoint a chairperson and vice chairperson.

(e) Duties. The committee shall:

(1) advise the board regarding rules and regulations for the implementation of this statute;

(2) review each "_____" nurse's application for authorization to prescribe, and advise the board regarding its recommendation of the application; and

nent definitions, establishes an advisory committee to the board of nursing and specifies the board's duties. The board's advisory committee would be comprised of APNs and would promulgate rules and act on applications for prescriptive authority.¹⁷⁷

In summary, the ANA recommends that (1) statutes (nurse practice acts) set minimum licensure qualifications for RNs for *mandatory* licensure; (2) nurse practice acts contain one professional definition that is broad enough to allow for role expansion commensurate with research and health care demands; (3) APN certification by specialty be on a voluntary basis; and, (4) statutes separate from the nurse practice act authorize APN prescription.¹⁷⁸

Elizabeth H. Hadley calls for a two-part prescription reform: (1) establishment of Authorized Prescriber Statutes and (2) elimination of unauthorized practice provisions and practice definitions in the professional practice acts.¹⁷⁹ The reform's goal is the promotion of economic efficiency by eliminating artificial constraints on the substitution of labor (APNs for MDs) in the provision of health services.¹⁸⁰

Hadley discusses current legislation authorizing prescription as either placing APNs in a role complementary to, or substitutive of MDs.¹⁸¹ In the complementary role, APNs must collaborate with an MD in order to prescribe, which increases costs to the consumer; whereas in the substitutive

(3) submit to the board for approval a form for application by "_____" nurses for approval to prescribe.

ARTICLE IV

Section 401. *Duties of the Board*

The board shall:

- (a) appoint the advisory committee(s);
- (b) upon recommendation of the advisory committee, grant to "_____" nurses duly licensed in (*state*) the authority to prescribe; and
- (c) upon advice of the committee, adopt and, from time to time, revise such rules and regulations regarding authorization to prescribe by "_____" nurses as may be necessary to carry out the provisions of this act.

Id.

177. ANA's separate Prescriptive Authority Act sets up an advisory committee for the nursing board composed of APNs promulgate applicable rules and act on applications for prescriptive authority.

178. *Id.* at 5; see Safriet, *supra* note 49, at 447. ANA's recommendation for one broad professional definition of nursing was tested in Hawaii. A 1991 opinion from the state Attorney General indicated that while the Hawaii NPA did not contain separate recognition or definition of NPs, the NPA did not preclude RNs from practicing as NPs. The opinion also indicated that the BON had authority to determine whether a particular practice was within the legitimate practice of nursing in the state. Attorney General opinions do not have the effect of a court decision and would have no controlling effect upon the same issue considered in a court of law.

179. Hadley, *supra* note 6, at 1.

180. Hadley, *supra* note 29, at 245-46.

181. *Id.* at 256.

role, APNs have a cost-efficient effect on health care. Thus, Hadley advocates legislation authorizing independent APN function.¹⁸²

Her authorized prescriber statutes would require examination in pharmacology and drug therapy of *every* professional (including MDs) who would prescribe, and subjects them to reexamination on a periodic basis. Successful candidates would be assigned prescriber numbers by State Pharmacy Boards and would be eligible to apply for federal Drug Enforcement Administration numbers to prescribe controlled substances. Hadley summarizes the benefits of her system:

[It] would enable consumers to choose their authorized prescriber from a variety of professionals . . . [and] would promote economic efficiency by enabling consumers to obtain prescriptions from providers whose costs are lower than those of physicians. At the same time the examination would safeguard the quality of an authorized prescriber's services.¹⁸³

Hadley notes that for this system to operate, insurers would have to reimburse non-physician prescribers. There would be every incentive for insurers to do so, since competition would ultimately lower costs.¹⁸⁴

Hadley also advocates the concomitant elimination of unauthorized practice provisions from practice acts. She argues that "licensure laws should regulate health professions by specifying minimum standards of education and protecting use of titles rather than by restricting the functions that each profession may perform."¹⁸⁵ Additionally, she argues that unauthorized practice provisions offer little protection from incompetent practitioners, promote inefficiency in the delivery of health care, prevent the appropriate substitution of labor and create economically unsound artificial bailiwicks.¹⁸⁶

Hadley argues that state practice acts err in attempting to define professional practice because such definitions are circular, overbroad and simultaneously overnarrow. She would eliminate these definitions from practice acts because she believes their sole importance is in providing a basis for prosecution under the unauthorized practice provisions. With her proposed eradication of unauthorized practice provisions, statutory definitions become unnecessary.

Hadley advocates a certification scheme whereby any health care provider would be legally defined by the training and education each received. Any health care provider could legally perform any task, but use of professional titles would be rigorously regulated to ensure the credentials of prov-

182. *Id.* at 284-85.

183. *Id.* at 286.

184. *Id.* at 286 n.180.

185. *Id.* at 292.

186. *Id.*

iders.¹⁸⁷ Theoretically, consumers would patronize credentialed, reasonably priced providers.

Hadley identifies one weakness of her proposal, namely that incompetent health care providers could practice. She counters that identification and decertification of these incompetent providers would result from malpractice suits, state board disciplinary actions and institutional safeguards such as internal review committees and admitting privilege committees.¹⁸⁸ In summary, Hadley advocates one prescriber statute for all prescribers and the elimination of professional definitions and unauthorized practice provisions from all practice acts.

In evaluating the recommendations of the ANA and these three commentators, Hadley's system resembles the earliest form of nurse licensure—that of voluntary registration. The evolution from voluntary registration and development to professional practice acts today has been a double-edged sword. While it has protected the public from charlatans, it also created a hierarchial, monopolistic and restrictive health care market. The catastrophic economic results are legendary. Additionally, today's professional practice definitions are the result of political compromise, are authored by legislators with limited health care backgrounds and reflect special interests as much as the protection of the public. These substantial shortcomings would be alleviated under Hadley's radical proposal, which would expand the authorization to provide health care delivery to many professionals. But it would run into formidable special interest group opposition coupled with legislative resistance to change.

The ANA's recommendation against an APN definition in the Nurse Practice Act fails to protect against litigation over the scope of practice and its APN prescriber statute can anticipate opposition from medicine. However, it promises a quicker fix because it is not as radical as Hadley's proposal and the public is accustomed to APNs delivering health care and prescribing. One advantage to the ANA's recommending placement of an APN prescriber statute outside the Nurse Practice Act is that it doesn't "open it up" to other adverse amendments during the legislative process. The ANA's delegation of rule-making to a nursing board's advisory committee composed of APNs insures realistic and knowledgeable drafting of rules and regulations. ANA's recommendation for voluntary certification of APNs promises reduced paper work.

Phillips' mandatory specialty credentialing of advanced practice nurses would add another regulatory layer to an administrative system that has

187. *Id.* at 295.

188. *Id.*

been under attack for years. Additionally, it mandates specialty certification of the female-dominated APN profession while it does not suggest the same for the male dominated medical profession. Phillips' suggestion to insulate supervisory MDs from APN malpractice suits promotes malpractice deterrence policy. However, it is a less viable solution to the problem of shifting liability than simple authorization of independent advanced practice nursing.

Safriet's proposal would add to nurse practice acts a single general definition for all APNs authorizing prescription and would expand the exclusive regulatory and delegatory power of boards of nursing. This would have the immediate effect of reducing litigation in the area and would clearly enable APNs to write prescriptions. It would also allow for a flexible evolution of the APN role by placing definitions and regulations of the specifics of APN practice with the nursing boards where changes are more easily made than in the legislature—provided there is an appropriately composed APN advisory committee. Safriet's proposal works as a comprehensive regulatory package. To reap its benefits, a state legislature would have to enact the entire scheme and that would require a committed legislative effort.

Conclusion

Statutory schemes need to reflect actual practice and promote sensible health care policy. APNs are now prescribing in at least 48 states, with or without independent prescriptive privileges, in spite of anticompetitive conduct and reimbursement barriers.

APNs and collaborative MDs are at risk of intimidation, discipline and prosecution for beneficial and competent health care practices from their own professional boards. Physicians face automatic, unnecessary malpractice liability imposed by those states mandating a dependent prescriptive practice which requires MD supervision of APNs, jointly developed health care protocols or indirect reimbursement of APNs. Such mandated physician supervision places inordinate control in individual physicians, creates a conflict of interest for those physicians, constitutes a serious threat to the quality of advanced practice nursing and dissuades RNs from becoming APNs. It also usurps the legitimate functions of the state legislatures, state licensing boards and the nursing profession in defining, regulating and setting standards for advanced nursing practice. Documents released by organized medicine do not reflect recognition of these serious shortcomings, particularly assumption of liability.

The anticompetitive and reimbursement barriers as well as improvident exposure to liability impede public access to cost effective, high qual-

ity primary health care. In the past, when nurses received less formal training and worked only under the direction of physicians, mandating dependant roles for nurses may have reflected a commitment to good patient care. Today, studies evincing the superior quality, cost effectiveness and access enhancing properties of APN care leave no room for such paternalistic efforts in the name of quality assurance.

Hadley's proposal offers the most improvement in health care. Her elimination of professional definitions and unauthorized practice provisions from practice acts is economically sound. Furthermore, the institution of independent prescriber statutes requiring periodic retesting of *all* prescribers promises real improvement in both the quantity and quality of health care delivered by all providers who would prescribe. Nonetheless, adoption of Hadley's radical proposals is unlikely anytime soon. The ANA's proposed free-standing APN prescriber statute with its mandatory APN advisory committee offers the most viable opportunity to establish legal authority for APNs to prescribe while limiting the role of the bureaucracy. Safriet's placement of exclusive APN regulation in BONs, statutorily specified delegatory power in BONs and statutorily defined advanced practice nursing promises the least litigation, the most autonomy for APNs and advancement in health care policy and malpractice theory.

In conclusion, the author makes the following recommendations for legislation and regulation authorizing independent prescriptive privileges for APNs:

- 1) mandatory Registered Nurse licensure, not mandatory certification by advanced practice specialty;
- 2) a single statutory definition of advanced nursing practice in the Nurse Practice Act authorizing independent practice specifically including medical diagnosis, treatment and prescription;
- 3) sole regulatory authority over APNs vested by statute in the State Board of Nursing;
- 4) statutorily mandated APN advisory committee to the State Board of Nursing to be composed of advanced practice nurse clinicians and educators;
- 5) statutorily enlarged delegatory power to State Boards of Nursing to be composed solely of nurses and one public member;
- 6) mandatory professional liability insurance for *all* prescribers; and,
- 7) mandatory continuing education and/or periodic retesting in pharmacology for *all* prescribers.

Such regulation would increase access to high quality, low cost primary health care by APNs. Mandatory licensure with voluntary specialty certification mirrors licensure in medicine which has been time tested; it also limits the role and expense of bureaucracy and red tape. The recommendation of a statutory APN definition authorizing independent APN practice promises relief from lawsuits and professional disciplinary actions against

nurses for practice outside the legitimate scope of nursing and against physicians for aiding and abetting the unauthorized practice of medicine. It also eliminates the exposure of physicians to malpractice liability for statutorily mandated dependant APN practice and furthers the deterrence goal of malpractice with regard to APNs. The recommendations mandating continuing education and liability insurance aspire to reduce negligent prescription and to insure financial protection for persons injured by medical and nursing negligence. Lastly, the vesting of sole regulatory authority over APNs in boards of nursing with simultaneous institution of mandatory APN advisory councils insures the constitutional and knowledgeable promulgation of APN rules and standards.

Appendix

Table A Definitions

Advanced practice nurse ("APN") will be used to include nurse practitioners ("NP"), certified nurse midwives ("CNM"), clinical nurse specialists and certified registered nurse anesthetists ("CRNA").

Physician ("MD") will be used to include doctors of medicine and doctors of osteopathy.

Primary Medical Care focuses on the health needs of individuals and families and is the first contact health care in the view of the patient, providing at least 80% of necessary care. Primary Medical Care provides a comprehensive array of services, on-site or through medical referral, including health promotion and disease prevention as well as curative services, and is accessible and acceptable to the patient population.

Diagnosis is the "identification, as of a disease, by analysis and examination."¹

Prescriptive authority will include 5 components:²

1. Determining the need for a drug/device/appliance or diagnostic test or treatment.
2. Administering the drug and/or applying the device/appliance or ordering the diagnostic test or treatment.
3. Causing another to administer the drug or apply the device/appliance or perform the diagnostic test or treatment.
4. Writing a prescription for a drug or device/appliance for a pharmacist to fill.
5. Dispensing limited quantities of a drug or a device/appliance in the absence of its immediate availability from a pharmacist.

Table B Characteristics of Practice

Substitutive vs. complimentary practice describes nursing as substitutes for physicians or as complements to physicians.³ Nurses' complementary functions are demonstrated in surgery where nurses assist a surgeon; nurses' substitutive functions are seen where nurse practitioners deliver primary care in outpatient settings in place of physicians.

1. WEBSTER'S II NEW RIVERSIDE UNIVERSITY DICTIONARY 195 (1984).

2. Ira P. Guin, *Nurses and Prescriptive Authority: What Is It? Who Needs It?*, NURSES AND PRESCRIPTIVE AUTHORITY: SPECIALTY NURSING FORUM CLEMSON UNIVERSITY COLLEGE OF NURSING NATIONAL CONFERENCE PROCEEDINGS 11, 16 (1990).

3. Elizabeth H. Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 AM. J.L. & MED. 245, 265-78 (1989).

Independent vs. dependent practice describes nursing vis a vis the state's requirement for supervision by a physician. Dependent practice is that which is "supervised" by a physician, whereas independent practice is that which is unsupervised.⁴ Supervision may take numerous forms. It may be on or off site, via informal or formal agreement, or via written treatment protocol or practice agreement.⁵

Limited vs. unlimited practice refers to the restricted or unrestricted scope of practice. Practice may be limited by restrictions to certain geographic areas, to certain populations (underserved or pediatrics) or to specific body systems (cardiology). Prescriptive authority may also be limited by formulary or by restrictions to certain classes of drugs, e.g. non-controlled substances.

4. P.H. DeLeon et al., *Prescription Privileges: Psychology's Next Frontier?*, 46 AM. PSYCHOLOGIST 384, 387 (1991).

5. For a different definition, see Linda J. Pearson, *1993 Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice*, 18 NURSE PRAC. 23, 24 (1993). Pearson published the following criteria to define independent prescriptive practice:

The board of nursing is the final decision-maker in authorizing the NPs (nurse practitioners) who are allowed to prescribe. This means that there are no requirements for board of medicine authorization in administering the NP prescriptive authority.

Within the actual practice of NP prescribing there are no requirements for a physician signature on the script.

Prescribing is not statutorily defined as a delegated medical act. Instead, prescribing is considered within the nursing scope of practice. Prescribing is still considered within the nursing scope of practice if it is done in collaboration with a physician in accordance with a mandatory practice agreement and/or protocols.

Id. at 24.

This last criterion for independent practice subsumes states in which physician supervision or collaboration is mandated, and is at odds with the usage of "independent prescriptive privilege" by other commentators. See DeLeon et al., *supra* note 4, at 384.