Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioner Autonomy Can Safely and Economically Meet the Growing Demand For Basic Health Care

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Abstract

As well-educated health care professionals, nurse practitioners are strongly positioned to fill the primary care gap created by the decreasing number of general practice physicians. However, due to robust opposition from the medical profession, nurse practitioners are burdened by a state by state patchwork of laws that impede their autonomous practice of medicine. Such barriers include limits on the right to prescribe medications, elaborate requirements to collaborate with physicians, and limits on insurance reimbursement.

Although the profession of nurse practitioner only began in the 1960s, at which point physicians had long enjoyed a legal monopoly over the practice of medicine, this rapidly growing profession has made great strides in gaining limited legal autonomy to provide medical care. For example, as of 2006, all 50 states allow nurse practitioners to prescribe medication. However, depending on the state, the power to prescribe may be limited to uncontrolled substances or subject to physician approval. Because nurse practitioner care has been shown to be safe, cost-effective, and well-received by patients, law makers should champion the further expansion of nurse practitioner autonomy as one simple and efficient way to solve the health care crisis.
I. Introduction

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

Due to the popularity and efficiency of NPs, the medical establishment has viewed the profession as a threat to their livelihood. In the forty plus years since the first NP graduated, NPs have had to continually fight and lobby for the right to practice their profession, preferably independent of physicians. The result has been a state by state patchwork of laws and regulations governing NPs’ scope of practice.
This article first discusses the history and educational requirements of the NP profession. It then discusses the policy reasons why NPs should and do play an important role in the country’s health care delivery system. The core of the article deals with the legal issues surrounding the NP’s scope of practice including the need for collaborative agreements with physicians, authority to prescribe drugs, and identification. Finally the article discusses how NPs fit into the health insurance scheme and their liability for malpractice.

II. Overview

A. History and Background

A nurse practitioner (NP)\(^1\) is a registered nurse who has undertaken additional education in order to perform tasks more traditionally associated with the medical profession.\(^2\) The American College of Nurse Practitioners provides the following definition: nurse practitioners are “registered professional nurses who are prepared, through advanced graduate education and clinical training, to provide a wide range of health care services, including the diagnosis and management of common, as well as complex, medical conditions . . . .”\(^3\) NPs distinguish themselves from physicians by emphasizing that, as nurses, they are patient focused – examining

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

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

the patient’s history and family – while physicians are disease focused. While some NPs specialize in areas such as neonatal, geriatric, psychiatric, or acute care, the majority of NPs provide primary care.

The role of NP began in the mid-1960s in response to a nationwide shortage of physicians. The first NP program began as a master’s degree at the University of Colorado School of Nursing in 1965. Other NP educational programs began springing up throughout the country. At the outset, most NPs practiced in traditional settings by associating with physician groups or hospitals. However, in 1977, the Arizona State University School of Nursing began a federally funded nurse-managed health care center, paving the way for NP independent practice.

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5 Buppert, supra note 2, at 7.


7 Id. at 2-3.


9 Id.

10 Id.
By the 1990s, the number of NPs had skyrocketed\textsuperscript{11} and between 1996 and 2001 the number doubled.\textsuperscript{12} Between 1999 and 2009, the number doubled again.\textsuperscript{13} As of 2009 there were 157,782 NPs in the United States.\textsuperscript{14} As of 2007, there were 250 nurse-managed health care centers, mostly in medically underserved rural and urban communities.\textsuperscript{15} However, the majority of NPs practice in settings supervised by physicians.\textsuperscript{16}

B. Educational Requirements

In most states, the NP profession is regulated by the state Board of Nursing (BON).\textsuperscript{17} However, in a minority of states, NPs are regulated by the BON and the Board of Medicine (BOM) or some other regulatory authority.\textsuperscript{18} In either case, the regulatory authority sets the minimal requirements needed for becoming a licensed NP.

\textsuperscript{11} Id.

\textsuperscript{12} Id.


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

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


\textsuperscript{18} Id. In some of these states, such as New Jersey, the BOM only has the power to regulate in the area of drug prescribing. \textit{Id}. In the following states, the BON is not the sole authority over NPs: Delaware, Florida, Georgia, Illinois, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, North Carolina, South Dakota, Tennessee, and Virginia. The role of the BOM is an indicator of NP autonomy in the state, as discussed in depth \textit{infra} sec. III.
All NPs must at least achieve the degree of a registered nurse (RN). NP programs generally consist of courses in “advanced practice nursing philosophy, advanced health assessment, diagnosis, advanced pathophysiology, advanced pharmacology, primary care and clinical decision making.” In 43 states and the District of Columbia NPs are also required to pass a national certification examination. NPs can gain additional certification in a number of specialties such as neonatal, geriatric, psychiatric, acute care, or midwifery.

Doctors argue that NPs’ education is insufficient to allow them to practice independently. According to James King, president of the American Academy of Family Physicians, “[w]ith four years of medical school and three years of residency training, physicians’ understanding of complex medical issues and clinical expertise is unequaled.” NPs counter that they have a

19 BUPPERT, supra note 2, at 5.
20 Pearson State-By-State, supra note 17; BUPPERT, supra note 2, at 5. The states which do not require a master’s degree are: Delaware, District of Columbia, Idaho, Indiana, Maryland, Massachusetts, Minnesota, New York, and Washington. Pearson State-By-State, supra note 17.
22 Pearson State-By-State, supra note 17. The states which do not require passage of a national certification examination are: California, Kansas, Indiana, Iowa, New York, Oregon, and Virginia. Id. Note that some states require national certification but do not require a master’s degree – Delaware, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, and Washington. Id. Indiana and New York are the only states which do not require either a master’s degree nor national certification. Id.
23 BUPPERT, supra note 2, 6.
24 This specialty is known as a Certified Nurse Midwife (CNM). See American College of Nurse-Midwives, What is a Midwife? http://www.midwife.org/about_midwife_profession.cfm (last visited Dec. 18, 2010).
proven track record of providing quality care and that new technologies allow them to cost-effectively diagnose common illnesses without extensive medical education. As for physicians’ argument that NPs’ lack of a comprehensive medical education will lead them to misdiagnose atypical cases, NPs reply that as professionals, they can recognize when a problem goes beyond the scope of their training and requires referral to an appropriate physician.

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

26 See infra, notes 52-54 and accompanying text.
28 Bertness, supra note 21, at 233.
30 Landro, supra note 25.
31 Id.
32 Id.
DNP degree the standard for all NPs, there has been opposition from the medical establishment as well as from NPs themselves.

C. Policy Arguments

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

The surge in the NP profession has coincided with and perhaps resulted from a steep decline in the number of medical students entering primary care. In 2007, less than half of the available family practice residency programs were filled as only seven percent of medical school graduates chose family practice. According to the American Academy of Family Physicians, the decline is attributable to “factors related to lifestyle and educational debt.” This has resulted in some areas of the country not meeting the general standard of one primary care

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

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

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

36 Ritter & Hansen-Turton, supra note 8, at 21.


38 Ritter & Hansen-Turton, supra note 8, at 21.
physician per 1,000-2,000 people.\textsuperscript{39} As will be shown below, NPs offer an affordable and efficient way to fill this gap without compromising on the quality of patient care.

NPs provide economically efficient health care by reducing the cost of buying basic care and freeing up physicians to focus on complex illnesses. On a basic level, since the time required to become a licensed NP is significantly less than the time needed to attain a medical license, training costs for NPs are much lower.\textsuperscript{40} NPs also provide care at a lower cost than doctors as insurance generally reimburses NPs 85\% of what it would pay a physician for similar services.\textsuperscript{41} At $40-$70 a visit, prices at retail health care centers,\textsuperscript{42} in which NPs provide service, are significantly lower than physician fees.\textsuperscript{43}

In a 2000 Harvard Business Review article, a professor of business administration and two physicians argue that since most patients see doctors for relatively straightforward illnesses, it is inefficient for physicians to treat such illnesses.\textsuperscript{44} That is because making a simple diagnosis

\begin{itemize}
\item \textsuperscript{39} See Freudenheim, supra note 37. See also Safriet, Health Care Dollars, supra note 29, at 432 (“In many rural and inner-city areas, [NPs] are the only providers available.”).
\item \textsuperscript{40} Safriet, Health Care Dollars, supra note 29, at 437.
\item \textsuperscript{41} Kate Pickert, If a Health-Care Bill Passes, Nurse Practitioners Could Be Key, TIME, Aug. 3, 2009.
\item \textsuperscript{42} See infra note 183 and accompanying text.
\item \textsuperscript{43} See Mary Kate Scott, Health Care in the Express Lane: Retail Clinics Go Mainstream, CAL. HEALTHCARE FOUND. (Sept. 2007) at 5. See also Susan Jenks, In a Hurry? Clinics Offer Speedy Care, FLA. TODAY, Nov. 17, 2009, at 1A (stating that NP-run retail health clinics in Brevard County, Florida charge $55-$65 per visit while the average doctor office visit costs $150-$200). Accordingly, NP salaries are significantly lower than physician salaries. While the median income of a family doctor is around $150,000, an NP makes only $87,400 on average. See Freudenheim, supra note 37; Landro, supra note 25. As a result, in order to maintain their high incomes, physicians must see more patients, frequently seeing each one for only a few minutes. Christensen et al., supra note 27, at 108. NP-staffed retail clinics on the other hand generally spend fifteen minutes with the patient. Scott, supra, at 5.
\item \textsuperscript{44} Christensen et al., supra note 27.
\end{itemize}
“tap[s] but a small fraction of what our medical schools have prepared physicians to do.”\textsuperscript{45} Because new scientific technology allows NPs to easily diagnose illnesses which a generation ago could only be made by doctors after extensive observation,\textsuperscript{46} it is a waste of resources to require such a diagnosis to be made by a physician.\textsuperscript{47} The authors note that “[h]istory tells us that major new growth markets coalesce when products, processes, and information technologies let less highly paid groups of people do things. . . .”\textsuperscript{48} The authors compare regulations requiring doctors to supervise NPs making simple diagnoses to requiring every personal home computer buyer to also purchase a mainframe computer.\textsuperscript{49} While there will always be some businesses which require large, expensive mainframes for complex data crunching, personal computers are more than adequate for simple tasks such as e-mail and word processing.\textsuperscript{50} Similarly, if NPs could independently diagnose and treat simple illnesses, doctors would have more time to treat more complex illnesses.\textsuperscript{51}

Even if NPs are needed to fill the primary care gap and prove to be more cost effective, these arguments are moot if NPs provide inferior care. However, a number of studies have shown that NPs provide the same or better quality of care than physicians. The first such study was conducted in 1986 by the Office of Technology Assessment of the United States Congress (OTA) which found that “the quality of care provided by NPs functioning within their areas of

\begin{footnotesize}
\begin{enumerate}
\item[\textsuperscript{45}] \emph{Id.} at 104.
\item[\textsuperscript{46}] \emph{E.g.}, portable blood glucose meters for diabetes detection. \emph{See id.} at 106.
\item[\textsuperscript{47}] \emph{Id.} at 109.
\item[\textsuperscript{48}] \emph{Id.} at 110.
\item[\textsuperscript{49}] \emph{Id.}
\item[\textsuperscript{50}] \emph{Id.}
\item[\textsuperscript{51}] \emph{Id.} at 109.
\end{enumerate}
\end{footnotesize}
training and expertise tends to be as good as or better than care provided by physicians.” In 2000, the Journal of the American Medical Association published a study in which 1,316 primary care patients were randomly assigned to either an NP or a physician. The study, which was corroborated by a follow-up study in 2004, concluded that “patient outcomes for nurse practitioner and physician delivery of primary care do not differ.”

Studies have also shown that NPs spend more time with patients during visits than physicians and “emphasize prevention and health maintenance to a greater degree.”

Patients themselves have expressed strong satisfaction for NP services. A 2002 study found that nurse-managed health centers had a higher retention rate of patients than physician-managed health centers. The study also found that the patients at the nurse-managed health centers expressed a high level of satisfaction with the care provided. NPs also point to the significantly lower numbers of malpractice suits against NPs in comparison to the number of suits against physicians as evidence of patient satisfaction with NP service. While 1 out of every 4 physicians is sued for malpractice, only 1 in 166 NPs is sued. Finally, despite the friction between physicians and NPs in the legal arena, most physicians who actually work with NPs

52 Ritter & Hansen-Turton, supra note 8, at 22.
53 Id.
54 Christensen et al., supra note 27, at 108.
55 Ritter & Hansen-Turton, supra note 8, at 22.
56 Id.
57 Pearson Report, supra note 13, http://www.pearsonreport.com/tables-maps/category/npdb-rates. There are, however, other explanations for this disparity. Plaintiffs’ lawyers may prefer to sue physicians who have deeper pockets and more professional liability insurance. See Bertness, supra note 21, at 249 (“Professional liability insurance carriers may only issue malpractice policies to NPs who are employed at [physician] managed sites.”).
58 See infra, sec. III.
have positive attitudes towards them.\textsuperscript{59} This is extremely important since NPs and physicians often work on a team or at least consult with one another in providing patient care.\textsuperscript{60}

\textbf{III. Nurse Practitioner Autonomy}

\textbf{A. Opposition from the Medical Establishment}

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

From the outset, the medical profession had the distinct advantage in fighting against NP autonomy. Physicians were the first health care providers to secure legal licensure in the United States.\textsuperscript{63}

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


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

\textsuperscript{62} Ritter & Hansen-Turton, \textit{supra} note 8, at 23. For the past 22 years, Linda Pearson, a family psychiatric mental health NP, has documented the current legal framework for NPs in each of the fifty states and the District of Columbia in a publication called the “Pearson Report.” \textit{Pearson Report}, \textit{supra} note 13, at 8. Her 2010 data is used throughout this article. The report also includes a state by state guide to legislative activity regarding NP autonomy and scope of practice.
States. By the early 1900s, almost every state had adopted “medical practice acts” which gave physicians exclusive domain over the “practice of medicine.” However, recognizing that other health care providers were competent to perform medical services, combined with the overwhelming demand for medical services, physicians lobbied state legislatures to allow them to supervise and delegate certain medical procedures to non-physicians. It was against this background of physician monopoly and mandatory supervision that NPs had to lobby for state legislatures to recognize their autonomy.

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

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

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

65 *Id.* at 307.

66 BUPPERT, supra note 2, at 7.

67 *Id.*

68 See infra notes 69 to 74 and accompanying text.
For example, Washington is a state which allows for broad NP autonomy.\textsuperscript{69} Nevertheless, this autonomy is at best an exception, if not a contradiction, to the existing medical licensure laws. According to the Washington statute, “[n]o person may practice or represent himself or herself as practicing medicine without first having a valid license to do so.”\textsuperscript{70} The practice of medicine is defined as one who:

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

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

(1) A licensed advanced registered nurse practitioner (ARNP) is a registered nurse prepared in a formal educational program to assume primary responsibility for continuous and comprehensive management of a broad range of patient care, concerns and problems . . . .
(6) Performing within the scope of the ARNP’s knowledge, experience and practice, the licensed ARNP may perform the following:
(a) Examine patients and establish diagnoses by patient history, physical examination and other methods of assessment;
(b) Admit, manage and discharge patients to and from health care facilities;
(c) Order, collect, perform and interpret diagnostic tests;
(d) Manage health care by identifying, developing, implementing and evaluating a plan of care and treatment for patients;
(e) Prescribe therapies and medical equipment;

\textsuperscript{70} WASH. REV. CODE § 18.71.021 (2010).
\textsuperscript{71} Id. § 18.71.011.
\textsuperscript{72} Id. § 18.71.030(4).
(f) Prescribe medications . . . 73

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

In Sermchief v. Gonzales, 75 a seminal case for NPs, 76 the Supreme Court of Missouri cut through similarly absurd statutory anomalies 77 to clearly uphold the legality of NP practice. NPs working for a non-profit family planning clinic took the medical history of incoming patients and provided those patients with breast and pelvic examinations, PAP smears, and information about contraception. 78 The NPs’ actions were done pursuant to written orders of resident physicians. 79 Nevertheless, the Missouri State Board of Registration for the Healing Arts threatened to find the

73 WASH. ADMIN. CODE § 246-840-300 (2010).
74 Quoting the Washington statute and regulations in supra notes 70 and 73 and accompanying text. For an example of proposed legislative language which attempts to clarify Rhode Island’s scope of practice statutes by replacing all physician and NP terms with “health care provider,” see Bertness, supra note 21, at 270.
75 660 S.W.2d 683 (Mo. 1983).
76 The court noted that the case “attracted amici briefs resembling a letter writing campaign directed at a legislative body.” Id. at 686.
77 The conflicting statutes restricting the practice of medicine, the exception for nurses, and the definition of NP, were similar to those mentioned above for Washington. See id. at 687-88.
78 Id. at 684.
79 Id. at 684-85.
NPs guilty of the unauthorized practice of medicine. The NPs sued for a declaratory judgment that their actions fit within Missouri’s NP statute and therefore did not constitute the unauthorized practice of medicine. The Board countered that the NP statute was unconstitutionally vague in permitting practices that resembled the practice of medicine and should be nullified under the Fifth and Fourteenth amendments of the U.S. Constitution.

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

In another significant NP victory, NPs sued the Oregon Workers’ Compensation Department for promulgating rules which excluded provider NPs from insurance

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80 Id. at 685. The physicians were also charged with aiding and abetting the NPs’ unauthorized practice of medicine. Id. at 684 n. 1.
81 Id. at 684.
82 Id. at 685.
83 Id. at 688.
84 Id. at 689.
85 Id.
86 The court cited the statutes of 40 other states which had expanded nurses’ roles. Id. at 690 & n. 6.
reimbursement. The Department had derived its rules from the state’s Workers’ Compensation statute which limited eligibility to a “doctor or physician” which was defined as a “person duly licensed to practice one or more of the healing arts.” In ruling for the NPs, the court said that the “term ‘healing arts’ is not a static concept, capable of only one definition, now and forever.” Noting that NPs can provide comprehensive medical care including diagnosis and treatment, the court concluded that NPs fell within the statutory definition of “doctor or physician” since “[diagnostic and treatment] services certainly fall within the commonly understood meaning of a ‘healing art.’”

Although the American Medical Association (AMA) endorses NP collaboration with physicians, it still opposes the provision of medical care by anyone other than a physician, unless supervised by a physician. The latest AMA House of Delegates adopted the following language: “Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.” Publicly, the AMA takes this position because it believes that NPs lack the appropriate education to properly medically supervise patients. However, financial self-interest

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88 Id. at 856 (emphasis added).
89 Id. at 858.
90 Id. at 859.
and competition clearly play a role. In reality, the AMA has been fighting a losing battle as state legislatures increasingly offer NP autonomy. Currently, all 50 states provide some form of prescriptive authority to NPs while 14 states and the District of Columbia allow NPs to practice completely autonomously.

B. Physician Involvement

The Pearson report divides state laws regarding physician involvement in NP practice into three categories: 1) states that do not require any physician involvement (22 states and the District of Columbia); 2) states that require physician involvement but without written documentation (4 states); and 3) states that require physician involvement documented in writing (24 states). However, since some states in the first category, such as New Jersey,

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

I can’t imagine the hours I have spent listening intently to the differences between . . . the various branches of medicine and nursing. Looking back on it, few of these arguments had anything to do with competency or public safety. It was monopoly and money and not safety and skill that usually were at stake. Safriet, Closing the Gap, supra note 63, at 316.

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

94 See supra note 62.


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

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

98 Id. The states are Alabama, Arkansas, California, Delaware, Florida, Georgia, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Nebraska, Nevada, New York, North Carolina, Ohio, South Carolina, South Dakota, Texas, Vermont, Virginia, and Wisconsin. Id. For a survey of each state’s statute regarding physician involvement, see Pearson State-By-State, supra note 17 and BUPPERT, supra note 2, app. 2-B at 75.
require physician involvement for prescribing medicine, a key component of most treatments, the actual number of states in which NPs are truly independent of physicians drops to fourteen (including the District of Columbia). Even in these states, NPs often collaborate and work in teams with physicians, despite the lack of a legal requirement to do so.

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

A process in which a CRNP works with one or more physicians to deliver health care services within the scope of the CRNP’s expertise. The process includes the following:
(i) Immediate availability of a licensed physician through direct communications or by radio, telephone or telecommunications.
(ii) A predetermined plan for emergency services.
(iii) A physician available to a CRNP on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the

99 See infra note 145 and accompanying text.
100 See infra sec. (C).
101 Ritter & Hansen-Turton, supra note 8, at 24.
102 I came to this number by starting with the states in Pearson’s data that did not require physician involvement in practice (listed supra, note 96) and removing states which were also on Pearson’s list of states requiring physician collaboration to prescribe (infra, note 142). The fourteen states are: Alaska, Arizona, District of Columbia, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, Rhode Island, Utah, Washington, and Wyoming.
103 Id. 24.
104 Christian et al., supra note 6, at 11.
105 Id.
106 63 PA. CONS. STAT. § 218.2 (2010).
practice setting, periodic updating in medical diagnosis and therapeutics and cosigning records when necessary to document accountability by both parties. 107

Similarly to the Pennsylvania statute, many states with physician involvement requirements mandate physician review of patient records. Although most such statutes are vague concerning how to implement these “chart reviews,” 108 five states mandate specific percentages. 109 For example, Texas requires that the collaborating physician review at least ten percent of all NP patient charts. 110

Missouri imposes a geographic limit on the distance between the NP and collaborating physician. In areas federally designated as “health professional shortage areas,” 111 the NP and collaborating physician must be no further than 50 miles apart, while in all other areas the maximum distance shrinks to 30 miles. 112 Although most states allow for physician supervision to occur remotely, seven states actually require that the physician be onsite for a minimum


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

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

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


amount of time.\textsuperscript{113} For example, Texas requires that the physician be at the NP’s practice site 20% of the time\textsuperscript{114} while Alabama has an onsite requirement of 10%.\textsuperscript{115}

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

As stated above, some states require an explicit written protocol outlining the physician-NP collaboration. The legal terms for these written protocols vary widely from “integrated practice arrangement” (Nebraska) to “written guidelines” (Massachusetts) to “standard care arrangement” (Ohio).\textsuperscript{119} The protocol “is a written instrument that guides the NP in collecting data from the patient and recommends specific action based upon the collected data. It consists of mutually agreed-upon medical guidelines between the physician and the NP that define the individual and shared responsibilities of the physician and NP.”\textsuperscript{120}

\textsuperscript{113} Ritter & Hansen-Turton, supra note 8, at 24. The states are: Alabama, Illinois, Missouri, South Dakota, Tennessee, Texas, and Virginia. Id. at 25.
\textsuperscript{114} TEX. OCC. CODE ANN. § 157.0541(c)(1)(A) (2010).
\textsuperscript{115} ALA. ADMIN. CODE r. 610-X-5-.08(4) (2010).
\textsuperscript{116} Ritter & Hansen-Turton, supra note 8, at 25.
\textsuperscript{117} N.Y. EDUC. § 6902 (3)(e) (McKinney 2010).
\textsuperscript{118} Ritter & Hansen-Turton, supra note 8, at 25.
\textsuperscript{119} Christian et al., supra note 6, at 12.
\textsuperscript{120} BUPPERT, supra note 2, at 45. For a sample protocol provided by the Florida Department of Health, see Florida Department of Health, ARNP Protocol, http://www.doh.state.fl.us/Mqa/nursing/ProtocolSample.htm (last visited Dec. 18, 2010).
For example, the New York statute mandates that the “practice protocol” contains provisions “for the resolution of any disagreement between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment that is within the scope of practice of both.”121 The agreement must also provide for review of patient records at least every three months.122 Furthermore, the New York law requires that the “practice protocol” be filed with the state’s department of education within 90 days and be clearly posted in the “practice setting” of the NP.123

Florida’s regulations go into more detail and require:

1. A description of the duties of the ARNP.
2. A description of the duties of the physician or dentist (which shall include consultant and supervisory arrangements in case the physician or dentist is unavailable).
3. The management areas for which the ARNP is responsible, including
   a. The conditions for which therapies may be initiated,
   b. The treatments that may be initiated by the ARNP, depending on patient condition and judgment of the ARNP,
   c. The drug therapies that the ARNP may prescribe, initiate, monitor, alter, or order.
4. A provision for annual review by the parties.
5. Specific conditions and a procedure for identifying conditions that require direct evaluation or specific consultation by the physician. . . .124

Similarly to New York, Florida requires that the protocol be filed with the state department of health within 30 days of the NP’s license renewal and be “kept at the site of practice of each party to the protocol.”125

121 N.Y. EDUC. § 6902 (3)(a) (McKinney 2010).
122 Id. (3)(c).
123 Id. (3)(c)-(d).
124 FLA. ADMIN. CODE ANN. r. 64B9-4.010(2)(b) (2010).
125 Id. 64B9-4.010(3).
It should be noted that despite legal requirements of physician involvement, NPs are still able to achieve a significant amount of independence. For example, Columbia Advanced Practice Nurse Associates (“CAPNA”), a primary care facility in New York City associated with the Columbia University School of Nursing, treats over 3,000 patients.\textsuperscript{126} CAPNA is fully staffed by NPs\textsuperscript{127} and “provides comprehensive primary care by advanced practice nurses who diagnose and treat illnesses, perform physical examinations, order diagnostic tests and refer to specialists as needed.”\textsuperscript{128} CAPNA emphasizes that its NPs are capable and certified by insurance companies to be a patient’s primary care provider.\textsuperscript{129} However in accordance with New York’s collaborative requirements, CAPNA’s NPs “work in partnership with the more than 2,000 physicians at New York-Presbyterian Hospital”.\textsuperscript{130}

Removing legal requirements of physician involvement tops the agenda for many state NP lobbying programs. For example, in New York, the Nurse Practitioner Association has

\textsuperscript{126} Mundinger e-mail, \textit{supra} note 108. CAPNA opened in 1998. See CAPNA faq, \textit{supra} note 4.

\textsuperscript{127} The founder of CAPNA, Mary Mundinger, is the Dean of the Columbia University School of Nursing. The four other NP providers are all faculty members at the nursing school. See Columbia University School of Nursing: CAPNA – CAPNA Practitioners, http://www.capna.com/practitioners.html (last visited Dec. 18, 2010).


\textsuperscript{129} CAPNA faq, \textit{supra} note 4.

\textsuperscript{130} About CAPNA, \textit{supra} note 128. \textit{See also} Tina Kelley, \textit{Like a Doctor’s Office, With a Little More Time}, N.Y. TIMES, Apr. 25, 2000, at F7 (interviewing an NP and patient at CAPNA in which the NP referred the patient to a cardiologist). However, when asked about how CAPNA implements the New York requirements of chart review and physician collaboration given CAPNA’s large number of patients, Dean Mundinger was evasive. She characterized the New York law as “consultative” rather than “supervisory” and stated that NPs were the ones who initiated the consultations. Mundinger e-mail, \textit{supra} note 108.
introduced legislation to eliminate the statutory requirement of collaboration. In 2005, the Oregon legislature accepted the changes of a team of 38 NPs who had reviewed more than 750 statutes with the goal of identifying physician specific statutes which could be made NP inclusive.

C. Prescriptive Authority

Despite opposition from the medical establishment, NPs have gained the legal right to prescribe medicine in all 50 states, with Georgia being the final state to approve in 2006. State laws require that NPs demonstrate proficiency in pharmacology. For example, Rhode Island requires completion of 30 hours of pharmacological education.

Physicians had argued that NPs lacked the required medical training to properly diagnose and prescribe the correct medicines. Further, physicians argued that only they were competent to identify the symptoms of adverse drug events (ADEs) and neutralize such problems.

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

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


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

137 Coleman & Shellow, supra note 135, at 50-51. “Even ordinarily benign drugs have side effects which may affect individuals in unusual ways.” Id. at 57.
However, even critics agreed that NPs were better at taking comprehensive medical histories\textsuperscript{138} thereby avoiding potential ADEs such as prescribing penicillin for a patient with a penicillin allergy. Subsequent studies have shown that clinical offices in diverse settings create the same number of ADEs independent of the number of NPs who work in the clinics.\textsuperscript{139}

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

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

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


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

\textsuperscript{142} Pearson Report, supra note 13, http://www.pearsonreport.com/tables-maps/category/prescribing. Utah only requires collaboration for schedules II-III drugs (\textit{see infra} notes 147-152 and accompanying text). \textit{Id}. 
direction, authorization, or delegation.\textsuperscript{143} For example, in sixteen states the law requires that the NP’s prescription pad contain the collaborating physician’s name.\textsuperscript{144} New Jersey’s law clearly delineates the requirements of physician collaboration for an NP to prescribe drugs:

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

Additionally some of these states specify the maximum number of prescribing NPs which a physician can supervise.\textsuperscript{146}

Even when the NP follows the state’s proper procedure for prescribing, he or she may be limited in the types of drugs which he or she can prescribe. The Drug Enforcement Agency

\textsuperscript{143}Id.

\textsuperscript{144}See Pearson State-By-State, supra note 17. See also BUPPERT, supra note 2, at 185 (conflicting data was resolved in favor of Pearson which is more recent). The states are: Alabama, Georgia, Hawaii, Kansas, Illinois, Louisiana, Massachusetts, Michigan, Missouri, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Texas.

\textsuperscript{145}N.J. STAT. ANN. § 45:11-49(c) (2010). For a survey of each state’s statute regarding NP prescriptive authority, see Pearson State-By-State, supra note 17 and BUPPERT, supra note 2, app. 5-A at 188.

\textsuperscript{146}See, e.g., 18 VA. ADMIN. CODE § 90-40-100(A) (2010) (physician cannot supervise more than four prescribing NPs at one time); N.Y. EDUC. § 6902 (3)(e) (McKinney 2010) (same).
classifies certain drugs that are prone to abuse as controlled substances. These controlled drugs are further classified into five schedules. Schedule I drugs, which have no medical use (such as heroin), may not be prescribed for by anyone, including physicians. Schedule II includes drugs with high abuse potential (such as morphine) while schedules III through V include drugs such as stimulants and depressants. While physicians can universally prescribe for schedules II through V, state laws vary regarding NPs. Alabama and Florida are the only states in which NPs are not allowed to prescribe any controlled substances. In Georgia, Michigan, Missouri, Oklahoma, South Carolina, Texas, and West Virginia, NPs are prohibited from prescribing schedule II drugs. In all other states, including the District of Columbia, NPs can prescribe (subject in some states to physician involvement) for schedules II through V.

D. Identification

As mentioned above, NPs can attain the degree of “Doctor of Nurse Practitioner” (DNP). As part of their opposition to the DNP degree, physicians have lobbied state legislatures to

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148 Id.
149 See id.
150 Id. § 829.
151 Id. § 812.
152 Id. § 829.
154 See Pearson State-By-State, supra note 17.
155 See id. See also BUPPERT, supra note 2, at 185 (conflicting data was resolved in favor of Pearson which is more recent).
156 See supra notes 30-35 and accompanying text.
impose limitations on how DNPs identify themselves. Six states statutorily prohibit DNPs from being addressed as “Doctor NP.” #158 Nine other states allow DNPs to be addressed as “doctor” only if the DNP clarifies that he or she is actually an NP. #159 Additionally, some states even require non-doctorate NPs “to wear some form of identification that visibly and unambiguously identifies them.” #160

**IV. Medical Reimbursement**

On the federal level, NPs achieved Medicare provider status in 1997 with the passage of the Balanced Budget Act. #161 Provider status allowed NPs to receive direct reimbursement, albeit at a rate of 85% of the physician fee schedule. #162 Direct reimbursement benefits NPs because it allows them to generate more revenue based on more procedures performed. #163 Achieving

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#157 *See supra* note 34 and accompanying text.


#160 Bertness, *supra* note 21, at 251-52. *See, e.g., GA. CODE ANN. § 43-26-6(c) (2010): Any person who is licensed as a[n advanced practice nurse] . . . shall identify that he or she is so licensed by displaying . . . the title “advanced practice registered nurse,” or the abbreviation “A.P.R.N.,” on a name tag or other similar form of identification during times when such person is providing direct patient care.


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

#163 *Id.* at 270.
Medicare provider status was a landmark for the NP profession in that it established NPs as “legitimate independent providers of primary and specialty care.”

While the federal legislation was important symbolically, most insurance regulation occurs on the state level. Compensation of NPs by managed care organizations (MCOs) can take the form of either salary arrangements or direct reimbursement. While 24 states and the District of Columbia have enacted legislation that allows for “some level of inclusion” of NPs in managed care payment schemes, most state insurance regulatory schemes do not mandate direct reimbursement of NPs.

Some states, such as New York and Arkansas, allow NPs to be included as “primary care gatekeepers” for managed care. Other states mandate “any willing provider” rules which require MCOs to credential any provider who meets the terms of the MCO’s provider agreement. These laws are designed to protect against non-physician discrimination in the health insurance market. Despite such legislative enactments, MCOs themselves are not

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165 Id. at 396.
166 Id.
167 Christian et al., supra note 6, at 15.
170 Sullivan-Marx & Keepnews, supra note 164, at 396. See also About CAPNA, supra note 128 (stating that CAPNPA NPs are recognized as “primary care provider[s] by major insurance companies”).
171 Tine Hansen-Turton et al., Insurer’s Contracting Policies on Nurse Practitioners as Primary Care Providers, POL’Y, POLS., & NURSING PRAC., Nov. 2008, at 244.
172 See, e.g., ARK. CODE ANN. § 17-87-311(b) (2010) (“The agency administering the state medicaid program shall not discriminate against practitioners providing covered services within
always willing to credential NPs as primary care providers. In a 2007 study, researchers found that only 53% of MCOs allowed for credentialing of NPs.\textsuperscript{173} Among these MCOs, only 56% reimbursed the NPs at the same rate as primary care physicians.\textsuperscript{174} Furthermore, the study found that the rate of NP credentialing and reimbursement was unaffected by the state’s laws requiring equal insurance treatment of non-physicians.\textsuperscript{175} Even among MCOs which participated in Medicaid, a federal program administered by the states, only 73% credentialed NPs.\textsuperscript{176} This figure is startling if not illicit considering that federal regulation prohibits provider discrimination by MCOs participating in the Medicaid program.\textsuperscript{177}

The study also found a strong correlation between MCO credentialing of NPs and state laws requiring physician involvement for NPs to prescribe.\textsuperscript{178} In states that did not require physician involvement, MCO credentialing of NPs rose to 71%.\textsuperscript{179} That figure dropped to 50% in states that required some form of physician involvement for NPs to prescribe.\textsuperscript{180} This suggests that state policies directly affecting NP autonomy have a greater effect on the private insurance

\begin{itemize}
  \item \textsuperscript{173} Hansen-Turton et al., \textit{supra} note 171, at 243.
  \item \textsuperscript{174} \textit{Id}.
  \item \textsuperscript{175} \textit{Id.} at 244.
  \item \textsuperscript{176} \textit{Id.} at 245.
  \item \textsuperscript{177} \textit{See} 42 C.F.R. § 438.12(a)(1) (2010) (“An MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.”).
  \item \textsuperscript{178} Hansen-Turton et al., \textit{supra} note 171, at 246.
  \item \textsuperscript{179} \textit{Id}.
  \item \textsuperscript{180} \textit{Id}.
\end{itemize}
market than state mandates that aim to prevent insurance discrimination by insurers. This

correlation is not surprising given that insurers will be more willing to credential NPs who can
provide services at a cost effective rate because they are not required by law to collaborate with a
(costly) physician. 181

This means that NP autonomy is essential if health care costs are to be lowered through the
use of NP-run clinics. Adequate reimbursement by insurers is essential for the economic
viability of these clinics as indicated by the statistic that 39% of nurse-managed health centers
which received federal funding between 1993 and 2001 have since closed. 182 Retail health care
clinics, which provide low cost basic health services in drug, grocery, and mass merchandise
retailers, 183 depend on employing NPs to be profitable. 184 If NPs are not directly reimbursed, let
alone credentialed, by insurers, these clinics find it difficult to do business. 185

V. Malpractice

As professionals, NPs are subject to malpractice suits. 186 Generally the standard of care
for an NP is that of a reasonably prudent NP, not of a physician. 187 Such a standard would

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

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

183 Scott, supra note 43, at 6. The retail clinic concept took off in 2006 with the opening of 220
new clinics. As of 2007, there were about 500 such clinics in 36 states with 2,500 to 6,000
expected by the end of 2012. Id.

184 Id. at 22.

185 Id.

186 BUPPERT, supra note 2, at 236.
probably be applied when the NP fails to recognize that a diagnosis or treatment is outside of the NP’s abilities and fails to refer the patient to an appropriate physician. However, jurisdictions are split on whether an NP can be held to a physician’s standard of care when performing services which overlap a physician’s scope of practice, such as diagnosis or drug prescribing.\(^{188}\)

California follows the majority view\(^{189}\) that an NP is always held to the standard of a reasonably prudent NP. In *Fein v. Permanente Medical Group*, the plaintiff claimed that his NP misdiagnosed his heart attack as a mere muscle spasm.\(^{190}\) The defendant insurer appealed the trial judge’s jury instruction that “the standard of care required of a nurse practitioner is that of a physician and surgeon . . . when the nurse practitioner is examining a patient or making a diagnosis.”\(^{191}\) The court agreed that the trial judge had erred and should have instructed the jury that “the standard of care was that of a reasonably prudent nurse practitioner.”\(^{192}\) According to the majority rule, NPs would be the most qualified to serve as expert witnesses on the issue of an NP’s standard of care.\(^{193}\)

\(^{187}\) *Id.* at 237.

\(^{188}\) Bertness, *supra* note 21, at 245; BUPPERT, *supra* note 2, at 237.

\(^{189}\) Coleman & Shellow, *supra* note 135, at 73, 75.


\(^{191}\) *Fein*, 695 P.2d at 673.

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

\(^{193}\) Coleman & Shellow, *supra* note 135, at 81.
Since in some states NPs must collaborate with physicians, the question arises whether a physician can be held liable for the NP’s negligence. In *State ex rel. Howenstine v. Roper*, the plaintiff claimed that a drug prescribed by an NP had destroyed his liver.\(^{194}\) The plaintiff argued that since the NP had a collaborative agreement with Dr. Howenstine, as required by Missouri law, Dr. Howenstine should be held vicariously liable for the NP’s malpractice.\(^{195}\) The Missouri Supreme Court rejected this argument stating “[t]he treatment provided by the [NP] to [the plaintiff] was under independent statutory authority, not under Dr. Howenstine’s medical license.”\(^ {196}\) In other words, even though Missouri law requires NPs to have a written protocol with a physician, their actions are autonomous and cannot be attributed to the collaborating physician.\(^ {197}\) Although the courts have held that a physician cannot be held vicariously liable for an NP’s negligence, he or she can be sued for negligently hiring the NP or failing to properly supervise the NP.\(^ {198}\)

**VI. Conclusion**

As cost-effective and qualified providers, NPs can play an important role in alleviating the health care crisis. The key to affordable health care is quick and affordable access to primary care.

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

\(^{195}\) *Id.* at 751, 753.

\(^{196}\) *Id.* at 754.


\(^{198}\) See BUPPERT, supra note 2, at 245; Bertness, supra note 21, at 247; Howenstine, 155 S.W.3d at 754 (considering the possibility that Dr. Howenstine breached a duty to supervise the NPs in his clinic but ultimately dismissing the claim because of Dr. Howenstine’s public immunity). *But see Monahan*, 59 Va. Cir. at 312 (“This new species of medical malpractice claim, based entirely on supervisory liability, is wholly unknown in the common law.”).
care providers who can provide preventative care, detect illnesses before they balloon into medical crises, and educate patients about healthy living.\textsuperscript{199} Unfortunately, the number of medical school graduates entering the field of primary care is declining, mainly due to the high cost of education and the low financial return of family practice when compared to the specialties.\textsuperscript{200} However, a simple solution already exists: NPs. NPs have become an increasingly visible presence in the primary care arena as new modes of health care delivery, such as NP-run retail clinics, have emerged.\textsuperscript{201} While the federal government can incentivize the use of NPs,\textsuperscript{202} it will ultimately be up to the states to expand NP practice. To fully utilize NP expertise, states should remove barriers to NP practice such as highly restrictive physician collaborative agreements which only serve to increase the cost of health care.\textsuperscript{203} NPs will be

\textsuperscript{199} See supra notes 44-51 and accompanying text.

\textsuperscript{200} See supra notes 36-39 and accompanying text.

\textsuperscript{201} See supra note 183 and accompanying text.


\textsuperscript{203} See supra sec. III.
able to provide quick and affordable access to primary care allowing more highly trained physicians to concentrate on more acute illnesses.\textsuperscript{204}

\textsuperscript{204} See supra notes 44-51 and accompanying text.