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# ANNALS OF HEALTH LAW

THE HEALTH POLICY AND LAW REVIEW OF  
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW

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ANNALS OF HEALTH LAW  
*Advance Directive*

Editor's Note

The *Annals of Health Law* is proud to present the Eleventh Issue of our online, student-written publication, *Advance Directive*. *Advance Directive* aims to support and encourage student scholarship in the area of health law and policy. In this vein, this issue explores the challenges and opportunities facing mid-level healthcare providers and their scope of practice. The authors examine a variety of issues related to scope of practice, ranging from increasing the scope of practice of nurse practitioners to allowing military medical personnel more opportunities once they end their service.

The Issue begins with a concentrated look at mid level providers in Illinois. First, we examine the possibility of Illinois' psychologists obtaining the ability to prescribe medication. Our authors also explore eliminating scope of practice barriers for physician assistants and nurse practitioners in Illinois. Then, our authors discuss the need for expanding midwifery scope of practice in Illinois to improve access to health care and also to advance both feminist and financial arguments.

Our Issue continues with an analysis of broad changes to scope of practice laws throughout the United States. First, we consider the PPACA's impact on the scope of practice laws affecting nurse practitioners. We also discuss the scope of practice laws that constrain nurse practitioners working in rural settings across the nation. Our authors then discuss new alternatives across the United States that aim to increase access to primary care such as pharmacists who are granted prescriptive authority, the use of retail clinics, onsite health clinics at large employers, and the use of telemedicine by nurse practitioners. Then, our authors discuss how acupuncture licensing laws should be changed to allow greater access to alternative medicine. We also discuss the potential of utilizing veteran military medical personnel to increase access to care.

Finally, our Issue concludes with a comparative look at states' policies concerning scope of practice laws. We first compare the policies of Oregon and California regarding nurse practitioners' scope of practice. We also compare New Mexico's and Texas' scope of practice laws for nurse practitioners and do so while examining these policies' impacts on physician liability.

We would like to thank Matthew Newman, our *Advance Directive* Senior Editor, and Donna Miller, our Technical Editor, because without their knowledge and commitment this issue would not have been possible. We would like to give special thanks to our *Annals* Editor-in-Chief, Jamie Levin, for her unwavering leadership and support. The *Annals* Executive Board Members, Serj Mooradian, Christopher MacDonald, Loukas Kalliantasis, and Michael Meyer, provided invaluable editorial assistance with this Issue. The *Annals* members deserve special recognition for their thoughtful and topical articles and for editing the work of their peers. Lastly, we must thank the Beazley Institute for

Health Law & Policy and our faculty advisors, Professor Lawrence Singer, Professor John Blum, and Megan Bess for their guidance and support.

We hope you enjoy your Eleventh Issue of *Advance Directive*.

Sincerely,

Meghan T. Funk  
Advance Directive Editor  
*Annals of Health Law*  
Loyola University Chicago School of Law

A Prescription for the  
Future of Illinois' Psychologists

*Jean Yi Jinn Liu\**

I. INTRODUCTION

Expanding the scope of practice in the psychology field is a controversial topic.<sup>1</sup> In particular, many debate the issue of whether to grant state-licensed psychologists the ability to prescribe psychotropic (RxP) medications.<sup>2</sup> While psychiatrists are medical doctors with prescribing privileges, psychologists do not have medical degrees and in most states, are unable to obtain prescribing privileges.<sup>3</sup> Since 1989, the American Society for the Advancement of Pharmacotherapy (ASAP), part of the American Psychological Association (APA), lobbies and advocates for prescription privileges for psychologists.<sup>4</sup> The ASAP is greatly influential,

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1. Robert J. Resnick & John C. Norcross, *Prescription Privileges for Psychologists: Scared to Death?*, 9 CLINICAL PSYCHOL.: SCI. & PRAC. 270, 272 (2002).

2. Carrie R. Ball, *Limited Prescription Privileges for Psychologists: Review and Implications for the Practice of Psychology in Schools*, 46 PSYCHOL. IN THE SCH. 836, 836 (2009); Phyllis Coleman & Ronald A. Shellow, *Extending Physician's Standard of Care to Non-Physician Prescribers: The RX for Protecting Patients*, 35 IDAHO L. REV. 37, 38 (1998) (stating that the expanding the scope of practice of non-physician professionals to allow them to prescribe medication would be a mistake); Hooper, Lundy & Bookman, Inc., *Bill Granting Psychologists Prescription Authority Moves Forward*, 8 NO. 13 CAL. HEALTH L. MONITOR 2 (2000); *Real Mental Health Answers*, Letters to the Editor, CHI. SUN-TIMES (June 6, 2013).

3. Doug T. Graham, *Illinois Psychologists Want Ability to Prescribe Drugs*, DAILY HERALD, Mar. 20, 2013, available at [www.dailyherald.com/article/20130319/news/703199813/](http://www.dailyherald.com/article/20130319/news/703199813/); although without medical degrees, psychologists hold doctorates, complete a dissertation, and undergo specialized post-doctoral training. *Id.*

4. Brent Pollitt, *Fool's Gold: Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority*, 29 AM. J.L. & MED. 489, 48 (2003); Ball, *supra* note 2, at 836; James E. Long, Jr., *Power to Prescribe: The Debate Over Prescription Privileges for Psychologists and the Legal Issues Implicated*, 29 LAW &

and two states, New Mexico and Louisiana, passed legislation granting psychologists the ability to prescribe after meeting requisite training requirements.<sup>5</sup> With New Mexico and Louisiana leading the way in scope of practice expansion in psychology, other states quickly followed with similar attempts at expansion.<sup>6</sup> Illinois was no exception, although their most recent attempt, Senate Bill 2187, failed.<sup>7</sup>

This article asserts that the problem of access to mental health care in Illinois may find resolution through legislation expanding psychologists' prescription privileges. However, future Illinois legislation establishing prescribing psychologists needs to define the scope of involvement of the supervising physician, to select an overseeing body without a conflict of interest, and to require additional training and coursework with a strong emphasis in the medical field. Part II will present arguments for and against allowing psychologists to prescribe RxP medications in Illinois. Further, Part III will examine provisions of Senate Bill 2187, compare main differences between other states' prescribing laws and Illinois' failed bill, and focus on the many controversies that the proposed bill sparked. Finally, Part IV will examine the legal consequences that would result from future Illinois legislation allowing psychologists the ability to prescribe.

## II. THE ONGOING DEBATE IN ILLINOIS

More than a quarter of American adults every year will have a diagnosable mental disorder based upon the *Diagnostic and Statistical Manual of Mental Disorders*.<sup>8</sup> In the United States, economic costs from

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PSYCHOL. REV. 243, 244 (2005).

5. Ball, *supra* note 2, at 836; Long, *supra* note 4 at 244.

6. Long, *supra* note 4, at 244.

7. See generally S.B. 2187, 98th Gen. Assemb., 1st Reg. Sess. (Ill. 2013) (providing statutory guidelines for allowing psychologists the right to prescribe psychotropic medications).

8. The *Diagnostic and Statistical Manual of Mental Disorders*, published by the



these disorders are at least \$315 billion.<sup>9</sup> In light of budget restraints, doctor shortages, and limited care options, this pressing demand for mental health care is especially obvious in Illinois.<sup>10</sup> In fact, more than fifty Illinois counties are without inpatient psychiatric services in their hospitals and twenty-four Illinois counties are without hospitals.<sup>11</sup> With only 1,300 psychiatrists for Illinois' population of over twelve million people, the shortage of mental health professionals with prescription power is a serious cause for concern.<sup>12</sup> People who need but cannot obtain the necessary mental health care often end up in hospitals or jails, ultimately becoming a financial burden to the state.<sup>13</sup> Including prescription privileges in psychologists' scope of practice could be the answer to Illinois' worsening mental health care shortage.<sup>14</sup>

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American Psychiatric Association, recognized by the United States healthcare system, and used by mental health professionals in the United States, lists all recognized mental disorders and their corresponding diagnostic criteria. *About DSM-5*, AM. PSYCH. ASS'N, [www.dsm5.org/about/Pages/Default.aspx](http://www.dsm5.org/about/Pages/Default.aspx) (last visited Dec. 3, 2013); Robin S. Rosenberg, *According to the New DSM-5, Odds Are You Will Have a Mental Disorder*, SLATE, [http://www.slate.com/articles/health\\_and\\_science/medical\\_examiner/2013/04/diagnostic\\_and\\_statistical\\_manual\\_fifth\\_edition\\_why\\_will\\_half\\_the\\_u\\_s\\_population.single.html](http://www.slate.com/articles/health_and_science/medical_examiner/2013/04/diagnostic_and_statistical_manual_fifth_edition_why_will_half_the_u_s_population.single.html) (last visited Nov. 3, 2013).

9. *Prescribing Psychologists, The RxP Difference: Answering the Crisis in Mental Health Care*, ILL. PSYCH. ASS'N, <http://www.illinoispsychology.org/prescribing-psychologists> (last visited Nov. 3, 2013) [hereinafter *The RxP Difference*].

10. *See generally id.* (explaining that with limited resources and a drastic amount of Illinoisans that need treatment, there is a serious demand for mental health care).

11. *Id.*

12. U.S. DEP'T OF COM., U.S. CENSUS BUREAU, STATE & COUNTY QUICKFACTS, ILL. (June 27, 2013), available at <http://quickfacts.census.gov/qfd/states/17000.html>; *see also Shaping the Debate: Focusing on Critical Illinois Health Care Issues*, ILLINOIS HOSP. ASS'N, 2 (May 2011), <http://www.ihatoday.org/uploadDocs/1/shapingdebatemay.pdf> [hereinafter *Shaping the Debate*] (claiming that 70% of the 84 medically underserved Illinois counties were without a psychiatrist); Bonnie Miller Rubin, *Health Professionals Split Over Allowing Psychologists to Prescribe Drugs*, CHI. TRIBUNE (May 12, 2013), [articles.chicagotribune.com/2013-05-12/health/ct-met-psychologists-prescriptions-20130512\\_1-psychologists-marlin-hoover-illinois-psychiatric-society](http://articles.chicagotribune.com/2013-05-12/health/ct-met-psychologists-prescriptions-20130512_1-psychologists-marlin-hoover-illinois-psychiatric-society).

13. *The RxP Difference*, *supra* note 9.

14. *See id.* (claiming that as a consequence of federal health care reform and Medicaid expansion, demand for mental health care will continue to grow).

*A. Prescribing Psychologists: a Solution to Illinois' Access Problem?*

Although unsuccessful, Senate Bill 2187 was not easily defeated.<sup>15</sup> Rather, on April 25, 2013, the Illinois State Senate passed the bill 37-10, making it the first bill to advance out of either chamber of the General Assembly.<sup>16</sup> However, on June 1, 2013, Illinois General Assembly Representative and Assistant Majority Leader John E. Bradley withdrew the bill from consideration in committee.<sup>17</sup>

Allowing psychologists to prescribe in Illinois appears to be the obvious solution to access problems. Bob Rinaldi, a psychologist at Adventist Hinsdale Hospital, claims the patients he refers with high end insurance have an eight-week wait to see a psychiatrist and that no psychiatrist is even willing to see underinsured individuals or those on Medicaid.<sup>18</sup> Illinois senators pinpoint the issue as a matter of access, dismissing arguments that allowing psychologists to prescribe would create issues of substandard care and emphasizing instead that the lack of access to psychiatrists already results in substandard care.<sup>19</sup> Because psychologists are found across more

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15. See Rafael Guerrero, *Senate Committee Passes Bill Allowing Psychologists to Prescribe Drugs*, CHI. TRIBUNE (Mar.13, 2013), [http://articles.chicagotribune.com/2013-03-13/news/ct-met-illinois-legislature-psychologist-prescript-20130313\\_1\\_psychiatrists-psychologists-senate-committee](http://articles.chicagotribune.com/2013-03-13/news/ct-met-illinois-legislature-psychologist-prescript-20130313_1_psychiatrists-psychologists-senate-committee) (noting that the Senate Public Health Committee voted 8-0 to for the bill's advancement).

16. Lauren Leone-Cross, *Senate Approves Allowing Psychologists to Prescribe*, THE STATE J.-REG. (April 25, 2013), <http://www.sj-r.com/archive/x1973693914/Senate-approves-allowing-psychologists-to-prescribe>; *Bill Status of SB2187*, ILL. GEN. ASSEMB., <http://www.ilga.gov/legislation/BillStatus.asp?DocNum=2187&GAID=12&DocTypeID=SB&SessionID=85&GA=98> (last visited September 27, 2013); Rubin, *supra* note 12; see Graham, *supra* note 3.

17. Ken Hausman, *Prescribing Bill Dies in Illinois Legislature*, PSYCHIATRIC NEWS, June 13, 2013, available at <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1697770>.

18. Rubin, *supra* note 12. Dr. Jeff Weishaar of suburban psychological treatment group Compass Behavioral Health claims that patients sometimes wait upwards from six months to see a psychiatrist for a prescription. Graham, *supra* note 3.

19. See Guerrero, *supra* note 15 ("Illinois faces a critical shortage of mental health professionals who are trained to prescribe medicine, resulting in inadequate treatment for mental illness across the state."); see Leone-Cross, *supra* note 16 ("You know, opponents have contended that prescribing psychologists would provide substandard care. But I believe

Illinois counties than psychiatrists are, granting psychologists prescription privileges would increase access, especially in rural counties, thus increasing the supply of mental health professionals to meet the ongoing demand for mental health care.<sup>20</sup>

The APA claims that psychologists are competent and that legislatures should allow psychologists to prescribe.<sup>21</sup> The organization asserts that psychologists' education and clinical training allows them to better diagnose and treat mental illnesses than primary care physicians, that studies prove psychologists could safely prescribe RxP medications, and that post-doctoral training requirements sufficiently train psychologists to follow safe prescription practices.<sup>22</sup> The Illinois Psychological Association (IPA) adds that allowing psychologists to prescribe would satisfy the goals of providing underserved populations with access to mental health care, of allowing patients to gain a broader continuity of care from their psychologists, and furthering psychologists' expertise in and knowledge of brain-behavior relationships.<sup>23</sup>

### *B. Merely a Turf War Issue or Genuine Cause for Concern?*

In order to succeed, future Illinois legislation expanding psychologists' scope of practice must include a provision requiring additional medical education that is comparable to the education that other non-physicians with

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that the lack of access to psychiatrists has already created substandard care for many in Illinois").

20. Graham, *supra* note 3; *see also Shaping the Debate*, *supra* note 12 (stating that of Illinois' 102 counties, fifty counties are without a psychiatrist and eighty-four counties have no child psychiatrist).

21. *See* Pollitt, *supra* note 4, at 490 (noting five main reasons why legislatures should allow psychologists the right to prescribe RxP medications).

22. *Id.*

23. *Prescriptive Authority for Psychologists. . . What is Being Proposed – and why?*, ILL. PSYCH. ASS'N., [www.illinoispsychology.org/RxP-FAQ](http://www.illinoispsychology.org/RxP-FAQ) (last visited Nov. 4, 2013) [hereinafter *Prescriptive Authority*].

prescribing privileges receive.<sup>24</sup> Illinois psychiatrists are medical doctors who have completed an Illinois State Medical Board-regulated four years of medical school, four years of a psychiatry residency, and one to two years of specialization.<sup>25</sup> Alternatively, Illinois psychologists possess doctorate degrees and undergo four years of academic training, consisting of three years of clinical experiences and a yearlong internship in a clinical setting, followed by a dissertation and postdoctoral position in his or her specialized field.<sup>26</sup> Some prominent Illinois psychiatrists argue that because psychologists can earn their degrees in an online, 462-hour class without spending any time in an anatomy or physiology lab, allowing psychologists to prescribe is an issue of public safety.<sup>27</sup> These psychiatrists further rebut the argument for increased access by stating that access to quality mental health care cannot improve by providing patients with mental health practitioners that have not undergone medical training and are unequipped to provide mental health care.<sup>28</sup> Many opponents are especially concerned about the potential emergence of avoidable drug side effects and

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24. See also Pollitt, *supra* note 4, at 503 (noting physicians, physician assistants, and nurse practitioners all undergo substantially more clinical training with mentally ill and non-mentally ill patients).

25. Graham, *supra* note 3; but cf. Pollitt, *supra* note 4, at 491 (asserting that “psychologists lack the requisite education and training to safely prescribe [RxP] medication”).

26. E.g. Graham, *supra* note 3. Coursework for Illinois clinical psychologists consists of 3 years of full-time graduate course work, covering: the biological basis of behavior; cognitive-affective basis of behavior; social basis of behavior; individual differences – theories of normal and abnormal personality functioning; assessment including clinical interviewing and the administration, scoring and interpretation of psychological tests; treatment modalities for mental, emotional, behavioral or nervous disorders; and ethics. *Prescriptive Authority*, *supra* note 23. Pre-doctoral clinical training consists of 1,500 hours. *Id.*

27. See Graham, *supra* note 3 (quoting Dr. Lisa Rone, Chicago psychiatrist, professor at Northwestern Medical School, and past president of the Illinois Psychiatric Association refuses to believe that the online, 462-hour class is a sufficient “substitute...for the understanding of anatomy, physiology, [and] organic chemistry”; see Pollitt, *supra* note 4, at 502).

28. Rubin, *supra* note 12; see also Pollitt, *supra* note 4, at 502 (showing that Psychology programs do not require medical science courses to be taken in order to successfully earn a Bachelor of Art, Master of Art, or Master of Science degree).

interactions.<sup>29</sup>

Likewise, the American Psychiatric Association and the Committee Against Medicalizing Psychology strongly oppose granting psychologists prescriptive authority, arguing that psychologists lack the medical education, training, and experience necessary to prescribe safely.<sup>30</sup> The American Medical Association (AMA) also points to the striking differences between the medical training of physicians and the lack of comparable training psychologists undergo.<sup>31</sup> Even some psychologists oppose the bill, citing insufficient training and potential risks to patients.<sup>32</sup> However, any future legislation requiring psychologists to undergo additional education and training emphasizing clinical experience, hands-on teaching, and the prescribing of medication under the direct supervision of doctors, would easily refute arguments opposing expansion of psychologists' scope of practice.<sup>33</sup>

If future Illinois proposals to expand psychologists' scope of practice mandate that psychologists seeking the prescription privilege undergo education and training similar to what other non-physician practitioners

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29. See Julia Johnson, *Whether States Should Create Prescription Power for Psychologists*, 33 LAW & PSYCHOL. REV. 167, 174 (2009) (noting that medications for the mentally ill are especially dangerous because of their direct effects on the chemistry within a patient's brain); Rubin, *supra* note 12; Letter from James L. Madara, M.D. Am. Med. Ass'n, to the Honorable John G. Mulroe, Senator 10th Dist, 2 (Mar. 12, 2013), available at <http://www.ama-assn.org/resources/doc/arc/il-ltr-2187.pdf> [hereinafter *AMA Letter*] (emphasizing that psychiatric medications for mental illnesses are most potent, interacting with other medications and affecting both central nervous system and other organs).

30. Pollitt, *supra* note 4, at 507.

31. See *AMA Letter*, *supra* note 29, at 2 (noting while physicians have more than 10,000 hours and seven to eleven years of clinical education and training, psychologists do not have any comparable training). Likewise, the Illinois Psychiatric Society, opposed to the Senate Bill 2187, claims that the bill brings serious concern for its impact on patient safety. Hausman, *supra* note 17.

32. Rubin, *supra* note 12.

33. Editorial, *Slow Down on Prescription Power, Psychologists and Mental Health Medicines*, CHI. TRIBUNE, (May 13, 2013), [http://articles.chicagotribune.com/2013-05-13/opinion/ct-edit-pills-0513-jm-20130513\\_1\\_technical-trends-psychologists-sudarshan-sukhani](http://articles.chicagotribune.com/2013-05-13/opinion/ct-edit-pills-0513-jm-20130513_1_technical-trends-psychologists-sudarshan-sukhani).

must undergo, the only opposition left would arise from a turf war.<sup>34</sup> Requiring more comprehensive education and training would rebut claims by expansion opponents that allowing psychologists to prescribe would disregard what is best for the patient.<sup>35</sup> More stringent educational requirements to obtain prescription privileges would dismiss doubts that prescribing non-physician healthcare providers and psychologists are comparable, as both groups of medical professionals would have a close working relationship with physicians.<sup>36</sup>

### III. THE CONTROVERSIAL SENATE BILL 2187

Senate Bill 2187 proposed that an individual is eligible for certification as a prescribing psychologist in Illinois if she or he completes a doctoral program in psychology, holds a state license to practice psychology in Illinois, graduates with a master's degree in clinical psychopharmacology, obtains certification by a supervising physician after completing a supervised and relevant clinical experience, and completes a national certifying exam.<sup>37</sup> To obtain certification by a supervision physician, the psychologist must complete at least an eighty hour supervised practicum in clinical assessment and pathophysiology and at least a 400 hour supervised practicum treating at least one-hundred mentally ill patients.<sup>38</sup>

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34. See Pollitt, *supra* note 4, at 521 (“Unfortunately, the psychologists seeking prescriptive authority view the situation as a “turf” war instead of what best serves the patient.”); *id.* (noting that this medical turf war is exemplified through psychologist and psychiatrists’ aggressive exchange of facts, figures, studies and claims).

35. See Pollitt, *supra* note 4, at 521 (claiming that psychologists’ pursuit of prescription privileges disregards what best serves the patient and instead is motivated by a desire to stay relevant in the future).

36. Rachel P. Berland, *Introducing Patient Scope of Care: Psychologists, Psychiatrists, and the Privilege to Prescribe Drugs*, 6 ST. LOUIS U. J. HEALTH L. & POL’Y 425, 446 (2013) (stating that criticisms of allowing psychologists to prescribe center around the claim that while prescribing non-physicians such as nurse practitioners have a medical background a close working relationship with physicians, psychologists do not).

37. S.B. 2187, 98th Gen. Assemb., 1st Reg. Sess. §§ 2(12), 4.1, 4.2 (Ill. 2013).

38. *Id.* at § 4.2 (4).

*A. Troubling Provisions*

Despite requiring that psychologists complete an additional master's degree and 480 hours of supervised training, many remain unconvinced that satisfaction of these requirements is enough to justify allowing non-physician psychologists to prescribe medications.<sup>39</sup> The required curriculum necessary to complete the two year master's degree in clinical psychopharmacology includes, among others, anatomy and physiology, biochemistry, neurosciences.<sup>40</sup> However, opponents of the bill remain unpersuaded, bringing attention to the vague descriptions of the required training in the proposed legislation's text and the fact that online training courses and online master's degrees in psychopharmacology would satisfy the stated requirements.<sup>41</sup> Opponents further argue that select courses in anatomy, physiology, and biochemistry are not a substitute for a medical education.<sup>42</sup>

To succeed, future Illinois legislation proposals must address sufficient collaboration between medical doctors and prescribing psychologists. Primary care physicians who work with prescribing psychologists in New Mexico and Louisiana report positive results of the collaboration.<sup>43</sup> Both states, as part of their enacted legislation, implemented provisions to

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39. See Graham, *supra* note 3 (noting that a psychologist can earn his degree without any hands on lab experience and this is a serious flaw which concerns the public health).

40. *Id.*

41. *Id.*; Mark Moran, *Illinois Senate Gets Bill on Psychologist Prescribing*, PSYCHIATRIC NEWS (Mar. 15, 2013), <http://psychnews.psychiatryonline.org/newsArticle.aspx?articleid=1668022&RelatedWidgetArticles=true>.

42. See Moran, *supra* note 41 ("[P]eople who have gotten a doctoral degree in psychology . . . may or may not have ever had any of the training in the scientific areas . . . that medically trained individuals receive.")

43. *The RxP Difference*, *supra* note 9; see also Dave McKinney, *State Senate OKs Bill to Let Psychologists Prescribe Mental Health Medications*, CHI. SUN-TIMES, May 29, 2013, available at <http://www.suntimes.com/news/metro/19720545-418/state-senate-oks-bill-to-let-psychologists-prescribe-mental-health-medications.html> (quoting Senator Harmon and noting the absence of complaints in states that have passed legislation allowing psychologists to prescribe).

minimize risks to patients.<sup>44</sup> In Louisiana, a prescribing psychologist can only issue a prescription with the primary physician's approval.<sup>45</sup> In New Mexico, the supervising physician is as responsible for the prescribing psychologist's action as the psychologist is, and assumes joint and several liability for the psychologist's acts or omissions.<sup>46</sup> Although Senate Bill 2187 requires that the certified prescribing psychologist maintains a written collaboration agreement with a physician, the cooperative working relationship between prescribing the psychologist and physician is vaguely defined.<sup>47</sup>

Future Illinois legislative proposals aimed at granting psychologists prescription privileges must better define the collaborative relationship between medical health care professionals. The failed bill's provisions are ambiguous, merely stating that a physician who signs a supervision agreement, or variation thereof, with a prescribing psychologist is not liable for the acts or omissions of the psychologist.<sup>48</sup> Furthermore, Senate Bill 2187 fails to provide a detailed description of what precisely consists of the collaborate relationship between a prescribing psychologist and medical physician.<sup>49</sup> In contrast, Illinois state provisions granting nurse practitioners the ability to prescribe RxP medications, do thoroughly define the corresponding roles of physician and nurse practitioners through a

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44. See Long, *supra* note 4, at 258.

45. *Id.*

46. *Id.*

47. See S.B. 2187, 98th Gen. Assemb., 1st Reg. Sess. § 4.4(d) (Ill. 2013) (stating the cooperative working relationship between the prescribing psychologist and physician should "include diagnosis and cooperation in the management and delivery of physical and mental health care").

48. *Id.* at § 54.5(e).

49. See S.B. 2187, 98th Gen. Assemb., 1st Reg. Sess. § 4.4(e) (Ill. 2013) (merely stating that a prescribing psychologist shall take measures, such as collecting a medical history, to ensure patient safety); see Moran, *supra* note 41.



formal legal agreement.<sup>50</sup> While the legal agreement between nurse practitioners and physicians contains provisions such as what may or may not be prescribed and requires that Schedule 2 prescriptions be limited to a thirty-day supply with refills approved by a collaborating physician, Senate Bill 2187 leaves the term written collaborative agreement virtually undefined.<sup>51</sup>

Perhaps most controversial was a provision of the bill that would allow Illinois' psychological licensing board to oversee prescribing credentials and activities.<sup>52</sup> The AMA strongly opposed this component of the bill, emphasizing that Senate Bill 2187 would inappropriately grant to the Illinois Board of Psychological Examiners the ability to determine the extent of prescriptive authority.<sup>53</sup> This bill stood in stark contrast with the legislation passed in Louisiana and New Mexico, where the enacted laws allowing psychologists to prescribe required each respective state medical licensing board to oversee and regulate.<sup>54</sup> Further, because the bill stipulates that a statewide organization representing licensed psychologists provide a minimum of twenty percent of the training that psychologists need to prescribe in the state, many claim that the bill directly financially benefits the Illinois Psychological Association, giving rise to an obvious conflict of interest.<sup>55</sup> To succeed, future proposed Illinois legislation to expand psychologists' scope of practice and include prescribing privileges must clearly describe required additional training and education, better

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50. See Moran, *supra* note 41 (noting that a prescribing nurses limitations are documented by a formal legal agreement).

51. *Id.*

52. See S.B. 2187, 98th Gen. Assemb., 1st Reg. Sess. § 4.3 (Il. 2013) (mandating a percentage of the prescribing psychologist's training to be provided by a "statewide organization").

53. See AMA Letter, *supra* note 29, at 1.

54. Hausman, *supra* note 17.

55. Moran, *supra* note 41; see Ill. S.B. 2187.

define the relationship between physicians and psychologists, address potential issues of liability, and allow Illinois' state medical licensing board to oversee prescribing psychologists' prescribing credentials and activities.<sup>56</sup>

### *B. Financial Ramifications*

Allowing psychologists to prescribe may be a step toward making psychiatric drugs more affordable.<sup>57</sup> Supporters of Bill 2187 claim that when people do not receive much-needed mental health care, they often end up in hospitals or jails, and in turn, greatly increase costs and taxes for Illinois citizens.<sup>58</sup> As a step toward increasing access and putting a stop to these cost increases, proponents of granting psychologists the privilege to prescribe argue that allowing psychologists to prescribe will generally reduce medical expenses, as patients will only have to visit one healthcare provider instead having to visit a psychologist for psychotherapy and a psychiatrist for medication.<sup>59</sup> Advocates remain hopeful, claiming that because many psychologists are already recommending what drugs should be prescribed to their patients, a one-stop shop makes the most sense.<sup>60</sup> Requiring patients to obtain a referral to see an additional healthcare provider for a prescription results in extra costs and time wasted for the patient, and many argue that allowing psychologists to obtain the appropriate training to prescribe not only make more economic sense, but would also result in more effective prescriptions.<sup>61</sup>

Allowing psychologists to obtain prescription privilege will result in

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56. See S.B. 2187, 98th Gen. Assemb., 1st Reg. Sess. §§ 2(12), 4.1-4.4 (Il. 2013).

57. See Pollitt, *supra* note 4, at 490-91; see *The RxP Difference*, *supra* note 9.

58. *The RxP Difference*, *supra* note 9.

59. *Id.*; Rubin, *supra* note 12.

60. Johnson, *supra* note 29, at 173.

61. *Id.*

lower costs for the citizens of Illinois.<sup>62</sup> A psychiatrist may earn \$150 for three 15-minute medication visits, but a psychologist may only earn \$90 for a forty-five minute talk therapy session<sup>63</sup>; however, savings would only become possible if prescribing psychologists do not dramatically raise their fees.<sup>64</sup> With the increased cost of additional education and malpractice insurance costs, prescribing psychologists are likely to charge more than they would have without this prescribing power.<sup>65</sup> Despite potential increases in psychologist fees, managed health care will likely support prescribing psychologists due to the potential for lower fees from a one-stop shop system.<sup>66</sup> As psychologists become the prescription writers, the need for psychiatrists will greatly diminish.<sup>67</sup>

#### IV. LEGAL CONSEQUENCES THAT WOULD EMERGE FROM GRANTING PSYCHOLOGISTS PRESCRIPTION PRIVILEGES

Courts in the United States are reluctant to hold prescribing non-physicians to the same standard of care of physicians when prescribing medications, and instead are more likely to apply the similar professional standard.<sup>68</sup> If psychologists in Illinois are allowed to prescribe medication,

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62. See *The RxP Difference*, *supra* note 9 (explaining how when a patient goes undiagnosed or does not receive the proper treatment, the patient can end up hurting themselves or others which may drive up costs via increasing state taxes to properly make up for their actions).

63. Gardiner Harris, *Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy*, N.Y. TIMES, Mar. 2011, available at [www.nytimes.com/2011/03/06/health/policy/06doctors.html?\\_r=0&pagewanted=print](http://www.nytimes.com/2011/03/06/health/policy/06doctors.html?_r=0&pagewanted=print). (see my previous comments about citing to electronic copies of print newspapers and adjusting accordingly).

64. Pollitt, *supra* note 4, at 519.

65. See also Long, *supra* note 4, at 258 (stating that the increased potential liability would give rise to a need to maintain malpractice insurance with greater coverage amounts or more expensive premiums); *id.*

66. Pollitt, *supra* note 4, at 521 (claiming that with the emergence of prescribing psychologists, psychologists will become "pseudo-psychiatrists," and that the need for psychiatrists and non-prescribing psychologists will disappear).

67. *Id.*

68. See *Baylor Med. Ctr. at Waxahachie, Baylor Health Care Sys. v. Wallace*, 278 S.W.3d 552, 558 (Tex.App. Dallas, 2009) (stating that there are different standards of care

Illinois courts would likely employ this similar professional standard, determined by taking into consideration the amount of training the prescribing psychologist received along with the reasonableness of his actions with respect to other psychologists in Illinois.<sup>69</sup> Prescribing psychologists would still be liable for negligently prescribing inappropriate medications, failing to warn or treat side effects, and failing to recognize or anticipate various drug interactions.<sup>70</sup> This similar professional standard appears troubling, as it seemingly punishes patients with a lower standard of care because they chose to consult a prescribing psychologist instead of a physician.<sup>71</sup> One possibility is that future proposed Illinois legislation may choose to follow New Mexico's example, deeming a supervising physician jointly and severally liable for the acts and omissions of the prescribing psychologist.<sup>72</sup>

#### IV. CONCLUSION

As of 2012, there are over twelve million people living in Illinois.<sup>73</sup> With the state's 1,300 psychiatrists and the estimated 614,000 residents needing treatment for serious mental illness, it is likely that the option of prescribing psychologists will resurface in proposed legislation.<sup>74</sup> To succeed, future Illinois legislation proposing the establishment of prescribing psychologists must define the scope of involvement of the supervising physician, select an overseeing body without a conflict of

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for doctors and other health care providers); *see* Long, *supra* note 4, at 257.

69. Long, *supra* note 4, at 257.

70. *Id.* at 258.

71. *See id.* at 257.

72. *See id.* at 257-58 ("[the] problem with this standard is it awards patients a lower amount of care just by seeing a psychologist who now performs tasks that were previously exclusive to psychiatrists or physicians").

73. *See* U.S. DEP'T OF COM., *supra* note 15.

74. *See The RxP Difference*, *supra* note 9 (claiming that the shortage of government funding to assist those needing psychiatric services is not only insufficient, but also continues to grow); *see* Rubin, *supra* note 12.

interest, and require additional rigorous medical training and coursework.<sup>75</sup> One possible solution to overcome the comparable education hurdle could be to require psychologists seeking prescription privileges to undergo coursework emphasizing clinical experience and affording students the opportunity to prescribe medication under close physician supervision, such as that required of a physician's assistant or an advanced practice nurse.<sup>76</sup> Requiring such additional education could ease the opposition's concerns and ensure patient safety.<sup>77</sup>

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75. See *supra* Parts IIB and III. However, if and when such a bill resurfaces, it is clear that the opposition will be relentless. See Hausman, *supra* note 17 (noting APA Presidents Lieberman and Summergrad have indicated that the APA is ready to combat future bills similar to Senate Bill 2187).

76. Editorial, *supra* note 33.

77. See *id.*

Eliminating Scope of Practice  
Barriers for Illinois Physician Assistants

*Jessica Wolf \**

I. INTRODUCTION

Among the major challenges facing the healthcare system in Illinois, the current gap in consumer access to primary care providers is a key concern.<sup>1</sup> Factors such as changing demographics, the increased volume of insured individuals under the Patient Protection and Affordable Care Act (PPACA), and a declining number of primary care physicians contribute to the need for expanding mid-level practitioner scope of practice in Illinois.<sup>2</sup> Mid-level practitioners are non-physicians and provide care to patients under the supervision of a licensed physician.<sup>3</sup> Examples of mid-level practitioners include registered nurses, nurse practitioners, and physician assistants (PAs).<sup>4</sup>

The current trend toward physician specialization further exacerbates consumer access to primary care.<sup>5</sup> A recent Congressional Report stated that the national physician population is approximately one-third primary

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1. ALEXANDRA LUTEREK & MARGIE SCHAPS, HEALTH AND MED. POL'Y RES. GRP., ELIMINATING SCOPE OF PRACTICE BARRIERS FOR ILLINOIS ADVANCED PRACTICE NURSES 6 (2013), *available at* <http://hmprg.org/assets/root/Safety%20Net/Nurse%20Practice%20Act%20Position%20Paper.pdf>.

2. *Id.* at 4, 6-7.

3. DAN TENNENHOUSE, ATTORNEYS MEDICAL DESKBOOK (4th ed. 2013), *available at* Westlaw.

4. *Id.*

5. *See* SUZANNE KIRCHHOFF, CONG. RESEARCH SERV., R42880, PHYSICIAN PRACTICES: BACKGROUND, ORGANIZATION, AND MARKET CONSOLIDATION 4 (2013), *available at* <http://www.fas.org/sgp/crs/misc/R42880.pdf>.

care physicians and two-thirds specialists.<sup>6</sup> The demand for primary care physicians in Illinois appears to follow this national trend, especially in Health Professional Shortage Areas (HPSAs), which exist in a majority of counties across the state and lack necessary health services in primary care.<sup>7</sup> One way to increase consumer access to primary health care in a specialty-focused industry is to ensure that mid-level practitioners are utilized to their full capacity.<sup>8</sup>

PAs play an integral role in the delivery of health care by managing common diagnoses, providing routine treatments, and allowing physicians to focus on more complex patient care that requires their full expertise.<sup>9</sup> Specifically, PA practice in areas experiencing a shortage in primary care physicians provides access for patients who would otherwise have to endure lengthy waiting periods or travel long distances to receive the care that they need.<sup>10</sup> Scope of practice for PAs is largely regulated by state legislatures through the implementation of laws that legally authorize PAs to provide certain medical services.<sup>11</sup> In some states, however, PAs' ability to provide care is constrained by laws that unnecessarily restrict the services that they may be otherwise qualified to provide and consequently limit consumer

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6. *Id.*

7. ILLINOIS HOSP. ASS'N, ILLINOIS NEW PHYSICIAN WORKFORCE STUDY 5 (2010), available at <http://www.ihatoday.org/uploadDocs/1/phyworkforcestudy.pdf>.

8. See REBECCA LEBUHN & DAVID SWANKIN, CITIZEN ADVOCACY CTR., REFORMING SCOPES OF PRACTICE 2 (2010), <https://www.ncsbn.org/ReformingScopesofPracticeWhitePaper.pdf>; see also Melinda Beck, *Battles Erupt Over Filling Doctors' Shoes*, WALL ST. J., Feb. 4, 2013, <http://online.wsj.com/news/articles/SB10001424127887323644904578271872578661246> (discussing the growing demand for PAs in primary care and rural areas as a result of more doctors choosing to specialize and work in urban areas).

9. AM. ACAD. OF PHYSICIAN ASSISTANTS, SUPERVISION OF PHYSICIAN ASSISTANTS: ACCESS AND EXCELLENCE IN PATIENT CARE 2-3 (Oct. 2011), available at [http://www.aapa.org/uploadedFiles/content/The\\_PA\\_Profession/Federal\\_and\\_State\\_Affairs/Resource\\_Items/SLI\\_PASupervision\\_110811\\_Final.pdf](http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/SLI_PASupervision_110811_Final.pdf).

10. Linda J. Vorvick, *Physician Assistant Profession (PA)*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/001935.htm> (last updated Aug. 12, 2011).

11. MICHELE ROTH-KAUFFMAN, THE PHYSICIAN ASSISTANT'S BUSINESS PRACTICE AND LEGAL GUIDE 29 (2006).

access to primary care.<sup>12</sup>

This article argues that the Illinois Legislature should eliminate certain restrictive supervision requirements for PAs in order to expand consumer access to primary health care. Part II reviews the history of the PA profession and the current legal framework in which Illinois PAs practice. Part III explores issues arising from physician supervision requirements that support their elimination and proposes policy changes to expand scope of practice for PAs. Finally, Part IV offers a conclusion on the issues surrounding scope of PA practice in Illinois and advocates for the elimination of certain restrictive supervision requirements in order to expand consumer access to primary health care.

## II. BACKGROUND

Duke University established the first PA training program in the mid-1960s.<sup>13</sup> A principal motivator for the creation of the PA profession was the need for greater patient access to primary care.<sup>14</sup> PAs are defined as healthcare professionals who have graduated from an accredited PA educational program and are authorized by a state to practice medicine under the supervision of a licensed physician.<sup>15</sup> PAs generally perform a range of traditional clinical activities such as taking patient histories, performing physical examinations, ordering and interpreting laboratory tests, diagnosing and tailoring treatment plans to individual patient needs, and prescribing medicine.<sup>16</sup>

The scope of PA practice is defined by four parameters: education and

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12. See LEBUHN & SWANKIN, *supra* note 8, at 3.

13. Vorvick, *supra* note 10.

14. Bettie Coplan et al., *Physician Assistants in Primary Care: Trends and Characteristics*, 11 ANNALS OF FAM. MED. 75, 75 (2013) (discussing the history and evolution of the PA profession).

15. ROTH-KAUFFMAN, *supra* note 11, at 1.

16. *Id.* at 2-4.



experience, healthcare facility policies, state laws, and delegation by supervising physicians.<sup>17</sup> The PA educational program provides students with extensive medical training through a combination of classroom and clinical instruction.<sup>18</sup> The length of the program is about twenty-seven months.<sup>19</sup> PA students also must complete 2,000 hours of supervised clinical practice in order to graduate from an accredited program.<sup>20</sup> Similar to other health practitioners, a PA's medical knowledge continues to develop while practicing in the clinical environment and through continuing medical education.<sup>21</sup> In addition to education and experience, the healthcare facilities that employ PAs also shape the scope of PA practice.<sup>22</sup> For example, healthcare facilities such as hospitals and acute care centers authorize PAs to provide services by granting them with privileges and maintain the right to limit the responsibilities assigned to employed PAs.<sup>23</sup>

Beyond educational training and the policies of healthcare facilities, state law governs PA practice.<sup>24</sup> The first state laws regulating PA practice in the 1970s were added as simple amendments to a state's medical practice act and allowed broad delegation authority for supervising physicians.<sup>25</sup> Many states subsequently attempted to identify specific tasks and medical services that PAs could provide as the profession continued to grow.<sup>26</sup> Today, the majority of state laws permit a supervising physician to determine the scope

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17. AM. ACAD. OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANT SCOPE OF PRACTICE 1 (Oct. 2011), *available at* [http://www.aapa.org/uploadedFiles/content/The\\_PA\\_Profession/Federal\\_and\\_State\\_Affairs/Resource\\_Items/PI\\_PAScopePractice\\_110811\\_Final.pdf](http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/PI_PAScopePractice_110811_Final.pdf).

18. *Id.* at 2.

19. *Id.*

20. *Id.*

21. *Id.*

22. *See* AM. ACAD. OF PHYSICIAN ASSISTANTS, THE SIX KEY ELEMENTS OF A MODERN PHYSICIAN ASSISTANT PRACTICE ACT 1 (March 2011), *available at* [http://www.aapa.org/uploadedFiles/content/Common/Files/SL\\_KeyElements\\_v3.pdf](http://www.aapa.org/uploadedFiles/content/Common/Files/SL_KeyElements_v3.pdf).

23. *See* AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 17, at 2-3.

24. *Id.* at 2.

25. *Id.*

26. *See id.*

of PA practice through broad delegation powers.<sup>27</sup> The reason that most states allow a supervising physician to determine a PA's scope of practice, rather than attempt to define every service that a PA can perform is because a statutory list created by state legislators could not possibly cover every service that all PAs are qualified to provide.<sup>28</sup> Additionally, state legislators would never be able to amend laws to keep pace with the rapidly evolving field of medicine.<sup>29</sup> Overall, PA scope of practice should be consistent with educational training and determined by the supervising physicians.<sup>30</sup>

#### *A. Current Legal Framework in Illinois*

The Physician Assistant Practice Act (the Act) regulates all PAs practicing in Illinois.<sup>31</sup> The Illinois Legislature enacted the Act in 1987.<sup>32</sup> The purpose of the Act was to protect the public from incompetent performance by unqualified non-physicians and to define the role of PAs in the healthcare system.<sup>33</sup> The Act defines a PA as a person who has been certified by the state and performs procedures under the supervision of a physician.<sup>34</sup> The Act does not require the physical presence of a supervising physician at all times when a PA renders services as long as a supervising physician is available for consultation when needed by telephone or telecommunications.<sup>35</sup>

Under the Act, supervising physicians are permitted to use seemingly broad discretionary authority to determine the number of PAs that they will

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27. See AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 22, at 1-2.

28. *Id.* at 1.

29. *Id.*

30. See AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 17, at 3.

31. Physician Assistant Practice Act of 1987, 225 ILL. COMP. STAT. § 95/4 (2013).

32. *Id.* § 95/1.

33. See *id.*

34. *Id.* § 95/4.

35. See *id.*

supervise and the tasks that they will delegate to PAs.<sup>36</sup> The Act further provides that written supervision agreements are required for all PAs, except those practicing in a hospital, hospital affiliate, or ambulatory surgical treatment center, as long as a PA in one of these settings possesses clinical privileges granted by the medical facility.<sup>37</sup> A written supervision agreement describes the working relationship between a PA and a supervising physician.<sup>38</sup> A written supervision agreement also defines a PA's scope of practice and duties, including the categories of care, treatment, and procedures that a PA will provide.<sup>39</sup> A supervising physician must periodically review a PA's orders and services to ensure that the PA is acting in accordance with accepted standards of medical practice.<sup>40</sup>

In 2012, the Illinois Legislature amended the supervision provision in the Act to change the previously established limit of two PA supervision agreements per physician to a seemingly broader limit of five full-time equivalents.<sup>41</sup> Accordingly, the Act provides that a supervising physician may supervise a maximum of five full-time equivalent PAs, however the maximum number of PAs allowed is then reduced by the number of collaborative agreements that a supervising physician maintains with other mid-level practitioners.<sup>42</sup> A collaborative agreement is similar to a supervision agreement required for PAs, but is required for all advanced

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36. *See id.* § 95/7.

37. *Id.* § 95/7.5-7.7.

38. *Id.* § 95/7.5.

39. *See id.*

40. *Id.*

41. Sandra DiVarco, *Implementing the Restrictions on the Number of Physician Supervision and Collaboration Agreements under Illinois Law*, MCDERMOTT, WILL, AND EMERY 1 (Feb. 2013), available at <http://www.mwe.com/Implementing-the-Restrictions-on-the-Number-of-Physician-Supervision-and-Collaboration-Agreements-under-Illinois-Law-02-04-2013/>.

42. Physician Assistant Practice Act of 1987, 225 ILL. COMP. STAT. § 95/7 (2013).

practice nurses engaged in clinical practice and collaborating physicians.<sup>43</sup> For example, if a physician entered into supervision agreements with two PAs and collaboration agreements with three advanced practice nurses, the physician is prohibited from entering into any additional supervision or collaboration agreements to avoid exceeding a total of five agreements pursuant to the Act.<sup>44</sup> This statutory limitation on the number of PAs that a physician can supervise ultimately restricts the locations that PAs can practice and functions as a barrier against patient access to primary health care in Illinois.

### *B. The Status of Health Care in Illinois*

According to the most recent Commonwealth Fund State Scorecard, Illinois ranks in the bottom quartile for its overall state health system based on factors such as access to care, prevention, treatment, avoidable hospital use and costs, and insurance coverage.<sup>45</sup> Additionally, Illinois ranks twentieth out of all states in the country for its accessibility of health care to various categories of patients.<sup>46</sup> The demand for accessible health care in Illinois will continue to increase for a variety of reasons.<sup>47</sup> As a result of increased life expectancy and the aging Baby Boom generation, the Medicare beneficiary population and the demand for long-term care services is expected to grow.<sup>48</sup> In 2010, about twelve percent of the Illinois population was aged sixty-five and older, and the percentage of the age

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43. See Nurse Practice Act, 225 ILL. COMP. STAT. § 65/65-35 (2013).

44. See DiVarco, *supra* note 41.

45. *Health System Data Center*, THE COMMONWEALTH FUND, <http://datacenter.commonwealthfund.org/scorecard/state/15/illinois/> (last visited Dec. 8, 2013).

46. *Id.*

47. See ST. OF ILL. COMPTROLLER, POPULATION AGING: ARE GOV'TS READY 1 (July 2007), <http://www.ioc.state.il.us/index.cfm/resources/fiscal-focus/july-2007-department-on-aging/>.

48. See LUTEREK & SCHAPS, *supra* note 1, at 4.

group is projected to become eighteen percent of the population by 2030.<sup>49</sup>

Additionally, a growing shortage of primary care physicians in Illinois also limits patient access to care.<sup>50</sup> In 2010, only about twenty-five primary care physicians for every 10,000 people and twenty PAs for every 100,000 people practiced in Illinois.<sup>51</sup> According to the Illinois Department of Public Health, about one hundred Illinois counties identified as HPSAs.<sup>52</sup> Significant areas of shortage exist in rural areas, small towns, and lower socioeconomic areas.<sup>53</sup>

The full implementation of the PPACA will further demand access to care because it will expand insurance coverage to previously uninsured or underinsured Illinois residents through health insurance exchanges or expanded Medicaid coverage.<sup>54</sup> Approximately 500,000 low-income Illinois residents will become eligible for Medicaid in 2014.<sup>55</sup> In order to meet this increased demand for patient access to primary health care, the federal government invested in the primary care workforce through the establishment of the National Health Service Corps Program, which repays educational loans and provides scholarships to primary care practitioners including PAs.<sup>56</sup> The changing of scope of practice laws is likely to have an

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49. ST. OF ILL. COMPTROLLER, *supra* note 47, at 3.

50. See LUTEREK & SCHAPS, *supra* note 1, at 6.

51. *Id.*; see also *Providers and Service Use*, THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/state-category/providers-service-use/> (last updated Jan. 14, 2009).

52. ILL. DEP'T OF PUB. HEALTH CTR. FOR RURAL HEALTH, AREAS OF ILLINOIS HAVING STATE PHYSICIAN AND/OR FEDERAL HEALTH PROFESSIONAL SHORTAGE AREAS (Jan. 2009), available at [http://www.idph.state.il.us/about/rural\\_health/shortageareas.htm](http://www.idph.state.il.us/about/rural_health/shortageareas.htm).

53. See LUTEREK & SCHAPS, *supra* note 1, at 6.

54. See *id.* at 7.

55. *Id.*

56. See MELINDA ABRAMS ET AL., THE COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: HOW THE AFFORDABLE CARE ACT WILL STRENGTHEN PRIMARY CARE AND BENEFIT PATIENTS, PROVIDERS, AND PAYERS 13 (Jan. 2011), available at [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jan/1466\\_Abrams\\_how\\_ACA\\_will\\_strengthen\\_primary\\_care\\_reform\\_brief\\_v3.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Jan/1466_Abrams_how_ACA_will_strengthen_primary_care_reform_brief_v3.pdf).

immediate effect on expanding the supply of primary care providers.<sup>57</sup> Enhancing the role of PAs by eliminating restrictive state regulations is another means of raising the efficiency of primary care practices and a key resource to enduring the challenges that face the primary care workforce.<sup>58</sup>

### III. RESTRICTIVE PA PRACTICE LAWS AND IMPLICATIONS FOR ACCESS TO HEALTH CARE

Several physician supervision requirements as provided under the Act unnecessarily constrain PA practice in Illinois and should be eliminated. Limiting a supervising physician to a maximum of five PAs reduced by the number of collaborative agreements the physician maintains ultimately restricts the total number of mid-level practitioners available to serve patients.<sup>59</sup> Furthermore, requiring a supervising physician to review and sign off on routine health services that the physician already deemed to be within a PA's qualifications is an inefficient use of time.<sup>60</sup>

#### *A. Limitations on The Number of PAs That a Physician May Supervise*

The American Academy of Physician Assistants recommends that state laws should not include specific numerical limits on the number of PAs that a physician may supervise because the limit may be appropriate in some clinical settings, but not for others.<sup>61</sup> While the number of collaboration agreements that a physician may enter into with advance practice nurses is unlimited, the number of PAs that a physician may enter into an agreement with is restricted.<sup>62</sup> The number of PAs a physician can supervise is further

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57. Sarah Klein, *Strengthening the Primary Care Workforce to Meet Population Needs*, THE COMMONWEALTH FUND 2 (May 2011), <http://www.commonwealthfund.org/Newsletters/Quality-Matters/2011/April-May-2011/In-Focus.aspx>.

58. *See id.*

59. *See* DiVarco, *supra* note 41.

60. *See* AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 27, at 3.

61. *Id.* at 4.

62. *See* DiVarco, *supra* note 41.

limited by how many collaboration agreements the physician already maintains.<sup>63</sup> A physician workforce study conducted in Illinois stated that physicians do not practice in rural settings in part because the workload is greater and the compensation is often lower than in other settings.<sup>64</sup> State regulations that limit physicians' authority to utilize the number of mid-level practitioners they deem necessary removes a valuable resource from physicians.<sup>65</sup> Consequently, a primary care physician practicing in a shortage area may not be able to employ the number of PAs that the healthcare facility requires to manage patient volume more effectively.<sup>66</sup>

The physician-to-PA ratio provision should be eliminated and instead permit supervising physicians to determine the number of PAs they will supervise based on the needs of the patient community and practice.<sup>67</sup> Supervising physicians are in the best position to evaluate the qualifications of PAs, the nature of the practice and patient population, and to implement an efficient supervisory approach.<sup>68</sup>

#### *B. Mandatory Physician Review & Approval of PA Services*

Under the Act, a supervising physician is responsible for directing and reviewing the services provided by a PA to ensure that the PA is practicing in accordance with accepted medical standards and that appropriate treatment is rendered.<sup>69</sup> This review requirement resembles chart co-signature requirements in other states where a supervising physician must

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63. See AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 27, at 3.

64. ILLINOIS NEW PHYSICIAN WORKFORCE STUDY, *supra* note 7, at 12.

65. See LEBUHN & SWANKIN, *supra* note 8, at 3.

66. *Id.*

67. See AM. ACAD. OF PHYSICIAN ASSISTANTS, *supra* note 27, at 4.

68. *Id.*

69. Physician Assistant Practice Act of 1987, 68 ILL. ADMIN. CODE tit. 1350, § 80 (2013).

co-sign every order or service provided by a PA.<sup>70</sup> The American Academy of Physician Assistants recommends that physician co-signature review should only be required when a supervising physician or healthcare facility determines that it is necessary because it removes a physician's discretion to exercise supervision in the way that works best for the practice.<sup>71</sup> Mandatory physician approval and review of PA services diminishes the effectiveness of healthcare providers by forcing supervising physicians to allocate time to review tasks that are already determined to be within PAs' capabilities and delegated to PAs in written supervision agreements.<sup>72</sup> Delegating basic services to mid-level practitioners such as PAs can improve access to care by allowing a supervising physician to manage patient volume more efficiently.<sup>73</sup>

#### V. CONCLUSION

The Illinois Legislature should eliminate the restrictive physician supervision requirements as provided by the Act. Specifically, the provision limiting the number of PAs that a physician is permitted to supervise should be eliminated because it unnecessarily restricts PA scope of practice. Additionally, the provision requiring supervising physicians to periodically review a PA's services in order to ensure that the services are in accordance with accepted standards of medical practice should be eliminated because it is an inefficient restriction on PA practice. In order to meet the challenges of the changing healthcare system, physicians must be

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70. See AM. ACAD. OF PHYSICIAN ASSISTANTS, CHART CO-SIGNATURE AND PHYSICIAN SUPERVISION OF PHYSICIAN ASSISTANTS: WHAT IS BEST FOR PATIENT CARE 2 (June 2011), [http://www.aapa.org/uploadedFiles/content/The\\_PA\\_Profession/Federal\\_and\\_State\\_Affairs/Resource\\_Items/SLI\\_ChartCoSig\\_070611\\_FINAL.pdf](http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/SLI_ChartCoSig_070611_FINAL.pdf).

71. See *id.* at 4.

72. See *id.* at 3.

73. *State and Federal Efforts to Enhance Access to Basic Health Care*, THE COMMONWEALTH FUND 3 (Mar./Apr. 2010), <http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Mar/March-April-2010/Feature/Feature.aspx>.



able to utilize mid-level practitioners to their full potential.

PAs play a key role in providing primary care by alleviating some of the basic, yet time-consuming tasks that a physician would otherwise have to address. By eliminating restrictive supervision requirements, PAs will be better able to assist physicians in managing a large patient volume and increase the efficiency in the overall delivery of primary health care.<sup>74</sup>

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74. Linda V. Green, *Primary Care Physician Shortages Could Be Eliminated Through Use of Teams, Nonphysicians, And Electronic Communication*, 32 HEALTH AFF. 11, 16 (2013).

The Nurse Will Be In Shortly:  
Expanding Access To Illinois' Rural Areas  
Through Greater Nurse Practitioner Autonomy

*Daniel J. Burns\**

I. INTRODUCTION

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) with an emphasis on providing health insurance to forty-eight million Americans while lowering the overall cost of health care.<sup>1</sup> In Illinois, over 1.6 million uninsured citizens will now have healthcare coverage, either by qualifying for Medicaid or by purchasing insurance through the federal exchanges.<sup>2</sup> Expanding nurse practitioners' scope of practice by reducing the regulations imposed on them can help meet the increase in demand for healthcare services. Easing restrictions can increase access and lower the cost of healthcare services for Illinois citizens, especially in rural areas. Unfortunately, while patients have expressed interest in receiving more care from nurse practitioners, changes to scope of practice laws have been met with resistance.

This article will analyze scope of practice regulations affecting nurse practitioners in Illinois. Section II begins this analysis with a discussion of current regulations in the state. Section III will advocate for easing

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1. See Alex Nussbaum, *Obamacare Exchanges Start as Questions Abound: Health Q&A*, BLOOMBERG (Oct. 7, 2013), <http://www.bloomberg.com/news/2013-09-30/obamacare-exchanges-start-as-questions-abound-health-q-a.html>.

2. LUVIA QUIÑONES & ABDELNASSER RASHID, AFFORDABLE CARE ACT IMPLEMENTATION IN ILLINOIS: OVERCOMING BARRIERS TO IMMIGRANT HEALTH CARE ACCESS (2013), available at <http://illinoishealthmatters.org/wp-content/uploads/2013/05/ICIRR-Report.-v2.May-2013.pdf>.

restrictions on nurse practitioners in order to meet the demand for primary care in rural areas. Finally, Section IV will examine opposition to expanding the scope of practice of nurse practitioners both nationally and in Illinois.

## II. THE NURSE PRACTITIONER IN ILLINOIS

Nurse practitioners are registered nurses who expand their expertise through advanced education and increased clinical training.<sup>3</sup> Currently, eighty-four percent of nurse practitioners in the United States have a master's degree, while four percent hold a doctoral degree.<sup>4</sup> Nurse practitioners utilize a nursing model in order to provide medical and holistic primary care.<sup>5</sup> Originally created as a result of physician shortages, as of 2011 there were over 180,000 nurse practitioners in the United States.<sup>6</sup> Of this total, over 4,500 are licensed to practice in Illinois.<sup>7</sup>

Nurse practitioners are generally regulated through licensure laws and scope of practice laws of the state in which they are employed.<sup>8</sup> In Illinois, the Medical Practice Act of 1987<sup>9</sup> and the Nurse Practice Act define the scope of practice of nurse practitioners.<sup>10</sup> The Medical Practice Act of 1987 allows for collaboration between physicians and nurse practitioners for

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3. Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1243(2010).

4. KAISER COMM'N ON MEDICAID AND THE UNINSURED, IMPROVING ACCESS TO ADULT PRIMARY CARE IN MEDICAID: EXPLORING THE POTENTIAL ROLE OF NURSING PRACTITIONERS AND PHYSICIAN ASSISTANTS 1 (March 2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf>.

5. Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH LAW. 21, 21 (2008).

6. *Total Nurse Practitioners*, THE KAISER FAMILY FOUND. (2011), <http://kff.org/other/state-indicator/total-nurse-practitioners/>.

7. *Id.*

8. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 4.

9. *See* 225 ILL. COMP. STAT. 60/54.5 (2013).

10. *See* ILL. ADMIN. CODE tit. 68, § 1300.440 (2013).

medical consultation.<sup>11</sup> This interaction must be defined through a written collaboration agreement and requires mandatory consultation between physicians and nurse practitioners at least once per month.<sup>12</sup> However, nurse practitioners authorized to practice in hospitals or ambulatory surgical treatment centers are exempt from written collaboration agreements.<sup>13</sup> The purpose of a written collaboration is to authorize what type of care a patient needs and to define how a nurse practitioner will deliver healthcare services.<sup>14</sup> A physician is not required to delegate prescriptive authority to the nurse practitioner, but he may do so at his discretion.<sup>15</sup> The scope of practice of nurse practitioners in Illinois includes patient assessment as well as ordering diagnostic and therapeutic testing to properly diagnose illnesses.<sup>16</sup> Once an illness is diagnosed, a nurse practitioner may order treatments to improve the health status of the patient.<sup>17</sup> A nurse practitioner may also delegate select nursing duties to other registered nurses.<sup>18</sup> While nurse practitioners have some authority to practice medicine in conjunction with physicians, ultimately nurse practitioners cannot autonomously practice medicine in Illinois.<sup>19</sup>

Ultimately, the Board of Nursing is responsible for any changes to rules, amendments, and policy statements concerning advanced practice nursing.<sup>20</sup>

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11. See 225 ILL. COMP. STAT.. 60/54.5(b) (2013).

12. See *id.* 60/54.5(b)(4).

13. *Id.* 65/65-35(a).

14. See *id.* 65/65-35(b).

15. Patrick M. Callahan, *Power Allocations and Professional Hierarchy in the Illinois Health Care System*, 13 DEPAUL J. HEALTH CARE L. 217, 223 (2010).

16. See ILL. ADMIN. CODE tit. 68, § 1300.440(c)(2) (201).

17. See *id.* § 1300.440(c)(3).

18. See *id.* § 1300.440(c)(7).

19. See ILL. ADMIN. CODE tit. 68, § 1300.440 (2013).

20. Callahan, *supra* note 15. The Board of Nursing consists of 13 members from across Illinois and includes four advanced practice nurses, three nursing educator representatives, two registered nurses, one nurse, on licensed practical nurse, one nursing administrator, and one public member. *Board of Nursing*, ILL. DEPT. OF FIN. & PROF'L. REG., [http://www.idfpr.com/dpr/learn/cb\\_doc/nursing.htm](http://www.idfpr.com/dpr/learn/cb_doc/nursing.htm) (last visited Oct. 22, 2013). The Board's

However, any purported changes are merely proposals and must be sent to the medical board for review and comment.<sup>21</sup> This procedure highlights the subservient role nurse practitioners hold with respect to physicians despite the fact they perform many of the same tasks.<sup>22</sup>

### III. RELAXING REGULATIONS TO INCREASE SCOPE OF PRACTICE

Illinois is one of twenty-seven states that require a physician's written collaboration agreement with nurse practitioners to diagnose, treat and prescribe medication.<sup>23</sup> Of the remaining twenty-three states, eight require a written collaboration agreement to prescribe medication but not to diagnose and treat, and fifteen require no physician involvement.<sup>24</sup> Despite these restrictions, Illinois is far from being the most restrictive state.<sup>25</sup> For example, Alabama and South Dakota require physicians to be present for ten percent of a nurse practitioner's practice time.<sup>26</sup> In Texas, physicians must be physically present at the institution twenty percent of the time the nurse practitioner is practicing.<sup>27</sup> Instead, Illinois law is less restrictive in many ways. For example, although monthly consultation between physicians and nurse practitioners is required, the law allows it to be accomplished through telecommunications.<sup>28</sup>

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tasks include recommending approval or denial of nursing education programs, making recommendations on the adoption and revisions to the rules and regulations needed to carry out the provisions in the Nurse Practice Act. *Id.* The medical board consists of seven physicians appointed by the Governor and tasked with advising the Department of Financial and Professional Regulation and the Secretary on the qualifications of applicants for licensure as physicians. *State Medical Licensing Board*, ILL. DEPT. OF FIN. & PROF'L. REG., [http://www.idfpr.com/dpr/learn/cb\\_doc/medlic.htm](http://www.idfpr.com/dpr/learn/cb_doc/medlic.htm) (last visited Oct. 22, 2013).

21. See Callahan, *supra* note 15.

22. Callahan, *supra* note 15, at 223-24.

23. See KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 5.

24. *Id.*

25. See Ann Ritter & Tine Hansen-Turton, *supra* note 5, at 25.

26. *Id.*

27. *Id.*

28. See 225 ILL. COMP. STAT. 60/54.5(b) (2013).

While Illinois is not the most restrictive state, it should still become more flexible by eliminating the mandatory consultations and written collaborative agreements between physicians and nurse practitioners. By removing these barriers, nurse practitioners will be able to provide healthcare services at a lower cost.<sup>29</sup> Because of the high cost of medical education and the nearly exclusive control over treatments and procedures, healthcare prices have risen significantly.<sup>30</sup> Providing competition for medical services by reducing nurse practitioner's regulations will help to lower costs to the consumer.<sup>31</sup> It is estimated that increased usage of nurse practitioners could save 6.4 to 8.75 billion dollars per year nationally, a portion of which would alleviate costs in Illinois.<sup>32</sup> Aside from lowering costs, expanding the scope of practice of nurse practitioners will increase access to health care.<sup>33</sup> Access to primary care continues to be problematic, as physicians willing to enter into the field of family medicine continue to decrease in the United States.<sup>34</sup> Additionally, heavy state restrictions facilitate the migration of nurse practitioners towards states with more flexible regulations.<sup>35</sup> As a result, rural and isolated areas have experienced a shortage of primary care providers.<sup>36</sup>

Allowing nurse practitioners greater autonomy when treating patients

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29. Julie A. Muroff, *Retail Health Care: "Taking Stock" of State Responsibilities*, 30 J. LEGAL MED. 151, 158 (2009).

30. Callahan, *supra* note 15, at 231-32.

31. *See id.* at 231.

32. *Id.* at 232.

33. John W. Rowe, *Why Nurses Need More Authority*, THE ATLANTIC (May 7, 2012), <http://www.theatlantic.com/health/archive/2012/05/why-nurses-need-more-authority/256798/>.

34. Ritter & Hansen-Turton, *supra* note 5.

35. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 5.

36. Amanda Cassidy, *Health Policy Brief: Nurse Practitioners and Primary Care*, HEALTH AFFS. (May 15, 2013), [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=79](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=79).

may help to alleviate these shortages.<sup>37</sup> Nationally, sixteen percent of citizens live in non-metropolitan areas.<sup>38</sup> In Illinois, eleven percent of the population lives in non-metropolitan areas, and the state<sup>39</sup> has 226 Primary Care Health Professional Shortage Areas (HPSAs).<sup>40</sup> Because of these shortages, over twenty percent of the Illinois population does not have its primary care needs met.<sup>41</sup> In order to alleviate this problem, 433 new physicians would be needed to support these underserved areas.<sup>42</sup> Fortunately, there has been an increase in the number of individuals graduating as nurse practitioners,<sup>43</sup> with over 14,000 nurse practitioners graduating in the United States in 2012.<sup>44</sup> However, until broader scope of practice laws for Illinois nurses are passed, Illinois residents will continue to experience a shortage in healthcare services.

One option to utilize the influx of nurse practitioners is to staff them in retail healthcare centers. Retail health care centers are located within preexisting businesses, such as CVS and Target, and they provide treatment for acute illnesses as well primary care.<sup>45</sup> These clinics are generally

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37. See KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 5.

38. *Population Distribution by Metropolitan Status*, THE KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/metropolitan-distribution/> (last visited Nov. 3, 2013).

39. *Id.*

40. *Primary Care Health Professional Shortage Areas (HPSAs)*, THE KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/> (last visited Nov. 3, 2013). Primary Care Health Professional Shortage Areas ("HSPA") refers to areas and population groups that are experiencing a shortage of health professionals. *Id.* The amount of health professionals relative to the population with consideration of high needs determines a HSPA. *Id.*

41. *See id.*

42. *Id.*

43. See JENNIFER NOONEY ET AL., HEALTH RES. & SERVS. ADMIN., HRSA'S 2012 NATIONAL SAMPLE SURVEY OF NURSE PRACTITIONERS 1, 4 (2013), <http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/nursepractitionersurvey/npsamplesurveyslides.pdf>. From 2009 to 2012 there has been a 48.41 percent gain in the amount of nurse practitioners graduating from programs in the United States. *Id.*

44. *See id.*

45. Michelle Andrews, *Retail Health Clinics Expanding*, KAISER HEALTH NEWS (Jun. 25, 2012), <http://www.kaiserhealthnews.org/features/insuring-your-health/2012/retail-health-clinics-michelle-andrews-062612.aspx> (last visited Nov. 4, 2013).

staffed by nurse practitioners and continue to increase as a result of a focus on providing less costly outpatient care.<sup>46</sup> In Illinois, the clinics are considered physician offices and are not licensed or overseen by the Department of Public Health.<sup>47</sup> However, while the benefit of retail health care centers could be significant for rural areas, very few of these clinics are currently located in HPSAs.<sup>48</sup> Only 12.5% of retail health care clinics are located in HPSAs, and less than eighteen percent are located in rural areas, the place where they are needed the most.<sup>49</sup> In order for rural areas to increase these clinics, restrictions placed on nurse practitioners that staff them should be removed.

In addition, patients are receptive to an increased role of nurse practitioners in their primary care needs, supporting an increase in their scope of practice.<sup>50</sup> Approximately fifty percent of consumers believe that a nurse practitioner can provide health services comparable to a primary care physician.<sup>51</sup> Forty-seven percent of consumers would seek care from a nurse practitioner or physician assistant,<sup>52</sup> but only eight percent of

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46. Bruce Japsen, *The Forbes Healthcare Summit 2013: The Walk-In Clinic Revolution and Obamacare*, FORBES (Oct 4, 2013), <http://www.forbes.com/sites/brucejapsen/2013/10/04/the-forbes-healthcare-summit-2013-the-walk-in-clinic-revolution-and-obamacare/> (last visited Nov. 4, 2013).

47. MARY TAKACH & KATHY WITGERT, CAL. HEALTHCARE FOUND., *RETAIL CLINICS: SIX STATE APPROACHES TO REGULATION AND LICENSING* 1, 8 (2009), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RetailClinicsSixStateApproaches.pdf>. As of 2009, there were approximately fifty-five retail health care clinics in Illinois. *Id.*

48. RENA RUDAVSKY AND ATEEV MEHROTRA, NAT'L. INST. PUB. HEALTH, *THE SOCIODEMOGRAPHIC CHARACTERISTICS OF THE COMMUNITIES SERVED BY RETAIL CLINICS* 1, 4 (2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848989/pdf/nihms180473.pdf>.

49. *See id.*

50. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 4, at 3.

51. PAUL H. KECKLEY & SHERYL COUGHLIN, DELOITTE CENTER FOR HEALTH SOLUTIONS, *DELOITTE 2012 SURVEY OF U.S. HEALTH CARE CONSUMERS: THE PERFORMANCE OF THE HEALTH CARE SYSTEM AND HEALTH CARE REFORM* 1, 6 (2012), available at [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/us\\_chs\\_IssueBrief\\_2012ConsumerSurvey\\_061212.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/us_chs_IssueBrief_2012ConsumerSurvey_061212.pdf).

52. *Id.*



consumers regularly use services outside of a physician.<sup>53</sup> The main focus for most patients is not who is providing the care, but rather that it is from a familiar source.<sup>54</sup> Most importantly, patients who use nurse practitioners have been found to display more satisfaction with their care than those who use physicians.<sup>55</sup> Specifically, patients have indicated that nurse practitioners perform better with follow-ups and consultation times.<sup>56</sup> The increasing acceptance of nurse practitioners coupled with healthcare shortages in rural areas presents a beneficial opportunity to alleviate shortages by increasing the autonomy of nurse practitioners.

#### IV. RESISTANCE TO NURSE PRACTITIONERS' SCOPE OF PRACTICE

Although patients have expressed interest in greater latitude for nurse practitioners, increasing scope of practice is met with resistance. One source of resistance is from doctors themselves and the American Medical Association.<sup>57</sup> Some physicians argue that the nurse practitioners are inferior service providers who lack the-necessary education and training to practice medicine.<sup>58</sup> They support their criticism by comparing a physicians' training of four years of medical school followed by three years of residency with a nurse practitioner's four years of nursing school and two years of graduate work.<sup>59</sup> Because of this discrepancy, physicians argue that direct supervision of nurse practitioners is vital to ensure patient safety.<sup>60</sup> More forcefully, the American Medical Association opposes the authorization of the independent practice of medicine by nurse

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53. *Id.*

54. *See* Cassidy, *supra* note 36.

55. Cassidy, *supra* note 36.

56. *Id.*

57. Ritter & Hansen-Turton, *supra* note 5, at 22.

58. *See* Cassidy, *supra* note 36, at 3.

59. Cassidy, *supra* note 36, at 3.

60. *See* Ritter & Hansen-Turton, *supra* note 5, at 22.

practitioners.<sup>61</sup> The American Medical Association states that increasing a nurse's responsibility is not the solution to physician shortages.<sup>62</sup> However, as states have begun to relax stricter scope of practice laws, the number of individuals receiving care from nurse practitioners has increased by a factor of fifteen.<sup>63</sup> In addition, research shows that nurse practitioners have been able to provide care that is as safe and effective as physicians.<sup>64</sup>

Recently, a bill in Illinois attempted to further restrict nurse practitioners' scope of practice by increasing the supervision requirements.<sup>65</sup> This bill in 2007 sought to limit the amount of nurse practitioners a physician could collaborate with from no maximum to two nurse practitioners.<sup>66</sup> However, the bill did not progress far as it failed to advance beyond the committee stage.<sup>67</sup> In 2008, a bill again sought to limit a nurse practitioner's scope of practice, this time by proposing legislation preventing retail health care clinics inside locations that sell alcohol and tobacco to the public.<sup>68</sup> The Federal Trade Commission expressed concerns that the bill would be anti-competitive, specifically finding that the bill's provisions could impair the

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61. *H-35.988 Independent Practice of Medicine by "Nurse Practitioners"*, AMERICAN MEDICAL ASSOCIATION, available at <https://ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-35.988.HTM>.

62. Rebecca J. Patchin, *AMA Responds to IOM Report on Future of Nursing*, AM. MED. ASS'N. (Oct. 5, 2010), <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>.

63. Christine Vestal, *Nurse Practitioners Slowly Gaining Autonomy*, THE KAISER FAMILY FOUND. (July 19, 2013), <http://www.kaiserhealthnews.org/stories/2013/july/19/stateline-nurse-practitioners-scope-of-practice.aspx>.

64. *See id.*

65. Ritter & Hansen-Turton, *supra* note 5, at 25.

66. Kristin E. Schleiter, *Retail Medical Clinics: Increasing Access to Low Cost Medical Care Amongst a Developing Legal Market*, 19 ANNALS HEALTH L. 527, 552 (2010).

67. *See Bill Status of HB1885*, ILL. GEN. ASSEMBLY, <http://www.ilga.gov/legislation/BillStatus.asp?DocTypeID=HB&DocNum=1885&GAID=9&SessionID=51&LegID=30721> (last visited Nov. 4, 2013).

68. Deborah Austin, *Bill Seeks Limits on Retail Health Clinics*, HEALTHY ROCKFORD (Jun. 30, 2008, 10:27 AM), <http://www.healthyrockford.com/health/news/x1346874368/Bill-seeks-limits-on-retail-health-clinics> (last visited Nov. 4, 2013).

growth of new clinics without offering equivalent benefits for health care consumers in Illinois.<sup>69</sup> This bill also did not advance beyond the committee stage.<sup>70</sup>

Rather than limit nurse practitioners' scope of practice, the Illinois Legislature should work to provide greater autonomy. Noting an impending influx of new health care consumers, Nevada recently passed a law allowing nurse practitioners to practice independently.<sup>71</sup> Nurse practitioners can now operate their own health clinics, with the legislature's hope that consumers in more remote areas will have their healthcare needs met.<sup>72</sup> Facing similar challenges, Illinois would benefit from comparable legislation to eliminate health care shortages in rural areas. Nevada's law provides a useful model for Illinois to follow and proves that even strong challenges to greater nurse autonomy can be overcome.

## V. CONCLUSION

With the influx of demand for healthcare services brought by the PPACA, Illinois needs a new way to provide access to these primary care services in rural areas while keeping the costs low. Increasing a nurse practitioner's scope of practice by allowing them greater autonomy while eliminating administrative barriers between physicians and nurse practitioners, will allow each Illinois citizen to receive the care he or she needs. Moreover, it will allow for more retail health clinics in rural areas, staffed by nurse practitioners, to provide primary care needs. Although

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69. MAUREEN K. OLHAUSEN ET AL., FEDERAL TRADE COMM'N, Letter from the Hon. Elaine Nekritz to Maureen K. Ohlhausen (2008), *available at* <http://www.ftc.gov/os/2008/06/V080013letter.pdf>.

70. *See Bill Status of HB5372*, ILL. GEN. ASSEMBLY, <http://ilga.gov/legislation/BillStatus.asp?DocTypeID=HB&DocNum=5372&GAID=9&SessionID=51&LegID=36672> (last visited Oct. 28, 2013).

71. Vestal, *supra* note 63.

72. *Id.*

there is support for these changes among consumers, resistance from doctors and the American Medical Association may make any substantive changes in the role of nurse practitioners' scope of practice difficult to effectuate. However, facing the same difficulties, Nevada's new law allowing nurse practitioner autonomy provides guidance that Illinois can defeat opposition to changes in nurse practitioners' scope of practice.

## Midwifery in Illinois: The Need for Independence

*Jarel Curvey\**

### I. INTRODUCTION

Midwives are, in most instances, as capable as obstetricians at natal care, yet midwives are negatively affected by physicians' broad scope of practice<sup>1</sup> as it provides them with exclusive control over the practice of medicine.<sup>2</sup> States create health profession acts, which serve to legitimize various professions, define their scope of practice, and create boards to continue regulating as the profession grows.<sup>3</sup> Through the use of scope of practice standards and punishments for their violations, health professionals are able to claim particular practices as their own.<sup>4</sup> In Illinois, a person is practicing medicine if he diagnoses, treats, recommends or prescribes for, or operates upon an individual for the relief or cure of any condition or ailment, whether it is mental or physical.<sup>5</sup> Furthermore, if he holds himself

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1. See Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 89-90 (1996). Scope of practice refers to the legislatively defined areas within which various professionals may engage in their trade. See Barbara J. Safriet 2, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 303 (2002).

2. *Id.* at 306. The Tenth Amendment of the United States Constitution reserves powers not delegated to the federal government by the Constitution, or prohibited by it to the states, to the states. U.S. CONST. amend. X. Among the powers that states receive under the Tenth Amendment is the police power, which provides states with the ability to regulate for the protection of their citizen's health, safety, morals, and welfare. Cohen, *supra* note 1, at 87.

3. See Patrick M. Callahan, *Power Allocations and Professional Hierarchy in the Illinois Health Care System*, 13 DEPAUL J. HEALTH CARE L. 217, 220 (2010).

4. Callahan, *supra* note 3, at 219.

5. 225 ILL. COMP. STAT. ANN. 60/49 (2013). "Holding oneself out to the public" includes attaching the title, abbreviation, or any other word to their name indicating that he

out to the public as having the knowledge, skill, or ability to engage in any of the aforementioned acts, he is practicing medicine.<sup>6</sup> This definition is overly inclusive. Because only physicians are allowed to practice medicine,<sup>7</sup> the over-inclusiveness creates a discrepancy between the knowledge and abilities of non-physicians and their legal authority.<sup>8</sup> This discrepancy leaves midwives in Illinois to either forego the safe practice of midwifery or risk sanctions for illegally practicing medicine.<sup>9</sup> These power allocations also affect patients by limiting their healthcare experiences, opportunities, and access to other groups of practitioners.<sup>10</sup> For the aforementioned reasons, Illinois should allow direct entry midwives (DEMs) and certified nurses midwives (CNMs) to practice independently of physicians.

This article will provide a brief history of midwifery in the United States. Then this article will look specifically at Illinois' current scope of practice laws and its limitations on the practice of midwifery and compare its laws to those of the state of Washington, which has nearly opposite legislation.<sup>11</sup> Next, the article will discuss how the limitations on midwifery increases the cost of birthing care, decreases access to birthing care, and denies mothers

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or she is a medical professional, and maintaining an office to examine or treat those in need of a medical professional. *See Id.*

6. 225 ILL. COMP. STAT. ANN. 60/49 (2013). "Holding oneself out to the public" includes attaching the title, abbreviation, or any other word to their name indicating that he or she is a medical professional, and maintaining an office to examine or treat those in need of a medical professional. *See Id.*

7. Safriet, *supra* note 1, at 306.

8. *See Id.* at 315.

9. *Id.* at 305.

10. Callahan, *supra* note 3, at 220.

11. Washington's Businesses and Professions provision specifically addresses the practice of midwifery and gives midwives a large scope of practice, whereas Illinois' Medical Practice Act does not allow DEMs to practice at all, and provides CNMs with only a limited scope of practice. *See* WASH. REV. CODE tit. 18 (2013); *Cf.* 225 ILL. COMP. STAT. ANN. 60 (2013). Furthermore, Washington was the first state to grant DEMs true autonomy. Suzanne Suarez, *Midwifery is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315, 357 (1993).

the full range of birthing options. This article will suggest that DEMs and CNMs are as capable as obstetricians at natal care and will conclude that Illinois should allow DEMs and CNMs to practice independently of physicians. Lastly, this article will suggest that the best way for Illinois to extend midwives' scope of practice in good conscious is to follow in Washington's footsteps and enact independent education statutes for midwives. By enacting independent educational standards similar to those in Washington, Illinois will be able to experience the benefits of midwifery while maintaining its interest in regulating for the health, safety, and welfare of its citizens.

## II. HISTORY OF MIDWIFERY IN THE UNITED STATES

Midwives were the primary birth attendants in the United States until the early twentieth century.<sup>12</sup> During this time, childbirth was considered a social event.<sup>13</sup> Throughout the pregnancy, midwives provided prenatal care, health screenings, and information on birthing and newborn care, while building trust with the expecting mother in order to maintain a safe, anxiety-free environment.<sup>14</sup> Friends and family gathered during the delivery, and the midwife provided the mother with practical and emotional delivery support.<sup>15</sup> Today, the early twentieth century midwives would be considered DEMs, midwives that typically practice in the home setting.<sup>16</sup> As the twentieth century progressed, childbirth changed from a communal

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12. Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813, 815 (1994).

13. Rachel P. Berland, *Introducing Patient Scope of Care: Psychologists, Psychiatrists, and the Privilege to Prescribe Drugs*, 6 ST. LOUIS U.J. HEALTH L. & POL'Y 425, 435 (2013).

14. *Id.* at 819.

15. *Id.*

16. Hafner-Eaton, *supra* note 12, at 816. DEMs can gain experience through clinical training, apprenticeships, or formal training. *Id.* at 815.

event into a medical event.<sup>17</sup> Obstetricians' newfound social, cultural, and legal authority, along with technological advancements, made them become more distant from their patients.<sup>18</sup> The practice of medicine was extended to include the birth process, and pregnancy came to be interpreted as intrinsically dangerous, requiring physician intervention.<sup>19</sup>

In 1925, the profession of nurse-midwifery was created as a compromise between obstetricians and DEMs.<sup>20</sup> As a result of this compromise, CNMs are permitted to practice in all fifty states.<sup>21</sup> After earning a nursing degree, CNMs obtain further education in gynecology and obstetrics to receive the necessary certification to attend deliveries without physician supervision.<sup>22</sup> Although CNMs are permitted to practice in all fifty states, they typically only practice in hospitals under the direct supervision and control of physicians.<sup>23</sup> This restriction is due to various statutory limitations placed on CNMs.<sup>24</sup>

DEMs, on the other hand, primarily practice in the home setting.<sup>25</sup> Traditionally, most DEMs gained experience in birthing through self-education or apprenticeships and clinical training.<sup>26</sup> However, in 1994, professional associations of DEMs created the National American Registry of Midwives (NARM), an education and certification agency, with the goal

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17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.* at 820.

21. Benjamin G. Chojnacki, *Pushing Back: Protecting Maternal Autonomy from the Living Room to the Delivery Room*, 23 J.L. & HEALTH 45, 49 (2010).

22. Berland, *supra* note 13, at 435.

23. Stacey A. Tovino, J.D., *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 69 (2004).

24. *Id.* Hospitals are also cautious to grant midwives privileges for fear that physicians will go on strike, which has happened in the past when osteopaths were granted hospital privileges. Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 Hous. L. REV. 1273, 1279 (1996).

25. Hafner-Eaton, *supra* note 12, at 815.

26. *Id.*



of re-introducing DEMs as an birthing attendant option by standardizing licensure and scope of practice requirements.<sup>27</sup> In order to receive certification through the NARM, a midwife must attend an accredited formal midwifery program, or attend forty births and complete seventy-five prenatal exams, twenty newborn exams and forty postpartum exams, all with the direct oversight of a clinical instructor, show proficiency in all required skills, and pass the certification exam.<sup>28</sup> By putting these standards in place, the NARM has legitimized the practice of midwifery in some states.<sup>29</sup>

### III. ADVANTAGES OF MIDWIFERY

One of the major justifications for giving physicians the broad authority over the practice of medicine is to protect patients and ensure that they receive the highest quality of care.<sup>30</sup> However, evidence suggests that midwives are just as, if not more than, qualified as physicians are to attend to low to moderate-risk childbirth.<sup>31</sup> Both in the home and hospital setting, midwife-attended births have lower morbidity and mortality rates than births attended by physicians.<sup>32</sup> Independent midwives perform approximately seventy-five percent of all births in all European countries, and all of those countries have lower infant mortality rates than the United States.<sup>33</sup> Washington's Department of Social and Health Services found that women under the care of midwives were less likely to give birth to an underweight baby than women who did not receive prenatal care from

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27. Berland, *supra* note 13, at 439.

28. Sarah Anne Stover, *Born by the Woman, Caught by the Midwife: The Case for Legalizing Direct-Entry Midwifery in All Fifty States*, 21 HEALTH MATRIX 307, 325-26 (2011).

29. See Berland, *supra* note 13, at 439-440; see Stover, *supra* note 28, at 318, 326.

30. Callahan, *supra* note 3, at 219.

31. Hafner-Eaton, *supra* note 12, at 813.

32. *Id.* at 818.

33. Hafner-Eaton, *supra* note 12, at 815.

midwives.<sup>34</sup>

Midwives perform well with high-risk patients as well.<sup>35</sup> When complications arise in pregnancy and childbirth that require the aid of a physician, midwives promptly transfer the patient.<sup>36</sup> According to a study that followed 5,418 women in the care of midwives, the midwives transferred around twelve percent of their patients to hospitals due to failure to progress during delivery and pain relief.<sup>37</sup> This study indicates that midwives, like physicians, recognize when a complication arises during pregnancy, and are willing to give up control when necessary. Midwifery is a safe practice, and Illinois would not risk the safety of its citizens by supporting it.

By allowing physicians the exclusive power to independently attend to births, Illinois is driving up the cost of birthing care.<sup>38</sup> Midwives are able to charge less than physicians for their services because they have lower training costs and receive lower salaries.<sup>39</sup> The salary of an obstetrician is about ten times that of a CNM.<sup>40</sup> Physicians also tend to order more costly tests, use higher cost treatments, and prescribe more drugs than midwives.<sup>41</sup> This discrepancy exists because obstetricians primarily focus on treating

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34. *Benefits of Midwifery go Beyond Money Saved*, THE OLYMPIAN (Feb. 2, 2010), <http://www.theolympian.com/2010/02/02/1123262/missing-headline-for-02oedits.html>.

35. Andrews, *supra* note 39, at 1284. One study found that when midwives attended high-risk patients the outcomes were as good as those of lower risk patients seen by physicians. *Id.*

36. Andrews, *supra* note 24, at 1286.

37. Stover, *supra* note 28, at 328.

38. See Callahan, *supra* note 3, at 219.

39. Andrews, *supra* note 24, at 1279.

40. *Id.*

41. *Id.* at 1285. The negative effects of a physician's intervention during labor typically causes the need for another intervention. Hafner-Eaton, *supra* note 12, at 817. For example, epidurals are usually given to control pain, but they often slow labor, causing a "failure-to-progress" and a need for a cesarean section delivery. *Id.* In Washington, physicians order nearly twice as many cesareans as midwives. Olympian, *supra* note 34. Cesareans can cause hemorrhages, infections, and maternal morbidity. Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX 325, 343 (2003).

problems that arise during pregnancy, causing them to treat all pregnancies as high-risk.<sup>42</sup> In contrast, midwives typically view childbirth as a normal process unless a problem arises.<sup>43</sup> Under midwives' view, the mother that delivers the baby is the primary decision-maker, not the midwife.<sup>44</sup>

Despite fewer tests and drugs, when midwives and physicians care for similar patients, midwives' patients fared just as well as those of the physicians.<sup>45</sup> Without insurance, the average cost of physician-attended birth in the United States is between \$8,000 and \$13,000, while the average cost of a midwife-attended home birth is between \$2,000 and \$3,000.<sup>46</sup> Based on those figures, if the United States followed in the footsteps of Europe, where midwives attend over seventy-five percent of births, it could save over \$8.5 billion a year.<sup>47</sup> In Washington, the Department of Health found that the cost of a midwife-attended birth was \$1,000, while the average cost of a physician-attended birth was \$3,800.<sup>48</sup> The Department went on to state that Washington would save \$2.7 million over just two years by utilizing more midwife-attended births.<sup>49</sup> By allowing midwives to practice independently, Illinois could reduce the cost of birthing care.<sup>50</sup>

In addition, if Illinois granted midwives the authority to practice independently, access to prenatal, natal, and postnatal care would increase,

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42. Stover, *supra* note 28, at 319. High-risk patients are often low income, uninsured, or underinsured. Andrews, *supra* note 24, at 1284. These women often present a "greater risk for obstetric complications because of the relative nutritional and psychosocial deprivation of poverty." *Id.*

43. Stover, *supra* note 28, at 320.

44. *Id.*

45. Andrews, *supra* note 24, at 1285.

46. *FAQ - Answers to Frequent Questions about Homebirth and Midwives*, NEW MOON MIDWIFERY, <http://newmoonmidwifery.com/faq/> (last visited Dec. 3, 2013).

47. Hafner-Eaton, *supra* note 12, at 831.

48. Olympian, *supra* note 34.

49. *Id.*

50. See Callahan, *supra* note 3, at 219. Reducing the cost of birthing care would allow low-income women who previously did not obtain care because they could not afford care to be able to pay for it. *Id.*

especially in rural and low-income areas.<sup>51</sup> Over 1.5 million of the 12.8 million Illinoisans live in rural areas, and the average per capita income is nearly \$10,000 lower than that of urban areas.<sup>52</sup> Across the United States, CNMs provide care in rural and low-income areas at higher rates than obstetrician-gynecologists.<sup>53</sup> CNMs are the only primary healthcare providers available in some rural areas in the country.<sup>54</sup> While only ten percent of obstetrician-gynecologists provided care in high-poverty areas, nineteen percent of CNMs provided care in high poverty areas.<sup>55</sup> Midwives serve rural and low-income areas at a higher percentage than physicians, providing affordable care to women who otherwise might not receive any. In 2011, CNMs and DEMs attended 309,514 births, about eight percent of the total births in the United States.<sup>56</sup> About 700 women have home births in Illinois every year.<sup>57</sup> Allowing midwives to practice independently in Illinois could increase the amount of home births and provide those living in rural areas with cheaper, alternative birthing care. In 2009, the Center for Disease Control (CDC) found that home births not attended by a physician or a midwife had an infant mortality rate of 16.56 per 1000 births, while home births attended by CNMs and DEMs had an infant mortality rate of

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51. *See Id.*

52. RURAL ASSISTANCE CTR., <http://www.raconline.org/states/illinois/> (last visited Nov. 16, 2013).

53. Mary Beck, *Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. REV. 951, 956 (1995).

54. *Id.*

55. *Id.* In addition, eighty-nine percent of CNMs reported serving low-income women, about eighty percent reported serving uninsured women; twenty-one percent of CNMs indicated that around ninety percent of their patients lived in high-risk areas, and thirteen percent indicated that all of their patients lived in high-risk areas. *Id.*

56. *Fact Sheet: Essential Facts about Midwives*, AM. COLL. OF NURSE-MIDWIVES, <http://www.midwife.org/Essential-Facts-about-Midwives> (last updated July 2013).

57. Rachel Wells, *Home Birth Bill Takes a Baby Step for Midwives*, ILLINOIS TIMES (Mar. 10, 2011), <http://illinoistimes.com/article-8430-home-birth-bill-takes-a-baby-step-for-midwives.html>.

2.81 per 1000 births.<sup>58</sup> If Illinois wants to protect women by providing the safest home birth possible, it should allow DEMs and CNMs to practice independently.

By not allowing midwives to practice independent of physicians, Illinois is denying expecting mothers a full range of care.<sup>59</sup> The birth location may be as important as the birth attendant to expectant mothers.<sup>60</sup> While only one percent of women in the U.S. reported giving birth at home, a study found that over twenty percent of mothers would have preferred this option.<sup>61</sup> This figure may be attributed to the fact that the home can provide emotional security.<sup>62</sup> The result of this study suggests that if midwifery were made more available, more women would choose it as their birthing option. The familiar setting of the home makes the patient feel safer than a hospital filled with equipment she may be unfamiliar with.<sup>63</sup> Childbirth can be one of the most intimate and important experiences for a family, and midwives provide their patients more control over the birthing process than physicians.<sup>64</sup> According to a government ordered study of midwifery in the United States, none of the patients in CNM-attended births preferred a physician, but some of the patients in an obstetrician-attended birth would

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58. CDC Wonder, *Linked Birth / Infant Death Records, 2007-2009 Results*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <http://wonder.cdc.gov/lbd-current.html> (last visited Dec. 3, 2013) (click agree, in section 4, select 'not in hospital' as birthplace, and 'other' as medical attendant, and then click submit. Reset form and select 'CNM' and 'other midwife' as medical attendant).

59. Stover, *supra* note 28, at 311.

60. "For many, choosing to deliver away from the hospital is a choice that reflects spiritual, religious, political, and feminist beliefs." Chojnacki, *supra* note 21, at 51.

61. Stover, *supra* note 28, at 308.

62. Hafner-Eaton, *supra* note 12, at 823.

63. *Id.* Added stress and anxiety during pregnancy can cause preterm births, lower birth weights, miscarriage, temperamental problems and lower attention spans in the infant, and delayed mental and emotional development. Katrina C. Johnson, Ph.D., *The Effects of Maternal Stress and Anxiety During Pregnancy*, EMORY U., [http://www.psychiatry.emory.edu/PROGRAMS/GADrug/feature\\_articles.html](http://www.psychiatry.emory.edu/PROGRAMS/GADrug/feature_articles.html) (last visited Nov. 13, 2013).

64. Andrews, *supra* note 24, at 1280.

have preferred a midwife.<sup>65</sup> This study suggests that the women who choose midwifery are more satisfied with their birthing experience than women who choose to have a physician as their birth attendant.

#### IV. A COMPARISON BETWEEN ILLINOIS AND WASHINGTON

Currently, forty-one states permit DEMs to practice through licensure, registration and certification, judicial or statutory interpretation, or lack of affirmative regulations expressly prohibiting DEMs to practice.<sup>66</sup> Illinois is one of the nine states, as well as the District of Columbia, that prohibit direct-entry midwifery.<sup>67</sup> While Illinois does not have a statute expressly prohibiting DEMs from practicing midwifery, the practice is still illegal in the state because it falls outside the definition of practicing medicine.<sup>68</sup> The director of the Illinois Department of Professional Regulation brings charges against those who engage in midwifery without a license, and Illinois courts have upheld these charges and subsequent convictions.<sup>69</sup>

Alternatively, the state of Washington's Businesses and Professions provision specifically addresses midwifery, setting out definitions and educational requirements.<sup>70</sup> Washington's secretary has the authority to grant licenses and a midwifery advisory committee advises and makes recommendations to the secretary regarding education, required

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65. *Id.*

66. Stover, *supra* note 28, at 310.

67. Hermer, *supra* note 41, at 356. The Illinois Medical Practice Act of 1987 defines a "physician" as a person licensed under the act to practice medicine in all of its branches. 225 ILL. COMP. STAT. 60/2 (2013). Section two of the act states, "No person shall practice medicine, or any of its branches, or treat human ailments without the use of drugs and without operative surgery, without a valid, existing license to do so. . ." 225 ILL. COMP. STAT. 60/3 (2013). Physicians may collaborate with CNMs, but in order to do so the physician must provide the actual delivery service. 225 ILL. COMP. STAT. 60/54.5 (2013). First time violations of the act are considered Class A Misdemeanors, while subsequent violations are considered Class 3 Felonies. 225 ILL. COMP. STAT. 60/59 (2013).

68. *See* 225 ILL. COMP. STAT. ANN. 60/49 (2013).

69. *See, e.g.,* People ex rel. Sherman v. Cryns, 786 N.E.2d 139, 161 (Ill. 2003).

70. *See* WASH. REV. CODE tit. 18 (2013).

examinations, and peer review.<sup>71</sup> In order to practice midwifery in Washington, an individual must obtain a certificate or diploma from an accredited midwifery program, receive three years of training, including the study of basic nursing skills, meet all educational requirements, observe fifty women in the intrapartum period,<sup>72</sup> and attend to the care of at least fifty women in each of the prenatal, intrapartum, and early postpartum periods.<sup>73</sup> The midwives are then tested to ensure they have the scientific and practical knowledge and ability to practice midwifery.<sup>74</sup> All the requirements and regulations Washington has in place appear to have the common goal of protecting women who choose midwifery as a birthing option. Enacting education standards similar to those of Washington is one way in which Illinois and its citizens can experience the benefits of midwifery. Washington mothers who use midwives experience decreased cost of care, increased access to care, alternative birthing options, and increased safety.<sup>75</sup> Washington is able to maintain its interest in guarding the health and safety of its residents who utilize midwifery because of its strict educational requirements on the profession.

## V. CONCLUSION

Illinois needs to expand midwives' scope of practice because the established benefits outweigh any kind of hypothetical disadvantage.

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71. WASH. REV. CODE § 18.50.020 (2013); WASH. REV. CODE § 18.50.150 (2013).

72. The intrapartum period is the when the woman is in labor.

73. WASH. REV. CODE § 18.50.040 (2013). The minimum educational requirements include the study of "obstetrics; neonatal pediatrics; basic sciences; female reproductive anatomy and physiology; behavioral sciences; childbirth education; community care; obstetrical pharmacology; epidemiology; gynecology; family planning; genetics; embryology; neonatology; the medical and legal aspects of midwifery; nutrition during pregnancy and lactation; breast feeding; nursing skills, including but not limited to injections, administering intravenous fluids, catheterization, and aseptic technique; and such other requirements prescribed by rule." *Id.*

74. WASH. REV. CODE § 18.50.060 (2013).

75. Olympian, *supra* note 34.

Enacting independent education standards similar to those of Washington is one method in which Illinois can protect the health and safety of its citizens while providing them with the benefits of midwifery. Currently, Illinois law prevents DEMs from practicing within the state,<sup>76</sup> and CNMs from practicing without the supervision of a physician.<sup>77</sup> Midwives have proven that they are capable of performing deliveries as safely, if not safer than, physicians, yet they are not given the authority indicative of their ability.<sup>78</sup> Illinois has the power to create the educational standards needed by midwives to practice within the state.<sup>79</sup> If Illinois does not accept the NARM standards, or those of other midwifery associations and programs, it should enact its own educational standards as Washington has done.<sup>80</sup> Washington's educational standards require those practicing midwifery to complete training and coursework in a variety of different fields.<sup>81</sup> To further protect its citizens, Washington also statutorily imposes a duty on midwives to consult a physician when there are deviations from normal childbirth.<sup>82</sup> Illinois should follow in Washington's footsteps because using statutorily-imposed education standards to regulate midwifery, rather than limiting or excluding the practice, can provide Illinois with the benefits of midwifery – decreased costs, increased access, and safe alternative birthing options – while maintaining its interest in protecting its citizens.

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76. See Hermer, *supra* note 41, at 356.

77. 225 ILL. COMP. STAT. 60/54.5 (2013).

78. See Safriet, *supra* note 1, at 307-08; Hafner-Eaton, *supra* note 12, at 813.

79. See Cohen, *supra* note 1, at 87.

80. WASH. REV. CODE § 18.50.040 (2013).

81. *Id.*

82. WASH. REV. CODE § 18.50.010 (2013).



Expanding the Scope of Midwifery Practice in  
Illinois: Feminist and Financial Arguments

*Molly Ryder\**

I. INTRODUCTION

In 2011, over ninety-eight percent of all childbirths in the United States occurred in a hospital setting.<sup>1</sup> However, in the last few years, statistics show a noticeable increase in the number of home births.<sup>2</sup> Many researchers claim that the developing home birth movement is motivated by some women's desire to retreat from the over-medicalization of physician-attended hospital birth.<sup>3</sup> Feminist theory claims that the trend is motivated by women's desire for greater autonomy in birthing decisions, which they feel is unavailable or inaccessible within the hospital-based, medical model of childbirth.<sup>4</sup>

Within this context, midwife-attended home birth has emerged as a viable alternative to hospital-based maternity care.<sup>5</sup> The broad field of midwifery can be separated into two primary groups of providers: certified nurse midwives (CNMs) and certified professional midwives (CPMs).<sup>6</sup>

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1. Joyce A. Martin et al., Ctrs. for Disease Control and Prevention, *Births: Final Data for 2011*, 62 NAT'L VITAL STAT. REP. NO. 1, 12 (2013), available at [http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62\\_01.pdf#table01](http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_01.pdf#table01).

2. *Id.* at 13.

3. See Catherine Elton, *American Women: Birthing Babies at Home*, TIME (Sep. 4, 2010), <http://content.time.com/time/magazine/article/0,9171,2011940,00.html> (noting that 32% of hospital childbirths end in cesarean section).

4. Rebecca A. Spence, *Abandoning Women to their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 CARDOZO J.L. & GENDER 75, 91 (2012).

5. Elton, *supra* note 3.

6. Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences*

CNMs are licensed nurse practitioners, falling under the umbrella category of Advanced Practice Nurses (APNs).<sup>7</sup> CNMs practice in all fifty states and are generally limited to working in hospital settings under the direct supervision of a physician, pursuant to state licensing acts.<sup>8</sup> On the other hand, CPMs, sometimes called lay midwives or direct entry midwives, generally do not hold nursing degrees.<sup>9</sup> Instead, CPMs learn their trade through more traditional apprenticeship methods, often combined with structured training at a midwifery school.<sup>10</sup> In most states that recognize the CPM credential, they are licensed according to guidelines and standards set by the North American Registry of Midwives (NARM).<sup>11</sup> Because CPMs do not receive formal nursing educations, they generally do not practice in hospital settings.<sup>12</sup>

This article presents two arguments for expanding the scope of practice of direct entry midwives in Illinois through recognition of the CPM credential. First, this article will examine social science research that suggests that the availability of home-birthing options and access to the midwifery care are important tools for providing reproductive rights to all

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for *Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 68-69 (2004).

7. *Id.* at 69.

8. *Id.*

9. Tovino *supra* note 6 at 68-69.

10. *Id.* One example of a formal midwifery program is the well-known program at Bastyr University (formerly known as the Seattle Midwifery School). See *Seattle Midwifery School is Now Part of Bastyr*, BASTYR UNIVERSITY, <http://www.bastyr.edu/seattle-midwifery-school-now-part-bastyr> (last visited Sep. 30, 2013). The program offers the nation's first accredited Masters of Science in Midwifery program for direct-entry midwifery practice. Students need not possess a nursing degree to enter the program. *Id.* Upon completion of all program requirements, students are eligible to be licensed and certified as a CPM. *Id.*

11. STATE LICENSURE OF CERTIFIED PROF. MIDWIVES, NORTH AMERICAN REGISTRY OF MIDWIVES POSITION STATEMENT 2 (April 2012) [hereinafter NARM POSITION STATEMENT], available at <http://narm.org/wp-content/uploads/2012/05/State-Licensure-of-CPMs2012.pdf>.

12. See Julie Deardorff, *Illinois Midwifery Debate Ongoing*, CHI. TRIBUNE (August 24, 2011), <http://www.chicagotribune.com/health/ct-nw-illinois-home-births-20110824,0,6427240.story>.

women.<sup>13</sup> Second, this article will address the financial incentives for Illinois CPM licensure, as increased access to midwife-attended home births would greatly reduce Medicaid childbirth expenditures.<sup>14</sup>

## II. MIDWIFERY THROUGHOUT AMERICAN HISTORY

The overwhelming dominance of hospitals as the primary location of childbirth in this country is a long-observed trend.<sup>15</sup> Yet the widespread assumption that a woman will always deliver in a hospital is relatively new, and it only gained footing in the medical community and public perception within the last century.<sup>16</sup> This trajectory is evidenced by the fact that, as recently as 100 years ago, nearly all births in the United States occurred at home.<sup>17</sup> Historically, midwives oversaw most American home births.<sup>18</sup> During the Colonial period, childbirth was seen as a social or communal event, rather than a medical one.<sup>19</sup> Family, neighbors, and friends were often present during a birth, and community-based midwives directed the birthing experience with little or no physician involvement.<sup>20</sup> These midwives received no formal training and gradually developed their competencies by assisting an already-established midwife.<sup>21</sup> At this time, midwives were highly-regarded local figures, and enjoyed a certain level of

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13. Spence, *supra* note 4 at 92.

14. Coalition for Ill. Midwifery, *Reducing Medicaid Maternity Care Expenditures through Utilization of Certified Professional Midwives in Illinois* (April 9, 2012), [hereinafter *Medicaid Proposal*], <http://www.illinoismidwifery.org/blog/wp-content/uploads/2012/04/Reducing-Medicaid-Maternity-Care-Expenditures-Through-Utilization-of-Certified-Professional-Midwives.pdf>.

15. See Deborah Boucher et al., *Staying Home to Give Birth: Why Women in the United States Choose Home Birth*, 54 J. MIDWIFERY WOMENS HEALTH 119, 119 (2009).

16. Marian F. MacDorman et al., Ctrs. for Disease Control & Prevention, *Home Births in the United States, 1990-2009*, 84 NCHS DATA BRIEF 1, 1 (2012) [hereinafter NCHS DATA BRIEF], <http://www.cdc.gov/nchs/data/databriefs/db84.pdf>.

17. Boucher, *supra* note 15 at 119.

18. *Id.*

19. Tovino, *supra* note 6 at 63.

20. *Id.*

21. *Id.*

cooperation and comity from physicians.<sup>22</sup>

Throughout the 1800's, the growing prestige of the medical profession resulted in a new specialty field: obstetrics.<sup>23</sup> Some viewed these physician specialists as elite and cutting-edge because they utilized new technologies such as forceps and were trained in female anatomy and physiology.<sup>24</sup> An increasing number of women sought to integrate physician care into their children's births throughout the 1800's, often combining the medical expertise of physicians with the familiarity and communal quality of midwifery-supervised homebirth.<sup>25</sup> Even with the rising profile of obstetricians, almost all births continued to occur at home at the turn of the 20th century, with approximately one-half of these births being primarily overseen by a midwife.<sup>26</sup>

However, the medical model of childbirth continued to gain momentum, and by 1940 over fifty percent of births were physician-attended hospital births.<sup>27</sup> This trend first arose with white, middle-class and upper-class women, who chose to deliver in hospitals to take advantage of rapidly-developing medical technologies and to reduce concerns about germs and infection that had become associated with home births.<sup>28</sup> These trends

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22. *Id.* at 64.

23. *Id.*

24. *Id.* at 64-65 (noting that early obstetricians "attempted to elevate the prestige of their new specialty by emphasizing the importance of anatomy and physiology, although complications erupted in their practices. These complications were due, in part, to interventions, including bloodletting, drugs, and forceps. . . However, many women still believed that medical progress would eventually lead to reductions in birth dangers and pain.").

25. *Id.* at 66.

26. *Id.* at 67.

27. *Id.*

28. Tovino, *supra* note 6 at 67-68 (quoting JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILD-REARING IN AMERICA 1750-1950, 12, 2006, "Popular medical journals in the 1920's and 1930's also encouraged women to deliver their babies in hospitals to ensure the safety of both mother and child. At that same time. . . hospital-based obstetricians aggressively managed childbirth by using pain-relieving drugs, labor inducers, and other technological interventions.").

quickly trickled down to women of all races and socio-economic statuses, and by 1950 almost ninety percent of American babies were born in hospitals.<sup>29</sup>

While Illinois mirrored these national trends, it was also home to two historically-significant home birth practices.<sup>30</sup> Between 1895 and the 1970s, the non-profit Chicago Maternity Center provided at-home obstetric services to Chicago's low-income population, serving hundreds and sometimes thousands of families per year.<sup>31</sup> The Center maintained a partnership with the Northwestern Memorial Hospital School of Medicine, which sent its medical residents and fourth year medical students into the homes of Chicago's underserved and minority populations to learn obstetrics.<sup>32</sup> Another Chicago program provided culturally sensitive midwifery services, administered both by CNMs and direct entry midwives, to low-income, immigrant families in the Pilsen neighborhood.<sup>33</sup> This program served approximately 150 families per year throughout the 1990s.<sup>34</sup>

Today, the vast majority of American babies are delivered in hospitals by physicians.<sup>35</sup> However, the 1.3% of American babies who are delivered outside of a hospital setting, either at home or in a free-standing birthing facility, account for nearly 50,000 births.<sup>36</sup> The most current research from

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29. *Id.* at 67.

30. *Medicaid Proposal*, *supra* note 14.

31. *Id.* at 1-2.

32. *Id.* at 1.

33. *Id.* at 2.

34. *Id.*

35. Martin et al., *supra* note 1 at 12.

36. *Id.* at 13. See also *What is a Birth Center?*, AM. ASS'N OF BIRTH CTRS, <http://www.birthcenters.org/open-a-birth-center/birth-center-experience/what-is-a-birth-center> (last visited Sep. 30, 2013) (defining a birthing facility as "a home-like facility existing within a healthcare system with a program of care designed in the wellness model of pregnancy and birth. Birth centers are guided by principles of prevention, sensitivity, safety, appropriate medical intervention, and cost effectiveness.").

the Centers for Disease Control (CDC) found that in 2011, the number of home births was the highest since reporting for this statistic began in 1989.<sup>37</sup> However, these trends are less apparent in the Illinois midwifery community, as the legal restrictions on CPM practice result in limited access to this growing trend of home delivery.<sup>38</sup>

### III. ISSUES IN CPM LICENSURE

The presence and role of CPMs in the maternity care field is a hotly debated issue, both within the medical community and in the public discourse on childbirth.<sup>39</sup> State legislatures continually address the question of CPM licensure and scope of practice in drastically varying manners.<sup>40</sup> As of 2012, twenty-six states legally authorize CPMs to practice.<sup>41</sup> In these states, the practice of direct entry midwifery is regulated either by use of the NARM-granted CPM credential as the basis for licensure, or by the issuance of another type of permit, certification, or registration.<sup>42</sup> In states that do not specifically recognize the CPM credential, the NARM written exam that is required for CPM licensure may still be employed as a prerequisite to certification.<sup>43</sup> Currently, eleven states that permit CPMs to practice also approve Medicaid reimbursement for the cost of midwife-

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37. Martin et al., *supra* note 1 at 13.

38. See Deardorff, *supra* note 12.

39. *Id.* (quoting Dr. Wayne Polek, President of the Illinois State Medical Society, ““Professional midwives have minimal training. . . That’s our major problem with the [Home Birth Safety Act]. It’s not about the home birth itself; it’s a question of who is delivering the care. . . If it’s a certified nurse midwife who has a physician supervising, then (home birth) is fine with us.”, and Katherine Prown, a spokeswoman for advocacy group thebigpushformidwives.org, ““[Certified Professional Midwives] have more training in the provision of home-birth services, which require a unique skill set, than most physicians will ever have.””).

40. See, N. AM. REG. OF MIDWIVES, DIRECT ENTRY MIDWIFERY STATE-BY-STATE LEGAL STATUS (Aug. 2013), available at <http://narm.org/pdf/files/statechart080213.pdf> [hereinafter *State-by-State*].

41. NARM POSITION STATEMENT, *supra* note 11 at 2.

42. *State-by-State*, *supra* note 40.

43. *Id.*

attended home births.<sup>44</sup>

Presently, twenty-two states do not afford any type of legal recognition, such as CPM licensure or registration, to direct entry midwives.<sup>45</sup> In thirteen of these states, the practice of direct entry midwifery falls into an unregulated gray zone.<sup>46</sup> In these states, direct entry midwives are legally permitted to practice pursuant to judicial or statutory interpretation.<sup>47</sup> In the remaining nine states, the practice of direct entry midwifery is strictly illegal, pursuant to legislation prohibiting anyone who does not hold a CNM credential from providing midwifery services.<sup>48</sup> The state of Illinois currently falls into this last category.<sup>49</sup> In Illinois, the Medical Practice Act of 1987 (the Act) provides that only licensed CNMs under the supervision of a physician may assist with labor and delivery care.<sup>50</sup> Recently, opinions of the Illinois Appellate and Supreme Courts further clarified the Act, cementing the notion that practicing midwifery without a CNM license is prohibited in Illinois.<sup>51</sup> It is estimated that only nine Illinois CNMs currently attend home births, as the state's requirement of physician supervision constrains midwifery services to hospital settings.<sup>52</sup> Direct

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44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. See Medical Practice Act of 1987, 225 Ill. Comp. Stat. 60/54.5(b)(3) (1987). See also Nurse Practices Act, 225 Ill. Comp. Stat. 65/50-15 (2007) ("No person shall practice or offer to practice advanced, professional, or practical nursing in Illinois or use any title, sign, card or device to indicate that such a person is practicing professional or practical nursing unless such person has been licensed under the provisions of this Act.").

51. See *Morris v. Dep't of Prof'l Regulation*, 824 N.E.2d 1151, 1158 (Ill. App. Ct. 2005) (holding that a direct entry midwife who had assisted her patient during labor and delivery had rendered midwifery services in violation of the Illinois Nurse Practices Act). See also *People ex. rel. Sherman v. Cryns*, 786 N.E.2d 139, 143-144 (Ill. 2003) (holding that a lay midwife who participated in a home birth had engaged in professional nursing and advanced practice nursing without a license).

52. Deardorff, *supra* note 12.

entry midwives in Illinois, including those who have obtained the CPM credential, are thus relegated to ‘underground’ practices, and face prosecution for overseeing a home birth.<sup>53</sup> As a result, many Illinois women seeking to deliver at home must navigate an unregulated ‘black market’ of direct entry midwives.<sup>54</sup> Expanding Illinois women’s access to licensed and regulated CPMs would therefore serve to reduce the risks currently arising from the unregulated state of homebirth Illinois.<sup>55</sup>

#### IV. MIDWIFERY AND REPRODUCTIVE JUSTICE

Feminist discourse suggests that recognizing women’s birthing rights is a critical element of the fight for reproductive justice.<sup>56</sup> Birthing rights include protection of a woman’s autonomy in birthing decision-making, access to supportive and culturally sensitive maternity care, and the freedom to give birth with dignity in the location of her choice.<sup>57</sup> Feminist jurisprudence grounds these rights in the fundamental right to bodily integrity protected by the Fourteenth Amendment.<sup>58</sup> Women may choose to seek alternatives to physician-directed hospital birth for a variety of reasons.<sup>59</sup> Common reasons for choosing home birth include the belief that non-hospital delivery is safer, the desire to avoid unnecessary medical

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53. *Id.*

54. *Id.*

55. *Id.*

56. Spence, *supra* note 4 at 92; see also Loretta J. Ross, *Understanding Reproductive Justice: Transforming the Pro-Choice Movement*, SISTER SONG 10 (2006), [http://www.sistersong.net/reproductive\\_justice.html](http://www.sistersong.net/reproductive_justice.html) (noting that “the reproductive justice framework – the right to have children, not have children, and to parent the children we have in safe and healthy environments—is based on the human right to make personal decisions about one’s life, and the obligation of government and society to ensure that the conditions are suitable for implementing one’s decisions.”).

57. Spence, *supra* note 4 at 75.

58. *Id.* at 78. *E.g.*, *Washington v. Glucksberg* 117 U.S. 2258, 2267 (1997) (“In a long line of cases, we have held that, in addition to the specific liberties protected by the Bill of Rights, the “liberty” specially protected by the Due Process Clause [of the 14<sup>th</sup> Amendment] includes the rights to . . . bodily integrity.”).

59. Boucher, *supra* note 15 at 119.



interventions, previous negative experiences with hospital birth, the desire for more control over the labor and birthing process, and preference for the comfort and familiarity of the home environment.<sup>60</sup>

While home birth is often criticized as an unsafe or even dangerous choice, proponents of home birth point to research finding that, for low-risk pregnancies, home birth safety rates are equivalent to hospital deliveries.<sup>61</sup> The American College of Obstetricians and Gynecologists (ACOG) takes the firm stance that hospitals are the safest settings for childbirth.<sup>62</sup> Yet ACOG admits that quality evidence to support this debate is limited as adequate clinical studies comparing home birth and hospital birth outcomes have not yet been conducted.<sup>63</sup> Moreover, ACOG recently issued guidelines that aim to promote natural childbirth by reducing the number of induced labors, and the CDC has named the reduction of cesarean sections in low-risk pregnancies as one of its Healthy People 2020 initiatives.<sup>64</sup> Reducing these types of unnecessary medical interventions during childbirth is a key tenet of CPM practice, and many women who opt for home birth describe their desire to avoid a medicalized hospital birth.<sup>65</sup> Feminist scholars also explain this sentiment as a desire to contest the assumption that obstetricians are indisputable experts and to refute the

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60. Boucher, *supra* note 15 at 119.

61. *Id.* See also JT Fullerton et al., *Outcomes of planned home birth: An integrative review*, 52 J. MIDWIFERY WOMENS HEALTH 323-333 (2007) (concluding that maternal and neonatal outcomes of planned home birth were comparable with planned hospital births or birth center births for low-risk pregnancies).

62. The Am. C. Obstetricians & Gynecologists, *Planned Home Birth*, 476 Comm. Op. (reaffirmed 2013), available at <http://www.acog.org/~media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co476.pdf?dmc=1&ts=20131213T1840289298> (stating, “Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth.”).

63. *Id.* at 1.

64. Martin et al., *supra* note 1 at 13.

65. See Boucher, *supra* note 15 at 119.

culturally embedded narrative of medical childbirth.<sup>66</sup> Ultimately, many women who choose home birth see hospitals as a setting where tensions between physicians' practices and their personal belief system are likely to arise.<sup>67</sup>

The Midwives Model of Care (Midwives Model) represents a solution for many women who are wary of hospital birth.<sup>68</sup> It is based on the assumption that pregnancy and childbirth are normal life events, which do not typically require biomedical interventions.<sup>69</sup> The Midwives Model emphasizes personalized care, cultural and religious sensitivity, greater education and participation for the mother, and a focus on the woman's physical, psychological, and emotional experience throughout the birthing process.<sup>70</sup> These methods are rooted in the goal of increasing personal agency and providing women with an empowering birthing experience.<sup>71</sup>

Women in Illinois currently face substantial obstacles in accessing the Midwives Model.<sup>72</sup> It is estimated that less than ten of the 102 counties in Illinois have legally-sanctioned home birthing practices, run by CNMs or physicians.<sup>73</sup> All but two of these practices are located within the Chicago metropolitan area.<sup>74</sup> The statutory requirement that a physician must

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66. Melissa J. Cheyney, *Home birth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace*, 18 QUALITATIVE HEALTH RES. 254, 256-257 (2008).

67. Spence, *supra* note 4 at 90.

68. MIDWIVES ALLIANCE N. AM. <http://www.mana.org/about-midwives/midwifery-model> (last visited Oct. 6, 2013).

69. *Id.*

70. *Id.*

71. Cheyney, *supra* note 66 at 260.

72. *Midwifery Model*, ILL. COUNCIL OF CERTIFIED PROF. MIDWIFES, <http://illinoismidwives.org/about-illinois-midwives/> (last visited Oct. 6, 2013).

73. *Id.* ("Outside of the Chicago metropolitan area, women's home birth options are extremely limited. It is not uncommon for women to search for months to locate an appropriate provider. Some women leave the state to give birth. Others try to find an out-of-state midwife who is willing to cross the border to attend her labor. Still others simply stop searching and opt to give birth unassisted.")

74. *Id.*

supervise a CNM ties these licensed midwives to hospital settings.<sup>75</sup> Recently, the Illinois government took certain small steps to increase access to midwifery care.<sup>76</sup> In February 2013, the Illinois Health Facilities and Services Review Board unanimously voted to approve plans for the first free-standing birthing center in the state.<sup>77</sup> This facility, which will be staffed by CNMs with a support team of physicians, will seek to create a home-like birth environment and de-emphasize unnecessary medical interventions.<sup>78</sup>

Although this facility is an important step towards greater access to midwifery services, it is one of few examples of pro-CNM legislation in Illinois.<sup>79</sup> For this reason, organizations such as the Coalition for Illinois Midwifery and the Illinois Council for Certified Professional Midwives state that their ultimate goal is to pass legislation that would license and regulate direct entry midwives using the CPM credential.<sup>80</sup> Legalizing CPM practices, they argue, would not only provide greater access to home birth services and the Midwives Model of Care, but would also serve to promote home birth safety by allowing regulatory boards such as NARM to certify and monitor service providers.<sup>81</sup> In this way, the implementation of a state-wide CPM licensing system would help to remove key obstacles to Illinois women's reproductive justice by increasing access to safe, midwife-

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75. Deardorff, *supra* note 12.

76. Julie Deardorff, *First Free-Standing Birthing Center in Illinois Gets Go-Ahead*, CHI. TRIBUNE (Feb. 5, 2013), [http://articles.chicagotribune.com/2013-02-05/news/ct-met-birth-center-update-20130206\\_1\\_facility-fees-birth-centers-pcc](http://articles.chicagotribune.com/2013-02-05/news/ct-met-birth-center-update-20130206_1_facility-fees-birth-centers-pcc).

77. *Id.*

78. Julie Deardorff, *1st Free-Standing Birthing Center in Illinois May Open*, CHI. TRIBUNE (Feb. 1, 2013), [http://articles.chicagotribune.com/2013-02-01/news/ct-met-birth-center-0201-20130201\\_1\\_free-standing-birth-illinois-hospital-association-home-births](http://articles.chicagotribune.com/2013-02-01/news/ct-met-birth-center-0201-20130201_1_free-standing-birth-illinois-hospital-association-home-births).

79. *Id.*

80. ILL. COUNCIL OF CERTIFIED PROF. MIDWIFES, *supra* note 72.

81. *Id.*

attended home births.<sup>82</sup>

#### V. CPM LICENSURE AND MEDICAID COSTS

Various midwifery advocacy groups lobby for legislation that would legalize the practice of direct entry midwifery in Illinois.<sup>83</sup> The most recent example of these efforts is House Bill 3636, which seeks to create the Certified Professional Midwife Licensure Act.<sup>84</sup> This act would allow for the licensure of midwives using the CPM credential and would establish guidelines for monitoring providers' qualifications and administering disciplinary action.<sup>85</sup> The bill notes that the practice of midwifery in non-hospital settings is a matter of public health and safety that should be subject to regulation in the public interest.<sup>86</sup> To this end, the act would create the Illinois Midwifery Board, which would license and monitor providers through use of the CPM credential.<sup>87</sup> This bill was filed in the Illinois House of Representatives on May 30, 2013 and is awaiting further action.<sup>88</sup> Another legislative effort, House Bill 1194, seeks to establish clearer regulatory guidelines for direct entry midwifery by creating the Home Birth Safety Act.<sup>89</sup> This bill is also awaiting further action.<sup>90</sup>

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82. *Id.*

83. *See* H.B. 3636, 98th Gen. Assemb. (Ill. 2013).

84. *Id.*

85. *Id.*

86. *Id.* at §5 ("The purpose of the Act is to protect and benefit the public by setting standards for the qualifications, education, training, and experience of those who seek to obtain licensure and hold the title of licensed midwife, to promote high standards of professional performance for those licensed to practice midwifery in this State, and to protect the public from unprofessional conduct by persons licensed to practice midwifery as defined in this Act. This Act shall be liberally construed to best carry out these purposes").

87. *Id.*

88. *Bill Status of H.B. 3636*, ILL. GEN. ASSEMB., available at <http://www.ilga.gov/legislation/BillStatus.asp?DocNum=3636&GAID=12&DocTypeID=HB&LegID=76536&SessionID=85&GA=98&SpecSess=0>. (last visited Dec. 13, 2013).

89. H.B. 1194, 98th Gen. Assemb. (Ill. 2013).

90. *Bill Status of H.B. 1194*, ILL. GEN. ASSEMB., available at <http://www.ilga.gov/legislation/billstatus.asp?DocNum=1194&GAID=12&GA=98&DocTypeID=HB&LegID=71652&SessionID=85>. (last visited Dec. 13, 2013).

Though efforts to pass legislation that would permit and regulate CPM practice are ongoing, many previous incarnations of similar legislation died in the House or Senate.<sup>91</sup> Recent lobbying efforts may prove to be more successful because they argue for CPM licensure from a Medicaid cost-containment perspective.<sup>92</sup> In 2012, the Coalition for Illinois Midwifery submitted a pilot project proposal to the Governor's Medicaid Advisory Committee that presents CPM licensure as a tool for significant cost-cutting to Medicaid childbirth expenditures.<sup>93</sup> In 2009, for example, Illinois Medicaid covered the costs of 81,104 births.<sup>94</sup> Moreover, recent statistics show that Medicaid now pays for fifty-four percent of Illinois childbirths.<sup>95</sup> Based on these findings, the study declares CPM recognition to be an important part of the solution to the state's Medicaid deficit.<sup>96</sup> The proposal suggests that integrating CPMs into the state's healthcare system as Medicaid providers would save Illinois billions of dollars, even at low utilization rates.<sup>97</sup> The study asserts that if two percent of Illinois childbirths annually covered by Medicaid were CPM-attended home births, the state would save approximately \$5 million per year.<sup>98</sup>

This study was endorsed by twenty-three Illinois legislators, who signed a letter to Governor Pat Quinn advocating for the integration of CPMs into

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91. *E.g.*, Deardorff *supra* note 12 ("The Illinois Senate last year passed the Home Birth Safety Act, which would have set standards for CPMs. Several groups opposed the bill, including the Illinois State Medical Society, which said it would allow the "least trained individual to independently provide one of the most critical services to women in Illinois." The measure died in the House.").

92. *See Medicaid Proposal, supra* note 14.

93. *Id.*

94. *Number of Births Financed by Medicaid*, KAISER FAMILY FOUND., <http://kff.org/medicaid/state-indicator/total-medicaid-births/> (last visited Oct. 7, 2013). *See also* NGA CTR. FOR BEST PRACS., MATERNAL AND CHILD HEALTH UPDATE: STATES MAKE PROGRESS TOWARDS IMPROVING SYSTEMS OF CARE, ISSUE BRIEF- 2010 at 13 (2011), *available at* <http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF>.

95. *Medicaid Proposal, supra* note 14 at 1.

96. *Id.*

97. *Id.*

98. *Id.*

the state's Medicaid reform plans.<sup>99</sup> The letter argues for CPM licensure stating that instead of reducing provider rates even further, taxpayer dollars could be better saved by giving mothers using Medicaid the option of a home birth with a certified midwife.<sup>100</sup> While midwife-attended home birth is clearly cost-effective, expanding and legitimizing Illinois CPM practices could also promote the creation of more free-standing birthing centers in Illinois.<sup>101</sup> State Medicaid programs are required to cover maternity care services provided in birthing centers.<sup>102</sup> Allowing CPMs to staff these facilities as Medicaid-reimbursable providers would effectively cut costs, as it is estimated that an uncomplicated birth in a free-standing birthing facility costs \$2,227, compared to \$8,920 at a hospital.<sup>103</sup> Overall, the increased presence of CPMs in the Illinois maternity care field would greatly cut Medicaid expenditures by reducing the substantial facilities costs that are attached to hospital births.<sup>104</sup>

## VI. CONCLUSION

Laws that forbid the licensure of direct entry midwives currently restrict the scope of midwifery practice in Illinois.<sup>105</sup> As a result, Illinois women seeking to give birth in a non-hospital setting face tremendous obstacles in accessing midwifery services.<sup>106</sup> Illinois' recognition of the CPM credential would positively impact women by providing greater access to the Midwifery Model of Care, which seeks to empower women throughout

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99. Letter from Ill. legislators to Ill. Governor Pat Quinn (May 9, 2012), *available at* <http://www.illinoismidwifery.org/blog/wp-content/uploads/2012/07/Legislator-Letter-to-Governor-Quinn.pdf>.

100. *Id.* at 2.

101. Deardorff, *supra* note 76.

102. *Id.*

103. *Id.*

104. *Medicaid Proposal*, *supra* note 14 at 1.

105. *State-by-State*, *supra* note 40.

106. ILL. COUNCIL OF CERTIFIED PROF. MIDWIFES, *supra* note 72.

their birthing process.<sup>107</sup> From a financial perspective, incorporating CPMs as Medicaid providers would drastically cut state childbirth expenditures by providing cost-effective midwifery services to low-income Illinois women.<sup>108</sup> Legal recognition of CPMs as crucial maternity care providers is an important step towards affording Illinois women reproductive justice, while simultaneously reducing the financial costs of childbirth for the Illinois Medicaid system.

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107. MIDWIVES ALLIANCE, *supra* note 68.

108. *Medicaid Proposal*, *supra* note 14 at 1.

Closing the Primary Care Gap: Is Pharmacist  
Prescriptive Authority the Answer?

*Leighanne Root\**

I. INTRODUCTION

America's primary care workforce is waning.<sup>1</sup> In the past decade, the United States saw a fifty percent decrease in the number of medical students entering primary care, and the country faces a potential shortage of 150,000 physicians in the coming decade.<sup>2</sup> However, as access to physicians decreases, pharmacists remain one of the most accessible medical professionals in the current healthcare system.<sup>3</sup> In 2010, the United States Department of Labor (DOL) reported that there were nearly 275,000 pharmacists.<sup>4</sup> The DOL projected that the profession will grow by twenty-five percent in the coming decade, increasing at a rate nearly double that of most occupations.<sup>5</sup>

Pharmacists can play an important role in closing the primary care gap by participating in teams of qualified professionals, such as collaborative

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1. See Erin Albert, *The Case for Pharmacists as Legal Health Care Providers*, 9 IND. HEALTH L. REV. 187, 188 (2012).

2. *Id.*

3. *Id.* at 189.

4. See Bureau of Labor Statistics, *Occupational Outlook Handbook, 2012-13 Edition, Pharmacists*, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK (Mar. 29, 2012), <http://www.bls.gov/ooh/Healthcare/Pharmacists.htm> (indicating that in 2010, there were 274,900 employed pharmacists).

5. *Id.*



drug therapy management (CDTM) programs.<sup>6</sup> CDTM is a collaborative practice agreement between one or more physicians and pharmacists where pharmacists working within the context of a defined protocol are allowed to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs; and selecting, initiating, monitoring, and adjusting drug regimens.<sup>7</sup> Nearly all states authorize some form of CDTM, but only a few states grant the broad privilege of prescriptive authority to advanced-practice pharmacists, who undergo training above and beyond that of traditional pharmacists.<sup>8</sup>

State legislatures should adopt regulations similar to those enacted in New Mexico and North Carolina, granting prescriptive authority to pharmacists in order to close the primary care gap. To make this feasible, Congress must allow these advanced-practice pharmacists to bill Medicare Part B by granting them provider status. This article will argue for the importance of prescriptive authority for advanced-practice pharmacists nation-wide, detailing the need for such authority in terms of cost-effectiveness and access to care, while addressing barriers to successful

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6. See Thomas Bodenheimer & Hoangmai H. Pham, *Primary Care: Current Problems And Proposed Solutions*, 29 HEALTH AFFS. 798, 804 (2010), available at <http://web.pdx.edu/~nwallace/AHP/StateofPC.pdf> (indicating that creating primary care teams is a possible solution to closing the primary care gap).

7. ANDREW MADDEN, JOSEPH RAMIREZ, JAMIE ROHRS & LEO VANDERPOOL, N.M. PHARMACISTS ASS'N ROTATION, PHARMACIST PRESCRIBING PRACTICES: INTERNATIONAL REGULATIONS AND IMPLICATIONS (2012), available at [http://www.nm-pharmacy.com/COP\\_/Extern\\_Articles/RPh\\_Prescribing.pdf](http://www.nm-pharmacy.com/COP_/Extern_Articles/RPh_Prescribing.pdf).

8. See *id.* (indicating that in 2012, forty-seven states had CDTM programs); See also Matthew Murawski, Kristin R. Villa, Ernest J. Dole, Timothy J. Ives, Dale Tinker, Vincent J. Colucci & Jeffery Perdew, *Advanced-Practice Pharmacists: Practice Characteristics and Reimbursement of Pharmacists Certified for Collaborative Clinical Practice in New Mexico and North Carolina*, 68 AM. J. HEALTH-SYST. PHARM. 2341, 2342 (2011), available at <http://www.ajhp.org/content/68/24/2341.full.pdf> (indicating that in 2011, thirty-eight states had CDTM programs, and that pharmacists with advanced-practice designations have more prescriptive privileges than pharmacists without an advanced-practice designation).

implementation of prescriptive authority.

## II. THE NEED FOR PHARMACIST PRESCRIPTIVE AUTHORITY

### *A. The Primary Care Gap*

Fifty-six percent of all physician visits are for primary care purposes.<sup>9</sup> Yet, only thirty-seven percent of physicians practice primary care, and the future of the profession looks bleak.<sup>10</sup> In a 2007 survey of fourth-year medical students, only seven percent of respondents indicated that they planned to pursue a career in adult primary care.<sup>11</sup> The number of primary care practitioners is expected to grow by a mere two to seven percent by 2025.<sup>12</sup> The aging baby boomers population will double the number of American seniors by 2030, and the rapid growth of the general population adds an additional level of concern for the growing primary care gap.<sup>13</sup>

The gap is glaringly obvious in rural areas, where the ratio of primary care physicians to patient population is less than half that of urban centers, with only forty-six physicians per 100,000 patients.<sup>14</sup> Twenty-one percent of Americans reside in rural areas, overwhelming the resources of the mere ten percent of primary care practitioners working outside of city limits.<sup>15</sup> In both urban and rural areas of the country, the difficulty of access to care is

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9. Bodenheimer & Pham, *supra* note 5, at 801.

10. *Id.*

11. *Id.*

12. *See id.* (indicating that the workload of primary care practitioners is expected to increase twenty-nine percent from 2005 to 2025, while the number of practitioners is estimated to grow by a mere two to seven percent in the same time frame).

13. Albert, *supra* note 1, at 188.

14. Bodenheimer & Pham, *supra* note 5, at 802 (noting that the ratio of primary care physicians to patient population in urban areas is 100 per 100,000).

15. *Id.*

increasing faster than the number of primary care physicians.<sup>16</sup> Physician extenders like nurse practitioners (NPs) and physician assistants (PAs) offer some hope of a solution to the problem.<sup>17</sup> However, the number of NPs and PAs graduating each year, in conjunction with the number entering primary care, indicate that these physician extenders alone are insufficient to close the primary care gap.<sup>18</sup> Even considering the number of primary care physicians, NPs, and PAs together, the gap in the ratio of practitioners to patient population is expected to grow in the coming years.<sup>19</sup>

Another factor expected to exacerbate the primary care problem will stem from the implementation of the Medicaid expansion provision in the Patient Protection and Affordable Care Act (PPACA) in January 2014.<sup>20</sup> In 2012, forty-seven million nonelderly Americans were uninsured.<sup>21</sup> The implementation of the Medicaid expansion, in concert with the increased affordability and accessibility of private insurance, is sure to increase the number of adults seeking primary care services.<sup>22</sup> States can begin to remedy the primary care gap by creating CDTM teams that include pharmacists with prescriptive authority, thus increasing the number of

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16. *See id.* at 801 (indicating that population growth and aging are estimated to increase primary care workload by twenty-nine percent, leading to estimated shortages of 35,000-44,000 primary care practitioners).

17. *See id.* at 804 (indicating that the creation of primary care teams is a possible solution to the primary care gap).

18. *Id.* at 801.

19. *See id.* (indicating that the ratio of primary care practitioners to patient population is expected to fall nine percent from 2005 to 2020).

20. *See* Ann Sanner, *Newly Insured to Deepen Primary Care Doctor Gap*, SANTA MARIA TIMES, (Sept. 30, 2013, 5:55 PM), [http://santamariatimes.com/news/local/features/affordable-care-act/newly-insured-to-deepen-primary-care-doctor-gap/article\\_34f9acfa-2a34-11e3-88ff-001a4bcf887a.html](http://santamariatimes.com/news/local/features/affordable-care-act/newly-insured-to-deepen-primary-care-doctor-gap/article_34f9acfa-2a34-11e3-88ff-001a4bcf887a.html).

21. *Key Facts About the Uninsured Population*, KAISER FAMILY FOUND. (Sep. 26, 2013), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

22. *See* Sanner, *supra* note 20 (predicting that the shortage of primary care physicians will worsen when an estimated 30 million uninsured Americans gain coverage under the PPACA in 2014).

accessible primary care practitioners.<sup>23</sup>

*B. Patient Non-Adherence to Medication*

Patients who fail to properly adhere to their prescriptions present significant problems for our healthcare system.<sup>24</sup> The New England Healthcare Institute (NEHI) recently released research indicating that one-third to one-half of patients do not take their medications properly.<sup>25</sup> The reasons for non-adherence include an array of medical and social issues, including intolerance, apathy, inability to pay, and poor memory.<sup>26</sup> The NEHI also reported that patients who fail to take their medications as prescribed cost the healthcare system approximately \$290 billion annually.<sup>27</sup> Creating CDTM programs that include advanced-practice pharmacists is a possible solution to this costly problem, as it would increase the number of practitioners monitoring adherence.<sup>28</sup>

Among those most susceptible to non-adherence are patients with chronic diseases, such as diabetes and heart disease.<sup>29</sup> When patients with chronic diseases fail to adhere to their prescribed medications, the

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23. See Bodenheimer & Pham, *supra* note 5, at 804 (indicating that creating primary care teams is a possible solution to closing the primary care gap).

24. See Press Release, New Eng. Healthcare Inst., NEHI Research Shows Patient Medication Nonadherence Costs Health Care System \$290 Billion Annually (Aug. 11, 2009) [hereinafter NEHI Press Release], available at [http://www.nehi.net/news/press\\_releases/110/nehi\\_research\\_shows\\_patient\\_medication\\_nonadherence\\_costs\\_health\\_care\\_system\\_290\\_billion](http://www.nehi.net/news/press_releases/110/nehi_research_shows_patient_medication_nonadherence_costs_health_care_system_290_billion) (noting that patient non-adherence to medication costs the health care system \$290 billion in avoidable spending annually).

25. *Id.*

26. Jannet M. Carmichael & Janice A. Cichowlas, *The Changing Role of Pharmacy Practice—A Clinical Perspective*, 10 ANNALS HEALTH L. 179, 184 (2001).

27. NEHI Press Release, *supra* note 24.

28. See *id.* (suggesting that creating health care teams incorporating nurses, care managers, pharmacists, and other clinicians is a possible solution to patient medication non-adherence).

29. See *id.* (indicating that patients with chronic diseases are particularly susceptible to spotty adherence practices).

inevitable implications are unnecessary hospitalizations, medical complications, and increased mortality rates.<sup>30</sup> Treating patients with chronic diseases is not cost-effective for physicians, but CDTM programs that include pharmacists can provide an answer to this spending crisis.<sup>31</sup> In a 2008 survey of advanced-practice pharmacists in New Mexico and North Carolina, respondents indicated that they primarily managed such chronic patients.<sup>32</sup> Advanced-practice pharmacists, with training in pharmacotherapy and diagnosis, can manage chronic disease states, resulting in longer intervals between patient visits to primary care physicians.<sup>33</sup> Allowing these credentialed pharmacists to manage patients with chronic diseases enables physicians to spend their time on more complex patients who require their expertise and monitoring.<sup>34</sup>

*C. Eliminating Unnecessary Primary Care Visits for Minor Ailments*

Just as advanced-practice pharmacists can reduce the need for chronic patients to visit a physician, they can also eliminate the need for patients to book primary care appointments for simple ailments like colds and minor infections.<sup>35</sup> Particularly in states like New Mexico, where the population is largely rural, pharmacists with prescriptive authority can eliminate

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30. *Id.*

31. C. Richard Talley, *Prescribing Authority for Pharmacists*, 68 AM. J. HEALTH-SYST. PHARM. 2313, 2333 (2011), available at <http://www.ajhp.org/site/TalleyEditorial.pdf>.

32. See Murawski, *supra* note 7, at 2344-45 (indicating that respondents primarily managed diabetes, coagulation or lipid disorders, hypertension, asthma or chronic obstructive pulmonary disease, pain, and heart failure).

33. Raymond W. Hammond & Ernest J. Dole, *The Pharmacist Clinician: Prescriptive Authority in New Mexico*, 2 J. OF MANAGED CARE PHARM. 594 (1996), available at [http://www.amcp.org/data/jmcp/Campus\\_v2\\_594-596.pdf](http://www.amcp.org/data/jmcp/Campus_v2_594-596.pdf).

34. Talley, *supra* note 28, at 2333.

35. See Hammond & Dole, *supra* note 30, at 594 (indicating that pharmacist clinicians in communities with no primary care physician may eliminate the need for patients to travel to see physicians for minor ailments).

unnecessary patient travel for minor illnesses.<sup>36</sup> Allowing qualified pharmacists to prescribe low-risk medications like antibiotics increases access to care and decreases the ever-present demand on the resources of primary care practitioners.<sup>37</sup>

### III. CURRENT ADVANCED-PRACTICE PHARMACY MODELS

#### *A. The New Mexico Pharmacist Prescriptive Authority Act*

Enacted to resolve the failing quality of care provided to the rural population of New Mexico, the Pharmacist Prescriptive Authority Act (PPAA) of 1993 provides that pharmacists who obtain extensive training in diagnosis and physical assessment may become licensed as pharmacist clinicians.<sup>38</sup> Under the PPAA, pharmacist clinicians undergo pharmacotherapy and physical assessment training equivalent to that of physician assistants, enabling them to register for a Drug Enforcement Administration (DEA) number and apply for prescriptive authority under a physician's supervision.<sup>39</sup> Pharmacists can qualify as clinicians by way of four methods: (1) national certification as a physician assistant, (2) satisfactory completion of sixty hours of physical assessment training, followed by a nine-month clinical residency, (3) satisfactory completion of the sixty-hour physical assessment curriculum, a 150-hour, 300-patient contact supervised preceptorship, and a passing examination score, or (4)

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36. *Id.*

37. *See id.* (indicating that pharmacist clinicians may alleviate excessive physician workload and address the concern of providing quality health care to under-served populations).

38. *See id.* (indicating that the PPAA was originally designed to address the concern of providing quality care to the under-served rural population); *See also* Murawski, *supra* note 7, at 2342 (indicating that pharmacist clinicians must complete training in diagnosis and physical assessment equivalent to that of physician assistants).

39. Murawski, *supra* note 7, at 2342.

certification through the Indian Health Service's Pharmacist Practitioner Program, verification of contact with six hundred patients within two years, and a supporting affidavit from a supervising physician.<sup>40</sup> New Mexico's CDTM program is a model of what other state legislatures should adopt, as it allows qualified, experienced pharmacists prescriptive authority under supervision of a physician.

*B. The North Carolina Clinical Pharmacist Practitioner Act*

North Carolina's Clinical Pharmacist Practitioner Act (CPPA) provides another example of collaborative advanced-practice pharmacy that state legislatures should emulate. Similar to New Mexico, North Carolina extended prescriptive authority to certified pharmacists in 2000 with the CPPA.<sup>41</sup> To earn the Clinical Pharmacist Practitioner (CPP) title, a licensed North Carolina pharmacist must sign a collaboration agreement with a supervising physician, and must obtain one of the following: (1) Board Certified Pharmacotherapy Specialist or Certified Geriatric Pharmacist certification, or American Society of Health-System Pharmacists residency, including two years clinical experience, (2) Doctor of Pharmacy degree with three years experience, plus completion of one North Carolina Center for Pharmaceutical Care or Accreditation Council for Pharmacy Education Certificate Program, or (3) Bachelor of Science degree with five years experience, plus completion of two certificate programs.<sup>42</sup> As in New Mexico, CPPs are granted prescriptive authority and may register for a

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40. Hammond & Dole, *supra* note 30, at 594, 596.

41. Betty H. Dennis, *An Overview of the Clinical Pharmacist Practitioner in N.C.*, N.C. ASS'N OF PHARMACISTS, <http://www.ncpharmacists.org/displaycommon.cfm?an=13> (last visited Oct. 4, 2013).

42. *Id.*

DEA number.<sup>43</sup> By allowing qualified pharmacists to prescribe and collaborate with physicians, the CPPA provides an example of a successful CDTM program that other states should adopt.

#### IV. THE REIMBURSEMENT PROBLEM

A major barrier to the success of advanced-practice pharmacy models lies in reimbursement.<sup>44</sup> Under current models, advanced-practice pharmacists are not recognized as midlevel providers for reimbursement purposes, including by federal programs such as Medicare.<sup>45</sup> The root of the problem stems from the language of the Social Security Act.<sup>46</sup> Professionals that are typically considered physician extenders, such as NPs and PAs, are eligible for billing to Part B as midlevel providers.<sup>47</sup> However, advanced-practice pharmacists are not on that exclusive list.<sup>48</sup> In 2004, Congress introduced a bill that proposed the Medicare Clinical Pharmacist Practitioner Services Coverage Act (MCPSPCA) to address the inability of advanced-practice pharmacists to bill to Part B.<sup>49</sup> Unfortunately, the bill later died in the House Ways and Means Subcommittee on Health.<sup>50</sup> Congress reintroduced the bill in 2008 and 2010, but the MCPSPCA suffered the same fate each time.<sup>51</sup> If enacted, the MCPSPCA would recognize advanced practice-pharmacists as midlevel

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43. Murawski, *supra* note 7, at 2342.

44. *Id.* at 2349-50.

45. *Id.* at 2342.

46. Talley, *supra* note 28, at 2333.

47. *See id.* (indicating that nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, qualified psychologists, clinical social workers, and certified registered nurse anesthetists are eligible for Medicare Part B payment).

48. *Id.*

49. H.R. 4727, 108th Cong. (2003).

50. Murawski, *supra* note 7, at 2342.

51. *Id.*; *See also* H.R. 5780, 110th Cong. (2007); *See also* H.R. 5389, 111th Cong. (2009).



providers, allowing them to bill Part B at 85% of the physician reimbursement rate.<sup>52</sup> This failure to recognize credentialed pharmacists as midlevel providers impedes the successful implementation of collaborative treatment programs throughout the nation.<sup>53</sup>

In a 2008 survey of advanced-practice pharmacists in New Mexico and North Carolina, 82.8% of respondents indicated that their services saved their patients money, and an overwhelming 92.2% reported that their services were decreasing costs for the United States healthcare system.<sup>54</sup> The responding pharmacists estimated that their services would cost approximately sixty-nine percent more if physicians provided them.<sup>55</sup> Notwithstanding the cost-effectiveness of their services, only sixty-four percent of the respondents were able to bill for their services through their employers.<sup>56</sup> Those respondents indicated that they were primarily using Evaluation & Management codes or billing incident-to fees to generate revenue for their employers, billing an average of \$6,500 per month.<sup>57</sup> These billable fees amount to less than the average monthly salary of an advanced-practice pharmacist.<sup>58</sup> The undeniable implication is that advanced-practice pharmacists are operating at a loss.<sup>59</sup>

The survey indicated that the respondents primarily managed chronic disease states associated with limited billing opportunities, such as diabetes,

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52. Murawski, *supra* note 7, at 2342.

53. *See id.* at 2349-50.

54. *Id.* at 2346.

55. *Id.*

56. *Id.* at 2344.

57. *Id.* at 2345 (indicating that thirty-seven respondents billed through use of Evaluation & Management codes 99211, 99212, 99213, and 99213, and thirteen respondents billed for "incident-to" fees).

58. *Id.* at 2348.

59. *Id.*

coagulation or lipid disorders, hypertension, asthma, and heart failure.<sup>60</sup> With such limited opportunity to bill for their non-dispensing services, each potential chance for reimbursement is vital to the success and continuation of advanced-practice pharmacy. Despite the growing primary care gap and the effectiveness and accessibility of advanced-practice pharmacists there is still resistance to granting them provider status.

#### V. RESISTANCE TO PHARMACIST PRESCRIPTIVE AUTHORITY

In a 2011 position paper, the American Academy of Family Physicians (AAFP) took a stance against extending prescriptive authority to pharmacists.<sup>61</sup> The statement indicated that the AAFP believes that only licensed doctors should have the authority to prescribe drugs.<sup>62</sup> In a 2012 press release, AAFP Board Chair Roland Goertz expounded upon the organization's fear, explaining that allowing pharmacist prescriptive authority without physician consultation could compromise the physician's ability to coordinate the care of patients with multiple medical issues.<sup>63</sup> Certainly, practitioners must carefully monitor patients who are prescribed multiple medications to manage compound medical issues.<sup>64</sup> But pharmacists, as the direct link between the prescription and the patient, are

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60. *Id.* at 2345.

61. See *Pharmacists (Position Paper)*, AM. ACAD. OF FAM. PHYSICIANS, [hereinafter *AAFP Position Paper*], <http://www.aafp.org/about/policies/all/pharmacists.html> (last visited Sep. 29, 2013).

62. *AAFP Position Paper*, *supra* note 57.

63. Press Release, Am. Acad. of Fam. Physicians, FDA Proposal to Allow Pharmacists to Prescribe Some Drugs Sparks Swift Rebuke From AAFP (May 2, 2012) [hereinafter *AAFP Press Release*], available at <http://www.aafp.org/news-now/government-medicine/20120502pharmprescribing.html>.

64. See Mary E. Tinetti, Sidney T. Bogardus, Jr. & Joseph V. Agostini, *Potential Pitfalls of Disease-Specific Guidelines for Patients with Multiple Conditions*, 351 NEW ENG. J. MED. 2870, 2873 (2004), available at [http://www.drmed.org/javne\\_datoteke/novice/datoteke/444-NEJM-guidelines.pdf](http://www.drmed.org/javne_datoteke/novice/datoteke/444-NEJM-guidelines.pdf).

trained experts in drugs, and their expertise extends to the implications of interactions between multiple drugs.<sup>65</sup> Pharmacists should not work entirely independently of the patient's physician. However, with proper supervision, credentialed pharmacists, as experts in medication, should be allowed prescriptive authority.

Similar to the AAFP, the American Medical Association House of Delegates Reference Committee is concerned that allowing pharmacists to independently prescribe will fragment the management of patient care.<sup>66</sup> The Reference Committee further indicated that it believed pharmacists' education and training are not equal to that of physicians.<sup>67</sup> Certainly, it would be ill advised to suggest that advanced-practice pharmacists receive training equivalent to that of physicians. However, major patient organizations, government agencies, and pharmacy organizations all recognize the value of pharmacists playing a role in the provision of health care.<sup>68</sup> Even AAFP indicated that pharmacist-managed clinics have been successful in managing patients with chronic diseases.<sup>69</sup> It is clear that even organizations that are adverse to pharmacist prescriptive authority see the value in CDTM programs.<sup>70</sup> But until the true value of advanced-practice pharmacy is acknowledged by our national legislature, denial of provider status will continue to impede the successful implementation of

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65. See Albert, *supra* note 1, at 190; See also Carmichael & Cichowlas, *supra* note 25, at 180,186.

66. AM. MED. ASS'N. H. OF DEL., REP. OF REFERENCE COMM. B 18 (2012), available at <http://www.ama-assn.org/assets/meeting/2012a/a12-refcomm-b-report.pdf>.

67. *Id.*

68. Albert, *supra* note 1, at 212 (noting that AARP, HRSA, Walgreens, and APhA see the value in pharmacists playing a role in providing health care to patients).

69. See *id.* at 209-10.

70. See *id.* at 212.

collaborative programs.<sup>71</sup>

## VI. CONCLUSION

Advanced-practice pharmacists should not serve as physician replacements. Rather, these professionals can enhance patient care and provide the kind of quality access to care that is declining as the primary care gap grows. As the cost-effectiveness and accessibility of advanced-practice pharmacists becomes more evident, Congress must move toward a solution to the reimbursement barrier. Recognizing advanced-practice pharmacists as midlevel providers may encourage states with CDTM programs to grant broader privileges to qualified pharmacists. Such prescriptive privileges may be the solution to the growing primary care problem.

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71. See Murawski, *supra* note 7, at 2349-50.

The PPACA's Impact on the  
Scope of Practice of Nurse Practitioners

*Matt Brothers\**

I. INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) is a comprehensive reform of the United States' healthcare system.<sup>1</sup> While the overhaul ushered in by the PPACA primarily consists of federal legislation and regulation, states have a vital role in deciding how best to implement many of the law's provisions.<sup>2</sup> A key tenet of the PPACA is its extension of health insurance to millions of Americans.<sup>3</sup> The conventional wisdom among health policy experts is that as more people obtain health insurance, the need for primary care practitioners will grow.<sup>4</sup> After the full implementation of the PPACA, there will be as many as thirty-two million newly insured Americans.<sup>5</sup> States must determine who will provide the primary care that these previously uninsured consumers will need.<sup>6</sup>

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1. THE HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT 1 (2013), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

2. REBECCA LEBUHN & DAVID A. SWANKIN, CITIZEN ADVOC. CTR., REFORMING SCOPES OF PRACTICE: A WHITE PAPER 2 (2010) [hereinafter CITIZEN ADVOC. CTR.], *available at* <https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf>.

3. Sarah Kliff, *Obamacare is Ramping up a Healthcare Turf War*, WASH. POST (Feb. 27, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/27/how-obamacare-is-ramping-up-a-health-care-turf-war/>.

4. *Id.*

5. SARAH GOODELL ET AL., ROBERT WOOD JOHNSON FOUND., PRIMARY CARE WORKFORCE IN THE UNITED STATES 1 (2011) [hereinafter ROBERT WOOD JOHNSON FOUND.], *available at* [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf70613](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70613).

6. Kliff, *supra* note 3.

This article argues that the PPACA contains provisions that encourage states to expand nurse practitioners' scope of practice and that states should take advantage of these incentives by passing bills to ease scope of practice restrictions on the profession. Part II provides a brief overview of the scope of practice of nurse practitioners. Part III examines key provisions of the PPACA affecting nurse practitioners, showing that federal legislators designed the PPACA to encourage states to ease scope of practice restrictions on nurse practitioners through a variety of financial incentives. Part IV discusses recent legislative trends regarding scope of practice bills. Finally, Part V provides recommendations for providers to move beyond current turf wars and work with states to pass legislation easing scope of practice restrictions on nurse practitioners.

## II. SCOPE OF PRACTICE OF NURSE PRACTITIONERS: AN OVERVIEW

Scope of practice is comprised of the activities that a healthcare provider is allowed to perform within a specific profession or specialty, as determined by education, training, experience, and legislation.<sup>7</sup> Determining scope of practice is done almost strictly on the state level.<sup>8</sup> As the PPACA shifts the healthcare paradigm to focus on preventative care, quality of care, and access to care for all consumers, states are recognizing that changes to their scope of practice laws are necessary.<sup>9</sup> Changes to state medical practice acts, which define the scope of practice of mid-level

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7. Robyn E. Marsh, *The Health Care Industry and its Medical Care Providers: Relationship of Trust or Antitrust?*, 8 DEPAUL BUS. & COMM. L.J. 251, 253 (2010).

8. NAT'L COUNCIL OF STATE BDS. OF NURSING, CHANGES IN HEALTHCARE PROFESSIONS' SCOPE OF PRACTICE: LEGISLATIVE CONSIDERATIONS 8 (2009), available at [https://www.ncsbn.org/ScopeofPractice\\_09.pdf](https://www.ncsbn.org/ScopeofPractice_09.pdf).

9. See *Scope of Practice Legislative Database, 2011-2013*, NCSL, <http://www.ncsl.org/research/health/scope-of-practice-legislation-tracking-database.aspx> (last visited Oct. 28, 2013) [hereinafter NCSL]. Between January 2011 and December 2012, there were 1795 SOP-related bills proposed in 54 states, territories or the District of Columbia, of which 349 have been adopted or enacted into law. *Id.* Further, as of April 1, 2013, there were 178 bills related to scope of practice proposed in 2013 alone. *Id.*

medical professionals, are not uncommon, as these acts often evolve as healthcare demands and capabilities change.<sup>10</sup> Such laws generally define mid-level providers to include nurse practitioners, physician assistants, and other providers that support clinical care with or without physician supervision.<sup>11</sup> These laws determine the range of services nurse practitioners can provide and the extent to which they can practice independently.<sup>12</sup> Nurse practitioners are registered nurses who complete additional graduate-level education and are trained to provide a broad range of primary care services.<sup>13</sup> Scope of practice laws determine whether nurse practitioners can make a diagnosis or prescribe medication on their own, or whether they must turn to a physician for ultimate approval.<sup>14</sup>

The American Association of Nurse Practitioners argues that nurse practitioners are in a strong position to provide primary care to the many Americans who will receive health insurance due to the PPACA.<sup>15</sup> Over sixty percent of nurse practitioners practice in primary care, and, in recent years, many states considered laws expanding the scope of practice for nurse practitioners with the goal of increasing primary care capacity.<sup>16</sup> One view arising out of current legislative debates is that restrictive scope of practice laws prevent nurse practitioners from practicing to the full extent of their training, thereby limiting consumer access to care and choice of

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10. NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 8, at 8.

11. *Primary Care: Expanding the Use of Nurse Practitioners*, CMTY. CATALYST, <http://www.communitycatalyst.org/resources/glossary?entry=mid-level-providers> (last visited Oct. 28, 2013).

12. Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioners Scope-of-Practice Laws and Payment Policies*, NAT'L INST. FOR HEALTH CARE REFORM, RES. BRIEF NO. 13 at 2 (December 2013) [hereinafter NAT'L INST. FOR HEALTH CARE REFORM, No. 13], available at <http://www.nihcr.org/PCP-Workforce-NPs>.

13. *Id.* at 1.

14. Kliff, *supra* note 3.

15. *Id.*

16. ROBERT WOOD JOHNSON FOUND., *supra* note 5, at 2. See NCSL, *supra* note 9.

providers.<sup>17</sup> However, physician groups, such as the American Medical Association, continue to express reservations over whether nurse practitioners should be allowed to practice independently because they lack the comprehensive medical knowledge gained in medical school.<sup>18</sup>

In some states, scope of practice for nurse practitioners is vaguely defined, which causes disputes over the tasks they can perform legally.<sup>19</sup> State scope of practice laws often exacerbate the turf battle between physicians and nurse practitioners in that they vary widely in the autonomy they grant to nurse practitioners to diagnose, treat, and prescribe medication to patients without physician oversight.<sup>20</sup> Inconsistent state scope of practice laws prevent nurse practitioners from practicing in a way that meets the needs of all healthcare consumers.<sup>21</sup> Accordingly, Congress included within the PPACA various provisions that encourage states to expand the scope of practice of nurse practitioners.<sup>22</sup>

### III. PPACA PROVISIONS AFFECTING NURSE PRACTITIONERS

The PPACA contains numerous provisions designed to address the anticipated shortage of primary care physicians.<sup>23</sup> For example, beginning in 2011 and lasting through 2015, primary care physicians who treat Medicare patients may be eligible to receive a ten percent increase in reimbursement if their Medicare charges for primary care office visits make

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17. CITIZEN ADVOC. CTR., *supra* note 2, at 3.

18. Kristen E. Schleiter, *Retail Medical Clinics: Increasing Access to Low Cost Medical Care Amongst a Developing Legal Environment*, 19 ANNALS HEALTH L. 527, 564 (2010).

19. Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1249 (2010).

20. Patrick M. Callahan, *Power Allocations and Professional Hierarchy in the Illinois Health Care System*, 13 DEPAUL J. HEALTH CARE L. 217, 220 (2010).

21. Hansen-Turton et al., *supra* note 19, at 1237.

22. *See id.* at 1240.

23. *Id.*



up at least sixty percent of their overall Medicare charges.<sup>24</sup> In addition, the PPACA contains various other provisions designed to increase general primary care capacity.<sup>25</sup> While such provisions may prove to be successful in increasing primary care capacity, they could be strengthened by complementary approaches implemented by the states that could take effect more rapidly.<sup>26</sup>

One such approach is for states to expand their scope of practice laws by easing restrictions on nurse practitioners.<sup>27</sup> The passage of the PPACA already led to a flurry of state legislation regarding nurse practitioners.<sup>28</sup> Much of this legislation is designed to ease restrictions on the scope of practice of nurse practitioners.<sup>29</sup> States should continue to debate such legislation in order to properly care for the growing population of insured individuals. Despite this recent uptick in legislation since the passage of the PPACA, ten states still require complete physician supervision of nurse practitioners, only a dozen states allow nurse practitioners to fully practice without physician supervision, and the remaining states fall somewhere in the middle, requiring collaboration with physicians or supervision for designated tasks such as prescribing medications.<sup>30</sup>

The PPACA contains provisions that encourage states to embrace

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24. Joseph J. Feltes & Dustin Vrabel, *One Bite at a Time: PPACA's Immediate Impact on Physicians*, MD NEWS, Nov. 16, 2010, [http://www.mdnews.com/news/2010\\_11/05788\\_octnov2010\\_one-bite-at-a-time.aspx](http://www.mdnews.com/news/2010_11/05788_octnov2010_one-bite-at-a-time.aspx).

25. See Emily R. Carrier, et al., *Matching Supply to Demand: Addressing the U.S. Primary Care Workforce Shortage*, NAT'L INST. FOR HEALTH CARE REFORM, POL. ANALYSIS No. 7, at 3 (December 2011), available at [http://www.nihcr.org/PCP\\_Workforce](http://www.nihcr.org/PCP_Workforce). For example, the PPACA contains care delivery reforms and pilot programs, support for primary care training in academic settings, and scholarships for students planning to study primary care. *Id.*

26. *Id.* at 3.

27. *Id.* at 4.

28. See NCSL, *supra* note 9 (editing search parameters to focus on 2013 legislation relating to nurse practitioners and other advanced practice nurses yields a result of 63 bills as of June 30, 2013).

29. See *id.*

30. ROBERT WOOD JOHNSON FOUND., *supra* note 5, at 3.

expansion of the scope of practice of nurse practitioners.<sup>31</sup> Congress included these provisions because it recognized the recent legislative debates regarding scope of practice and aimed to encourage increased reliance on nurse practitioners to address primary care needs.<sup>32</sup> Notable provisions include the authorization of funding for nurse-managed health clinics (NMHCs) and school-based health clinics, both of which can be led by nurse practitioners.<sup>33</sup> In addition to expanding funding for practice models that may be led by nurse practitioners, the PPACA authorizes funding for advanced nursing degrees through loans and grants.<sup>34</sup> The PPACA provides fifty million dollars annually from 2012 through 2015 for hospitals to train advanced practice nurses.<sup>35</sup>

#### *A. NMHCs*

The purpose of Section 5208 of the PPACA is to fund the development and operation of NMHCs.<sup>36</sup> The PPACA defines a NMHC as a clinic managed by advanced practice nurses that provides primary care or wellness services to underserved or underprivileged populations and is associated with a school, department of nursing, federally qualified health center, or independent nonprofit health or social services agency.<sup>37</sup> In order to be eligible to receive a grant under this section, an entity must show that it is an NMHC, and it must submit an application containing an assurance that the NMHC will continue providing comprehensive primary healthcare

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31. See Hansen-Turton et al., *supra* note 19, at 1240.

32. *Id.*

33. *Id.*; See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, §§ 3024, 4101, 5208 (2010) [hereinafter the PPACA].

34. Hansen-Turton et al., *supra* note 19, at 1240; See The PPACA, *supra* note 33, at §§ 5307-5312. The PPACA authorizes advanced nursing education grants, nurse practice and retention grants, and a loan repayment and scholarship program. See The PPACA, *supra* note 33, at §§ 5308-5312.

35. Carrier, et al., *supra* note 25, at 5.

36. The PPACA, *supra* note 33, at § 5208.

37. *Id.*

services or wellness services without regard to income or insurance status of the patient for the duration of the grant period, in addition to other assurances.<sup>38</sup> The law authorized the appropriation of fifty million dollars for fiscal year 2010, and whatever sums are deemed necessary for each of the fiscal years 2011 through 2014.<sup>39</sup>

The PPACA encourages state reliance on nurse practitioners to alleviate primary care shortages through grants for NMHCs that provide comprehensive primary healthcare services.<sup>40</sup> Some studies anticipate that permitting nurse practitioners to practice to the full extent of their professional scope will result in improved outcomes and value-driven health care.<sup>41</sup> States should ease scope of practice restrictions on nurse practitioners because they can provide cost-effective healthcare through models such as the NMHC.<sup>42</sup>

### *B. School-Based Health Centers*

Section 4101 of the PPACA establishes a grant program to eligible

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38. *Id.* In addition, an entity's application must provide assurances that that nurses are the major providers of services at the NMHC, and that at least one advanced practice nurse holds an executive management position within the organizational structure of the NMHC, as well as an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee. *See id.*

39. *Id.* In 2010, the Department of Health and Human Services released \$14.8 million to support grants to ten NMHCs. Tine Hansen-Turton, *Nurse-Managed Health Clinics Provided Badly Needed Primary Care - But Without Funding, They and their Patients are at Risk*, ROBERT WOOD JOHNSON FOUND. HUMAN CAPITAL BLOG (Jan. 27, 2012), <http://www.rwjf.org/en/blogs/human-capital-blog/2012/01/nurse-managed-health-clinics-provided-badly-needed-primary-care-but-without-funding-they-and-their-patients-are-at-risk.html>. The clinics receiving funding were expected to provide primary care to more than 94,000 patients and train more than 900 advanced practice nurses by 2012. However, in an effort to reduce federal spending, both Congress and the Obama administration elected not to renew funding for this program in 2011 and 2012. *See id.*

40. *See* AM. NURSES ASS'N, *NEW CARE DELIVERY MODELS IN HEALTH SYSTEM REFORM: OPPORTUNITIES FOR NURSES AND THEIR PATIENTS* 6 (2010), *available at* <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/HealthSystemReform/HealthCareReformResources/Care-Delivery-Models.pdf> [hereinafter AM. NURSES ASS'N].

41. *Id.* at 7.

42. *See id.*

entities to support the operation of school-based health centers.<sup>43</sup> In awarding grants under this section, the government gives preference to school-based health centers that serve a large population of children eligible for medical assistance under the state's Medicaid plan.<sup>44</sup> Congress's intent to expand nurse practitioner scope of practice is evident in its allocation of grants to school-based health centers, which can be run by nurse practitioners.<sup>45</sup> The 2014 expansion of the Medicaid program, mandated by the PPACA, will enroll approximately sixteen million new participants, many needing a primary care provider for the first time.<sup>46</sup> Some argue that states should grant nurse practitioners the authority to diagnose and prescribe without physician oversight to help ensure that there is an adequate primary care workforce to serve this new population, especially because nurse practitioners are more likely than physicians to treat patients in areas lacking primary care providers.<sup>47</sup>

#### IV. STATE LEGISLATION POST-PPACA

State legislatures already debated many bills relating to the scope of practice of nurse practitioners since the passage of the PPACA in 2010.<sup>48</sup> As of February 2013, fourteen states were considering legislation to expand nurse practitioner scope of practice, up from just seven states considering similar reforms in 2012.<sup>49</sup> As of April 2013, 250 bills relating to scope of practice for various professions were introduced in forty-seven states.<sup>50</sup>

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43. The PPACA, *supra* note 33, at § 4101.

44. *Id.*

45. See Hansen-Turton et al., *supra* note 19, at 1240.

46. CMTY. CATALYST., *supra* note 11.

47. See *id.*

48. See NCSL, *supra* note 9.

49. Kliff, *supra* note 3.

50. Alicia Gallegos, *Doctors Troubled by FTC's Role in Scope-of-Practice Issues*, AM. MED. NEWS (Apr. 29, 2013), <http://www.amednews.com/article/20130429/profession/130429953>.

In 2012, seven states debated legislation that would have increased nurse practitioners' scope of practice, yet none of those bills were passed.<sup>51</sup> Such legislation often must contend with a strong physician lobby, which successfully defeats many attempts to expand scope of practice.<sup>52</sup> Some nurse practitioners and other groups encourage state use of nurse practitioners to address primary care concerns arguing that states should consider changing scope of practice restrictions and adequately reimbursing nurse practitioners for their services as a way of encouraging their provision of primary health care.<sup>53</sup> There is strong support for an expansion of the scope of practice of nurse practitioners at the state level.<sup>54</sup> The incentives contained within the PPACA should continue to increase such support and encourage the passage of bills in the state legislatures that ease restrictions on nurse practitioners.<sup>55</sup>

#### V. RECOMMENDATIONS

This article proposes several recommendations to foster increased reliance on nurse practitioners to address primary care concerns. First, states should grant nurse practitioners the authority to diagnose and prescribe without physician oversight to help ensure that there is an adequate primary care workforce to serve the newly insured population.<sup>56</sup> Easing the scope of practice restrictions currently in place on nurse practitioners in some states will help meet the growing demand for primary

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51. Kliff, *supra* note 3.

52. STEPHEN ISAACS & PAUL JELLINEK, THE PHYSICIANS FOUND., ACCEPT NO SUBSTITUTE: A REPORT ON SCOPE OF PRACTICE I (2012), *available at* [http://www.physiciansfoundation.org/uploads/default/A\\_Report\\_on\\_Scope\\_of\\_Practice.pdf](http://www.physiciansfoundation.org/uploads/default/A_Report_on_Scope_of_Practice.pdf).

53. *Id.*

54. *See* NCSL, *supra* note 9.

55. *See* Hansen-Turton et al., *supra* note 19, at 1240.

56. *See* NAT'L INST. FOR HEALTH CARE REFORM, No. 13, *supra* note 12, at 2.

care services.<sup>57</sup> Congress should also continue to authorize funding for NMHCs. NMHCs have provided primary care to thousands of new patients according to early projections, and they should be expected to do so in the future if Congress reauthorizes the necessary funding.<sup>58</sup> This reauthorization would allow NMHCs to provide care for underprivileged populations.<sup>59</sup> Finally, school-based health centers staffed by nurse practitioners will potentially serve a large population of children eligible for medical assistance under states' Medicaid plans.<sup>60</sup> The potential to adequately serve this new population should provide states with further incentive to grant nurse practitioners the authority to diagnose and prescribe without physician oversight.<sup>61</sup>

## VI. CONCLUSION

Congress recognized the recent legislative debates regarding scope of practice restrictions on nurse practitioners when it passed the PPACA. Accordingly, Congress included measures in the PPACA designed to encourage increased reliance on nurse practitioners to address primary care needs. Such provisions will likely encourage states to rewrite legislation and expand the scope of practice of nurse practitioners in order to provide adequate primary care to the millions of Americans who will obtain health insurance upon full implementation of the PPACA. It is incumbent upon the states to utilize the incentives in the PPACA and ease scope of practice restrictions on nurse practitioners. Only then will nurse practitioners realize their full potential to address the predicted shortage of primary care providers as millions of Americans obtain insurance. Increased reliance on

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57. *See Id.*

58. *See Hansen-Turton, supra* note 39.

59. *See the PPACA, supra* note 33, at § 5208.

60. *See the PPACA, supra* note 33, at § 4101.

61. *See CMTY. CATALYST, supra* note 11.

nurse practitioners could result in important improvements to the healthcare delivery system through expanded access to primary care services and lower costs.

## Scope of Practice Constraints on Nurse Practitioners Working in Rural Areas

*Courtney Kahle\**

### I. INTRODUCTION

Nurse Practitioners (NPs) are a fundamental part of providing health care in the United States.<sup>1</sup> The role of the NP as the primary care provider is especially important in rural areas where the growing decline of primary care physicians is most acute.<sup>2</sup> The implementation of the Patient Protection and Affordable Care Act (PPACA) will drastically affect how individuals are able to access care.<sup>3</sup> Thirty million Americans are predicted to gain access to health insurance, driving up this need for primary care providers.<sup>4</sup> However, a significant portion of individuals will not be able to receive the care they need because there are many laws and regulations that impede NPs from practicing to their full potential, which has a negative impact on the accessibility of care in less populated regions of the United States.<sup>5</sup>

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1. Rebecca J. Patchin, *AMA Responds to IOM Report on Future of Nursing*, AM. MED. ASSOC. (Oct 5, 2010), <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>.

2. *Primary Care Physician Shortage Expected to Worsen*, ASSOCIATED PRESS (Sept. 11, 2013), <http://www.sanduskyregister.com/article/4641571> [hereinafter *Prim. Care Physician Shortage*].

3. Christine Vestal, *Nurse Practitioners Slowly Gain Autonomy*, KAISER HEALTH NEWS (Jul 19, 2013), <http://www.kaiserhealthnews.org/stories/2013/july/19/stateline-nurse-practitioners-scope-of-practice.aspx> [hereinafter *Autonomy*].

4. *Id.*

5. Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, (Nat'l Inst. for Health Care Reform, Research Brief No. 13, 2013), available at <http://www.nihcr.org/PCP-Workforce-NPs>.



This article argues that the expansion of NP scope of practice laws is necessary in order to provide health care to those living in rural areas following the full implementation of the PPACA, and the article also provides the laws of states that allow full NP autonomy, such as Arizona, as models for other states to follow. This article begins in Part II by providing background information about NPs, discussing the role NPs play in providing health care to patients, the history of NPs, and the educational and certification requirements for practicing in the United States. In Part III, it then examines scope of practice laws and other regulations that have an adverse effect on NPs' ability to provide sufficient care to people living in rural communities. Finally, Part IV proposes a possible solution to these adverse effects by providing examples of states that flourish by allowing NPs to practice to the full extent of their education.

## II. BACKGROUND

### A. General

The American Association of Nurse Practitioners defines NPs as providers that blend clinical expertise in diagnosing and treating health conditions with an emphasis on disease prevention and health management.<sup>6</sup> NPs must continue their education past their registered nursing preparation and receive a master's or doctoral degree.<sup>7</sup> Nursing school and medical schools emphasize different focuses.<sup>8</sup> Some argue that one major difference is that nurses are more patient-focused while

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6. *What's an NP?*, AM. ASS'N OF NURSE PRACS., <http://www.aanp.org/all-about-nps/what-is-an-np> (last visited Sept. 29, 2013).

7. *Id.*

8. Michael Zand, *Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioners Autonomy Can Safely and Economically Meet the Growing Demand for Basic Health Care*, 24 J.L. & HEALTH 261, 261 (2011).

physicians are more disease-focused.<sup>9</sup> Like physicians, NPs can specialize; however, while the majority of physicians do specialize, most NPs choose to remain in primary care.<sup>10</sup> NPs' duties include, but are not limited to, analyzing patient histories, ordering lab tests, consultations, diagnostics and treatment, administering immunizations, illness prevention and wellness.<sup>11</sup>

### B. History

In 1965, the University of Colorado started the first NP program.<sup>12</sup> By the 1970s, NPs were able to manage the care of patients through nurse-managed health centers.<sup>13</sup> At that time, there were between 15,000 and 20,000 practicing NPs.<sup>14</sup> The number of practicing NPs tripled to over 60,000 NPs by 2000.<sup>15</sup> Currently, in the United States, there are over 171,000 practicing NPs.<sup>16</sup>

In early 2000, retail health clinics, primarily operated by non-physicians such as NPs, started opening in the United States.<sup>17</sup> Some believe within the next few years the amount of these clinics will expand from 5,000 to 10,000 clinics.<sup>18</sup> Since non-physicians largely run these clinics, they are able to

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9. *Id.*

10. *NP Fact Sheet*, AM. ASS'N OF NURSE PRACS., <http://www.aanp.org/all-about-nps/np-fact-sheet> (last visited Sept 29, 2013) [hereinafter *Fact Sheet*]; see also Zand, *supra* note 8, at 261 (stating some NPs chose to specialize in areas such as neonatal, geriatric, psychiatric or acute care).

11. CAROLYN BUPPERT, *NURSE PRAC.'S BUS. PRAC. AND LEGAL GUIDE* 10 (4th ed. 2011).

12. *Historical Timeline*, AM. ASS'N OF NURSE PRACS., <http://www.aanp.org/all-about-nps/historical-timeline> (last visited Sept 29, 2013).

13. Ann Ritter, Esq. & Tine Hansen-Turton, Note, *The Primary Care Paradigm Shift: An Overview of the State-Level Framework Governing Nurse Practitioner Practice*, 20 HEALTH LAWYER 21, 21 (Apr. 2008).

14. *Historical Timeline*, *supra* note 12.

15. *Id.*

16. *Fact Sheet*, *supra* note 10.

17. *Retail Health Clinics: State Legislation and Laws*, NAT'L CONF. OF STATE LEGISLATURES, <http://www.ncsl.org/issues-research/health/retail-health-clinics-state-legislation-and-laws.aspx> (last visited Sept. 29, 2013) [hereinafter *Retail Health Clinics*].

18. Linda J. Pearson, *The Pearson Report: A National Overview of Nurse Practitioner Legislation and Healthcare Issues*, AM. J. NURSE PRAC., Feb. 2008, available at

provide services at lower costs to patients.<sup>19</sup> NPs are typically paid less than physicians for providing the same services.<sup>20</sup> NPs are reimbursed at eighty-five percent of Medicare reimbursement rates for physicians.<sup>21</sup>

### *C. Education, Certification Requirements, and Legal Framework*

By 1989, most NPs possessed, at minimum, a master's degree.<sup>22</sup> In order to complete their master's degree, NPs accrue 500 to 700 supervised clinical hours, depending on their program.<sup>23</sup> Some states regulate NPs by using a Board of Nursing.<sup>24</sup> A large percentage of states also require NPs to be nationally certified before they practice.<sup>25</sup> In most states, in order to sit for the certification exam, a NP must complete a master's in nursing.<sup>26</sup> Either the National Commission for Certifying Agencies or the American Board of Nursing Specialties must accredit NP board certification in all but three states.<sup>27</sup>

A majority of the laws and regulations regarding NPs are enforced at the state level.<sup>28</sup> Each state's Nurse Practice Act is the principle regulator of the profession.<sup>29</sup> Moreover, regulations at the federal level, such as

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[http://www.npfreebies.com/ajnp\\_pearson08.pdf](http://www.npfreebies.com/ajnp_pearson08.pdf) [hereinafter *Pearson Report*].

19. *Retail Health Clinics*, *supra* note 17.

20. *Nurse Practitioners and Primary Care. Federal and State Laws and Other Policies Limit How These Professionals Can Help Meet the Growing Need for Primary Care*, HEALTH AFFAIRS, available at [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_79.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_79.pdf) (last visited Sept 29, 2013) [hereinafter *Health Policy Brief*].

21. *Health Policy Brief*, *supra* note 20.

22. *Historical Timeline*, *supra* note 12.

23. John K. Iglehart, *Expanding the Role of Advanced Nurse Practitioners – Risk and Rewards*, 368 NEW ENG. J. OF MED. 1935, 1936 (May 16, 2013).

24. *Pearson Report*, *supra* note 18.

25. BUPPERT, *supra* note 11, at 5.

26. *Id.*

27. Susan D. Hellier & Denise R. Ramponi, *What NP Graduates Need to Know About Certification*, ADVANCE HEALTHCARE NETWORK (Mar. 22, 2013), available at <http://nurse-practitioners-and-physician-assistants.advancweb.com/Student-and-New-Grad-Center/Student-Top-Story/What-NP-Graduates-Need-to-Know-About-Certification.aspx>.

28. Ritter & Hansen-Turton, *supra* note 13, at 23.

29. Lauren E. Battaglia, Note, *Supervision and Collaboration Requirements: The*

Medicare reimbursement laws, further constrict NPs.<sup>30</sup> Restrictions on NPs' ability to be reimbursed for the services they provide to patients coupled with insurance companies' refusal to recognize NPs as primary care providers prevent NPs from using the full scope of their education.<sup>31</sup> Advocates of expanding NPs' scope of practice believe that insurance companies should reimburse NPs and physicians at equal rates when they are performing the same services.<sup>32</sup> The reimbursement of NPs at lower rates disincentivise them to practice in rural areas because these NPs are typically operating on a smaller budget.<sup>33</sup> For instance, in Arizona, Medicaid laws make it nearly impossible for NPs to independently practice because they are not able to get sufficiently reimbursed for the services they provide.<sup>34</sup> Medicaid and Medicare should reimburse NPs at an equal rate to encourage them to work in rural areas.<sup>35</sup>

#### *D. Scope of Practice*

Scope of practice laws in many states restrict the services that NPs are allowed to provide to patients.<sup>36</sup> These restrictions include an inability to prescribe medications, work independently without physician supervision, and regulations limiting their capability to admit patients to hospitals.<sup>37</sup> Since the enactment of the PPACA, numerous states are choosing to expand

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*Vulnerability of Nurse Practitioners and Its Implications for Retail Health*, 87 WASH. U. L. REV. 1127, 1134 (2010).

30. Ritter & Hansen-Turton, *supra* note 13, at 23.

31. Health Policy Brief, *supra* note 20.

32. Raymond Rendleman, *Nurses Raise Battle Cry Over Reimbursement*, THE LUND REPORT (Jan. 23, 2012), [http://www.thelundreport.org/resource/nurses\\_raise\\_battle\\_cry\\_over\\_reimbursement](http://www.thelundreport.org/resource/nurses_raise_battle_cry_over_reimbursement).

33. *Id.*

34. Tammy Worth, *Nurse Practitioners Hemmed In by Scope of Practice Laws and Payment Policies*, HEALTHCARE FIN. NEWS (Mar. 21, 2013), <http://m.healthcarefinancenews.com/news/nurse-practitioners-hemmed-scope-practice-laws-and-payment-policies>.

35. Rendleman, *supra* note 32.

36. *Autonomy*, *supra* note 4.

37. Health Policy Brief, *supra* note 20; Yee et al., *supra* note 5, at 2.

NPs scope of practice to fulfill the need of the growing insured population.<sup>38</sup> Surveys show that, currently, only about twelve percent of medical school graduates pursue primary care residency.<sup>39</sup> This marked decline in primary care physicians, combined with the expansion of access to health care by the PPACA's expansion of healthcare, highlights the necessity of expanding NP scope of practice in order to ensure that the United States population may adequately address its healthcare needs, especially within rural communities.<sup>40</sup>

Many physician groups oppose broadening NPs' scope of practice.<sup>41</sup> These groups believe the expansion of NPs' role in providing health care will compromise the quality of care and the safety of patients.<sup>42</sup> The American Academy of Family Physicians and American Medical Association (AMA) are concerned that by expanding NPs' scope of practice laws, patients would be confused by the title of doctor and whether that title also applied to non-physicians.<sup>43</sup> The AMA believes that medical doctors should remain the leaders of the healthcare industry.<sup>44</sup> It further believes that increasing the responsibility of nurses is not the answer to the primary care physician shortage.<sup>45</sup> The groups opposed to expanding NP scope of practice believe that physician-led teams best meet patients' needs because the differences in NP and physician education and clinical experience create different standards of care.<sup>46</sup>

On the other hand, many NPs believe that they should be allowed to

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38. Karen Donelan et al., *Perspectives of Physicians and Nurse Practitioners on Primary Care Practice*, 368 NEW. ENG. J. OF MED. 1898, 1899 (May 16, 2013).

39. *Autonomy*, *supra* note 4.

40. *Autonomy*, *supra* note 4.

41. Donelan et al., *supra* note 38, at 1904.

42. *Id.*

43. Iglehart, *supra* note 23, at 1937.

44. Patchin, *supra* note 1.

45. *Id.*

46. Health Policy Brief, *supra* note 20.

practice to the full extent of their education and training.<sup>47</sup> The Federal Trade Commission supports these NPs and believes that physician groups opposing the expansion of NPs' scope of practice do not provide a legitimate reason for their stance.<sup>48</sup> The Institute of Medicine also advocates for the expansion of the NP role, stating that policy changes are essential for the health and safety of people in the United States.<sup>49</sup> Without changes to the scope of practice, many individuals living in rural areas will not have access to the medical attention they need.<sup>50</sup>

### III. NP SCOPE OF PRACTICE IMPLICATIONS ON RURAL AREAS

People living in rural communities are one of the populations most adversely affected by NP scope of practice regulations.<sup>51</sup> Currently there are sizeable shortages of primary care physicians in these areas creating heavy reliance on NPs.<sup>52</sup> Surveys show that five million patients are currently living in rural shortage areas, and that number will only continue to grow with the implementation of the PPACA.<sup>53</sup> Another concern for those living in rural areas is finding physicians willing to work in these locations.<sup>54</sup> It can take years for these communities to find a physician

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47. Iglehart, *supra* note 23, at 1936; Donelan et al., *supra* note 38, at 1899; *see also* PRIORITIES FOR NURSING'S FUTURE- RECOMMENDATIONS FROM THE NURSING CMTY. PREPARED FOR THE OFF. OF MGMT. AND BUDGET, ASSOC. OF CMTY. HEALTH NURSING EDUCATORS, *available at* <http://www.achne.org/files/public/NCPrioritiesForNursing'sFuture.pdf> (emphasizing that NPs should practice to the full extent of their education and training to ensure that patients are receiving access to providers).

48. *Autonomy*, *supra* note 4.

49. Health Policy Brief, *supra* note 20.

50. Yee et.al, *supra* note 5, at 7

51. *Id.* at 1.

52. CTR. FOR HEALTH REFORM & MODERNIZATION, UNITEDHEALTH, MODERNIZING RURAL HEALTH CARE: COVERAGE, QUALITY AND INNOVATION 3 (2011), *available at* [http://www.unitedhealthgroup.com/hrm/unh\\_workingpaper6.pdf](http://www.unitedhealthgroup.com/hrm/unh_workingpaper6.pdf).

53. *Id.* at 4.

54. *Prim. Care Physician Shortage*, *supra* note 2; Wannapa Khaopa, *Dire Need For Doctors in Rural Areas*, THE NATION (May 3, 2011), <http://www.nationmultimedia.com/2011/05/03/national/Dire-need-for-doctors-in-rural-areas-30154461.html>. Most physicians are from urban areas and prefer to stay in that environment to work resulting in a severe

willing to work in their area.<sup>55</sup>

In order to fill the void of primary care physicians in rural areas, one approach is to expand the scope of NPs' practice allowing them to be put to greater use.<sup>56</sup> One-third of NPs providing primary care in rural areas are not allowed to see patients independently.<sup>57</sup> However, in some areas, it is not possible or practical for patients to see their physician, and they rely on the care NPs are able to provide them.<sup>58</sup> All states should allow NPs to practice independently from a physician.

NPs who choose to specialize play an integral role in providing care to people in rural areas because they can supplement or replace care that would ordinarily be provided by physicians.<sup>59</sup> For instance, advance-practice psychiatric nurses can provide mental health services to those individuals living in areas with shortages of mental health professionals.<sup>60</sup> One survey reveals that more than half of rural patients have to travel over twenty miles for specialty care, which could instead be provided to them locally by specialized NPs.<sup>61</sup> This travel is caused, in part, by physician supervision regulations.<sup>62</sup>

Many NPs believe the restrictions requiring them to work under the supervision of physicians create barriers on their ability reach vulnerable populations that live in rural communities.<sup>63</sup> Some physicians find it difficult and refuse to collaborate with NPs working in rural communities

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shortage of physicians in rural areas. *Id.*

55. *Id.*

56. Yee et al., *supra* note 5, at 1.

57. CTR. FOR HEALTH REFORM & MODERNIZATION, *supra* note 52, at 35.

58. *Id.*

59. CTR. FOR HEALTH REFORM & MODERNIZATION, *supra* note 52, at 35.

60. *Id.*

61. *Id.* at 3. The average length a patient travels to see a primary care physician is 60 miles. *Id.*

62. Yee et al., *supra* note 5, at 3.

63. *Id.*

because it is not feasible to provide the supervisory role from many miles away, as required by restrictive scope of practice laws.<sup>64</sup> The direct supervision requirement not only interferes with NPs' ability to treat patients, but also to what extent they are able to provide important care.<sup>65</sup> Some states, like Arizona, adopted scope of practice laws to rectify this problem by allowing NPs to practice autonomously.<sup>66</sup>

In some states, NPs are able to practice independently without physician supervision, but these nurses still face restrictions on prescribing medications.<sup>67</sup> In more restrictive states, NPs are not granted any prescribing authority without collaboration with, or supervision by, a physician.<sup>68</sup> The limitations placed on NPs' prescribing authority in rural and other areas cause patients to experience unnecessary delays in obtaining and refilling prescription medications.<sup>69</sup>

Some states are beginning to remove restrictions on NPs' scope of practice by streamlining collaborative agreements, lifting prescription authority bans, allowing NPs to have hospital admittance authority, and adjusting payer policies.<sup>70</sup> Some states, such as Maryland, provide their NPs more freedom to engage with individuals of rural communities by allowing them to work at multiple sites.<sup>71</sup> Instead of being confined to strictly a hospital setting, NPs have the freedom to go out into other areas of

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64. *Id.*

65. *Id.*

66. *Autonomy*, *supra* note 4.

67. *Id.*

68. *Id.*; *see also* Ritter & Hansen-Turton, *supra* note 13, at 24 (detailing "some states require physicians to 'delegate' their prescriptive authority to nurse practitioners that they supervise").

69. *Autonomy*, *supra* note 4. Washington provides a different outlook for their NPs, stating that they only need consultation if they are performing something new or unfamiliar. WASH. ADMIN. CODE § 246-840-300 (2013), *available at* <http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-300>.

70. Yee et al., *supra* note 5, at 3.

71. *Id.*



the community, so long as they have a consultation agreement with a physician.<sup>72</sup> If states want to improve their residents living in rural areas access to much needed health care, they must lessen the restrictions on NP scope of practice by adopting less oppressive standards and oversight regulations.<sup>73</sup> To this end, Arizona passed expansive laws relating to independent practice of NPs, granting them authority to prescribe medications without the oversight of physicians.<sup>74</sup> Reasons for these expansive laws include a lack of primary care providers in the state and the large amount of individuals living in rural areas.<sup>75</sup> States with large rural populations, such as Arizona, tend to have no physician involvement with NPs in order to meet these demands, and other states should follow their lead.<sup>76</sup>

Like Arizona, Virginia's legislature passed laws in order to expand NPs' abilities to reach more patients.<sup>77</sup> The state removed restrictions that forced NPs to primarily work in the same location as a physician, and the state permits them to use telemedicine techniques.<sup>78</sup> These techniques include remote monitoring systems for patient data through the internet, call centers

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72. *Id.*

73. *Autonomy*, *supra* note 4; Yong-Fang Kuo et al., *States With The Least Restrictive Regulations Experienced The Largest Increase In Patients Seen By Nurse Practitioners*, 32 HEALTH AFFS. 1236, 1236 (2013), available at <http://content.healthaffairs.org/content/32/7/1236.full.pdf+html> (last visited Dec. 5, 2013). Patients in states with the least restrictive regulations had over two times greater likelihood of receiving their primary care from a NP. *Id.*

74. SHARON CHRISTIAN, CATHERINE DOWER & ED O'NEIL, THE CTR. FOR HEALTH PROFS., OVERVIEW OF NURSE PRACTITIONER SCOPES OF PRACTICE IN THE US – DISCUSSION (2007), available at [http://futurehealth.ucsf.edu/Content/29/2007-12\\_Overview\\_of\\_Nurse\\_Practitioner\\_Scopes\\_of\\_Practice\\_In\\_the\\_United\\_States\\_Discussion.pdf](http://futurehealth.ucsf.edu/Content/29/2007-12_Overview_of_Nurse_Practitioner_Scopes_of_Practice_In_the_United_States_Discussion.pdf).

75. *Id.*

76. *Id.*

77. Christine Vestal, *In Many Communities, Nurse Practitioners Fill an Important Void*, KAISER HEALTH NEWS (Dec. 6, 2012), <http://www.kaiserhealthnews.org/stories/2012/december/06/nurse-practitioners-rural-health-care.aspx>.

78. *Id.*

staffed by nurses, live video consultations, and interactive videos.<sup>79</sup> Telemedicine techniques allow NPs to interact remotely with patients to conduct medical evaluations, patient education, and provide follow up care.<sup>80</sup> Telemedicine provides individuals living in rural areas with quicker access to health professionals.<sup>81</sup> Instead of having to travel or wait long spans of time to receive care, they can log into web meetings or online videos to talk to NPs.<sup>82</sup> Patients conveniently use telemedicine to participate in in-home care and monitoring.<sup>83</sup> Rural areas in Virginia also utilize mobile imaging centers and lab specimen collections, which send the information through secured emails improving diagnostic capabilities.<sup>84</sup> Telemedicine has a large impact on rural communities by providing direct access to clinical care.<sup>85</sup>

Because of these changes to scope of practice laws in Virginia, the non-profit organization Health Wagon can better assist an underserved population of individuals in the Appalachian Mountains.<sup>86</sup> Health Wagon staffs a converted recreation vehicle with NPs, creating a mobile unit that is able to travel to the difficult mountainous terrain to reach patients that urgently need medical care.<sup>87</sup> In order to satisfy Virginia's scope of practice laws, Health Wagon consults with a volunteer physician.<sup>88</sup> NPs working for Health Wagon are able to provide assistance to patients suffering from a wide range of ailments such as chronic obstruction, cancer

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79. *Telehealth Nursing Fact Sheet*, AM. TELEMEDICINE ASS'N, (Apr. 2011), [http://www.americantelemed.org/docs/default-document-library/fact\\_sheet\\_final.pdf](http://www.americantelemed.org/docs/default-document-library/fact_sheet_final.pdf).

80. *Id.*

81. Michelle McNickle, *5 Ways Telemedicine Can Boost Care in Rural Communities*, HEALTHCARE IT NEWS (Oct. 13, 2011), <http://www.healthcareitnews.com/print/36102>.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. Vestal, *supra* note 77.

87. *Id.*

88. *Id.*

and heart disease.<sup>89</sup> This is a beneficial program and by easing restrictions, other states' NPs will be able to utilize similar programs.

#### IV. PROPOSAL

In order to utilize NPs to their full abilities in rural areas, states must broaden their scope of practice laws by allowing NPs to practice to the full extent of their education with minimal physician oversight.<sup>90</sup> Studies have shown that unnecessary physician oversight reduces patient access jeopardizing patient health and safety and hinders medication management.<sup>91</sup> States should preferably mirror Arizona's laws by entirely removing supervision requirements of NPs.<sup>92</sup> Once these supervision requirements are removed, NPs will be able to prescribe medication independently.<sup>93</sup> By eliminating these barriers, NPs would be able to practice autonomously and fill in the primary care void exacerbated by the PPACA.<sup>94</sup> Some believe that physician oversight causes communication barriers between the provider and the patient leading to unnecessary confusion.<sup>95</sup> These adaptations, along with other scope of practice expansions, would allow more NPs nationwide to effectively run a rural

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89. *Id.*

90. NICOLE BLAZEK, THE CLINICAL ADVISOR, PHYSICIAN OVERSIGHT HINDERS NP SCOPE OF PRACTICE, (2013), *available at* <http://www.clinicaladvisor.com/physician-oversight-hinders-np-scope-of-practice/article/299936/>.

91. *Id.*

92. CTR. FOR HEALTH REFORM & MODERNIZATION, *supra* note 52, at 5; *see also* INST. OF MED. OF THE NAT'L ACADS., THE FUTURE OF NURSING FOCUS ON SCOPE OF PRACTICE 2 (October 2010), *available at* <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf> [hereinafter FUTURE OF NURSING] (suggesting that states need to keep up with the evolving health care industry and adjust their scope of practice laws so that NPs can practice autonomously); *see also Autonomy*, *supra* note 4 (describing that states should relax out-of-date scope of practice restrictions that do not allow NPs to play lead roles in providing health care to patients).

93. FUTURE OF NURSING, *supra* note 92.

94. *Id.*

95. BLAZEK, *supra* note 90.

health clinic without the oversight of physician.<sup>96</sup>

Medicare laws that interfere with NPs' abilities to receive payment and provide services need to be reformed.<sup>97</sup> Medicare laws should be adjusted so that coverage for NPs' and physicians' services is consistent.<sup>98</sup> Medicare regulations that prevent NPs from ordering home care services without a physician cosigner cause unnecessary delays in care and should be removed in order to increase needed access to these services.<sup>99</sup> This barrier does not allow independently practicing NPs to provide the full range of healthcare services needed by their patients.<sup>100</sup> In states like Arizona that do allow NP autonomy, many choose not to open their own practices because of reimbursement issues.<sup>101</sup> Scope of practice laws and reimbursement issues must be solved simultaneously in order to provide the access needed in rural areas.<sup>102</sup>

## V. CONCLUSION

People living in rural areas do not have sufficient access to health care, which is exacerbated by a lack of primary care physicians.<sup>103</sup> This lack of primary care physicians will continue to increase as the PPACA is implemented.<sup>104</sup> NPs are more than capable of filling this void, but many are unable to do so because of restrictive state laws. In order for this

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96. Yee et.al, *supra* note 5, at 7

97. *Nurse Practitioners and Primary Care*, HEALTH AFFAIRS, available at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=92](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=92) (last visited Dec. 5, 2013).

98. *Id.*

99. Rendleman, *supra* note 32.

100. *Id.*

101. Yee et.al, *supra* note 5, at 4; see also Julie Appleby, *Nurse Practitioners Try New Tack To Expand Foothold In Primary Care*, KAISER HEALTH NEWS, (Sept. 08, 2013) <http://www.kaiserhealthnews.org/stories/2013/september/09/nurse-primary-care-slowed-by-insurer-credentialing.aspx> (noting some insurers still do not accept NPs as primary care providers in their networks).

102. *Id.*

103. *Prim. Care Physician Shortage*, *supra* note 2.

104. *Id.*

geographic population to best be served, scope of practice laws need to be expanded to allow NPs to practice to the full range of their abilities. This expansion must be a collaborative effort amongst all facets of government and healthcare providers. The focus in solving the primary care shortage needs to turn away from increasing primary care physicians and towards allowing NPs to serve the needs of the patients living in rural communities. Allowing NPs to practice independently from physicians is the best way to provide this important and desperately needed care.

The Retail Clinics' Place in the Primary Care  
Shortage and the Need for Collaboration,  
Communication and Integration as a means of  
Preventing Fragmented Care

*Kelly Gallo Strong\**

I. INTRODUCTION

The United States currently faces a serious shortage of primary care physicians.<sup>1</sup> One solution to this epidemic is to place increased responsibility on non-physician primary care practitioners who have the ability to manage acute, non-serious ailments, and alert the physician when more care is required.<sup>2</sup> Partnerships between healthcare systems and retail clinics help to relieve the severe pressure on hospitals and primary care physicians.<sup>3</sup> For the retail clinic model to be successful, non-physician primary care practitioners and physicians must effectively communicate.<sup>4</sup> This paper addresses the need for states to develop retail clinic specific regulations that promote continuity of care through the utilization of formal communication mechanisms with physician practices, and it advocates for the integration of retail clinics with larger healthcare systems to optimize

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1. Marsha Mercer, *How to Beat the Doctor Shortage*, AARP (March 2013), <http://www.aarp.org/health/medicare-insurance/info-03-2013/how-to-beat-doctor-shortage.html>.

2. Donna Marbury, *There Are No Easy Solutions to the Scope of Practice Debate*, MED. ECON. (Sept. 10, 2013), <http://medicaleconomics.modernmedicine.com/print/373212>.

3. ACCENTURE, RETAIL MEDICAL CLINICS: FROM FOE TO FRIEND? (2013), *available at* <http://www.accenture.com/SiteCollectionDocuments/PDF/Accenture-Retail-Medical-Clinics-From-Foe-to-Friend.pdf>.

4. Marbury, *supra* note 2.

collaboration and ultimately quality of care.<sup>5</sup> Part II provides a brief explanation of the primary care shortage in the United States and the need for an expansion of the scope of practice for non-physician primary care providers. Part III discusses the value of continuity of care and a consistent medical home. Part IV contends that retail clinics may put patient safety and coordinated care at risk by disrupting the patients' continuity of care in a consistent medical home. Part V provides potential solutions to this problem to include a regulatory state approach, as well as an integrated business model.

## II. THE UNITED STATES IS FACING A SHORTAGE OF PRIMARY CARE PHYSICIANS

By 2025 there will be fifteen million more patients eligible for Medicare and more than thirty million Americans brought into the healthcare system as a result of the Patient Protection and Affordable Care Act (PPACA).<sup>6</sup> A recent figure reported that the United States will need 51,880 primary care physicians to keep up, a majority of which will be required as soon as 2015.<sup>7</sup> Primary care physicians fear that it will be a strain to absorb all of these new patients into the healthcare system.<sup>8</sup> Thus, as the shortage of primary care physicians relative to demand continues to grow, patients with lower acuity cases can alleviate strain by visiting retail clinics.<sup>9</sup> Patients visiting retail clinics allow primary care physicians more time to attend to more complex cases.<sup>10</sup>

An increasing amount of people are utilizing the retail clinic model as

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5. *See infra* Part III, V.

6. Marbury, *supra* note 2.

7. *Id.*

8. Mercer, *supra* note 1.

9. ACCENTURE, *supra* note 3.

10. ACCENTURE, *supra* note 3.

the concept grows to meet patient demand.<sup>11</sup> As of May 2013, there were 1,423 clinics, and there are expected to be 3,200 by the end of 2014.<sup>12</sup> People often choose retail clinics because they are relatively inexpensive, offer evidence-based care and are easily accessible.<sup>13</sup> Located in drug, grocery, or large merchandise stores, these types of clinics are open evenings and weekends and do not require an appointment or a long waiting times to see a clinician.<sup>14</sup> However, while there is an apparent value in the retail clinic model, there is valid concern that the retail clinic could exacerbate the problems in communication across care settings.<sup>15</sup>

### III. THE VALUE OF CONTINUITY OF CARE AND A CONSISTENT MEDICAL HOME

Continuity of care is an ongoing and cooperative process of healthcare management wherein the patient and physician share the common goal of achieving high quality and cost effective care.<sup>16</sup> Through this partnership, the provider gains first-hand knowledge of the patient's medical history to more effectively initiate treatment regimens without extensive examination or review of medical charts and history.<sup>17</sup> This process makes early recognition of health problems possible and allows providers to proceed with cost-effective coordination of care and make referrals to other

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11. Stephanie Watson, *More Americans Using Retail Health Clinics*, HARVARD HEALTH PUBL'NS, May 10, 2013, available at <http://www.health.harvard.edu/blog/more-americans-using-retail-health-clinics-201305106189>.

12. *Id.*

13. CAL. HEALTHCARE FOUND., *RETAIL CLINICS: SIX STATE APPROACHES TO REGULATION AND LICENSING 1* (2009), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RetailClinicsSixStateApproaches.pdf>.

14. *Id.*

15. Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients' Visits*, 27 HEALTH AFF. 1272, 1280 (2008), available at <http://content.healthaffairs.org/content/27/5/1272.full.pdf+html>.

16. See *Continuity of Care, Definition of*, AMERICAN ACAD. OF FAMILY PHYSICIANS (last visited Dec. 9, 2013), <http://www.aafp.org/about/policies/all/definition-care.html>

17. *Id.*



specialized healthcare professionals.<sup>18</sup> A continuous relationship between patient and provider allows the provider to be a more effective patient advocate, while at the same time enables the patient to have increased confidence in the provider.<sup>19</sup>

It is also valuable for the patient to have a consistent medical home.<sup>20</sup> A medical home seeks to maximize health outcomes throughout a patient's life by providing continuous and coordinated care.<sup>21</sup> Studies demonstrate that patients with a consistent medical home experience improved access to higher quality and lower cost of care with reduced errors and better overall health outcomes.<sup>22</sup> Each switch to a new physician practice leads to more medical tests and longer appointment times as new physicians must reassess the patient's medical history at each visit.<sup>23</sup> A consistent medical home builds familiarity, trust and confidence for the provider and patient, and coordinated care often results in better health for patients.<sup>24</sup> It is thus pertinent that retail clinics coordinate care with each patient's primary care physician.<sup>25</sup> An ideal method for care coordination is through the usage of shared electronic medical record (EMR) networks to improve patient safety, identify larger trends, and ensure optimal preventive and chronic disease care.<sup>26</sup>

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18. *Id.*

19. *Id.*

20. Isabelle Dills, *Study Stresses Value of 'Medical Home'*, NAPA VALLEY REGISTER.COM (July 7, 2013), [http://napavalleyregister.com/news/local/study-stresses-value-of-medical-home/article\\_6fc4e502-e772-11e2-8393-001a4bcf887a.html](http://napavalleyregister.com/news/local/study-stresses-value-of-medical-home/article_6fc4e502-e772-11e2-8393-001a4bcf887a.html).

21. Craig Pollack, *The Growth of Retail Clinics and the Medical Home: Two Trends in Conflict*, 29 HEALTH AFFS. 998, 998 (2010), available at <http://content.healthaffairs.org/content/29/5/998.full.pdf+html>.

22. Dills, *supra* note 20.

23. *Id.*

24. *Id.*

25. Victoria Stagg Elliott, *Retail Clinics Create Continuity Gap in Patient Care*, AM. MED. NEWS (Nov. 26, 2012), <http://www.amednews.com/article/20121126/business/311269958/4/>.

26. Pollack, *supra* note 21, at 998.

IV. RETAIL CLINICS OFTEN DO NOT EFFECTIVELY SUPPORT CONTINUITY OF CARE OR THE EXISTENCE OF A CONSISTENT MEDICAL HOME FOR ITS PATIENTS AND THEREFORE PUT PATIENT SAFETY AND COORDINATED, CONTINUOUS CARE AT RISK

Various physician organizations such as the American Medical Association (AMA), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP) question whether retail clinic clinicians make accurate diagnosis and triage decisions and if they have the potential of disrupting the primary care physician-patient relationship and continuity of patient care.<sup>27</sup> Many of the physician organization quality-based concerns are unnecessary as the quality of care scores between retail clinics and more conventional clinics are comparable.<sup>28</sup> A 2009 study found that retail clinics did as well or even better than other places of care in the assessment of fourteen objective measures of quality.<sup>29</sup> The PPACA recognizes the value of advanced practice nurses as providers of primary care as well as potential leaders in integrated care systems.<sup>30</sup> However, retail clinics can lead to increased fragmentation while undermining the patients' connection to their primary medical home and ultimately compromise coordinated and continuous care.<sup>31</sup> The incoming AMA president recently spoke with excitement about the addition of retail clinics to our delivery system; though, he stressed the need for continuity of care and connectivity of retail clinics with primary

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27. Mehrotra, *supra* note 15, at 1273.

28. Michelle Andrews, *Retail Health Clinics Expanding*, KAISER HEALTH NEWS (June 25, 2012), <http://www.kaiserhealthnews.org/features/insuring-your-health/2012/retail-health-clinics-michelle-andrews-062612.aspx>.

29. *Id.*

30. AMERICAN NURSES ASS'N, *NEW CARE DELIVERY MODELS IN HEALTH SYSTEM REFORM: OPPORTUNITIES FOR NURSES & THEIR PATIENTS* (2010), *available at* <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Care-Delivery-Models.pdf>.

31. *See* Pollack, *supra* note 21, at 998.

care physicians.<sup>32</sup>

Patients who go to retail clinics are more likely to return to them again and less likely to visit a primary care physician for any reason, or to have two or more visits with the same primary care physician.<sup>33</sup> Many people who seek care at a retail clinic do not have a medical home.<sup>34</sup> As a result, some doctor groups worry that the clinics could replace primary care physicians, and thus, people who use clinics may miss out on comprehensive health services.<sup>35</sup> The continual utilization of retail clinics can, incidentally, lead to fragmentation of patient healthcare if it is not coordinated with a primary care physician.<sup>36</sup> The AAFP promotes a healthcare system with strong, team-based primary care.<sup>37</sup>

Retail clinics can provide this type of team-based care, but they must work in coordination with primary care physicians so that the care is not fragmented.<sup>38</sup> According to the AAFP, fragmented care does not serve the individual nor does it improve health outcomes for the society.<sup>39</sup> For retail clinics without an EMR system in place, the burden of communication and record keeping oftentimes falls on the patient.<sup>40</sup> Many clinics can provide patients with an EMR, or it can be sent to patients' physicians with the patients' consent.<sup>41</sup> However, the frequency of this communication is

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32. Kym White, *The Retail Health Solution to Cost, Quality and Access*, EDELMAN (Oct. 16, 2013), <http://www.edelman.com/post/the-retail-health-solution-to-cost-quality-and-access/>.

33. Elliott, *supra* note 25.

34. CAL. HEALTHCARE FOUND., *supra* note 13, at 6.

35. Amy Norton, *Retail Clinics May Cut into Primary Care: Study*, REUTERS, (Nov. 1, 2012), <http://www.reuters.com/article/2012/11/02/us-clinics-idUSBRE8A101I20121102>.

36. *Retail Clinics Definition*, AMERICAN ACAD. OF FAMILY PHYSICIANS (Dec. 9, 2013), <http://www.aafp.org/about/policies/all/retail-clinics.htm>.

37. *Id.*

38. *Id.*

39. *Id.*

40. Watson, *supra* note 11.

41. Mehrotra, *supra* note 15, at 1280.

unknown.<sup>42</sup> Lack of communication increases the risk of missing major ailments, drug interaction complications, and the absence of a true physician-patient relationship.<sup>43</sup>

V. COMMUNICATION AND COORDINATION BETWEEN RETAIL CLINIC AND  
PRIMARY CARE PHYSICIANS IS CRUCIAL TO PROMOTE CONTINUITY OF  
CARE AND SUPPORT SAFETY AND OVERALL HEALTH

The American College of Physicians (ACP) adopted principles for retail clinics that focus on effective collaboration as the key for their success.<sup>44</sup> The ACP defines collaboration in the context of care as ongoing interdisciplinary communication between primary care physicians and nurse practitioners regarding the care of individuals and populations for the purpose of quality and cost-effective care.<sup>45</sup> As a result, their guidelines encourage the development of referral systems from retail clinics to physician practices as well as mechanisms to alert a patient's primary care provider about more complex cases and medications prescribed to help nurture continuous care for the patient.<sup>46</sup> The ACP supports the utilization of EMR systems to facilitate communication between retail clinics and the patients' other providers, as well as the formation of formal relationships with these providers to support continuity of care for each of its patients.<sup>47</sup>

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42. *Id.*

43. See Antoinette Alexander, *Physician-Authored JAMA Article Highlights the Importance of Retail Clinics, Drug Store Medicine*, DRUG STORE NEWS (May 23, 2012), <http://drugstorenews.com/article/physician-authored-jama-article-highlights-importance-retail-clinics-drug-store-medicine>.

44. AMERICAN COLLEGE OF PHYSICIANS, NURSE PRACTITIONERS IN PRIMARY CARE, A POLICY MONOGRAPH OF THE AMERICAN COLLEGE OF PHYSICIANS 10 (2009), available at [http://www.acponline.org/advocacy/current\\_policy\\_papers/assets/np\\_pc.pdf](http://www.acponline.org/advocacy/current_policy_papers/assets/np_pc.pdf).

45. *Id.* at 2.

46. *Id.* at 10.

47. *Id.*

*A. State Regulation in Support of Communication:  
The Massachusetts Model*

States have the responsibility for the public health of their residents,<sup>48</sup> and most regulations affecting retail clinics are under the jurisdiction of the state in which the retail clinic is located.<sup>49</sup> States need to regulate and create legislation pertaining to communication and follow-up between retail clinics and primary care providers.<sup>50</sup> To do this task, policymakers must develop regulations requiring retail clinics to assist patients in following-up with primary care physicians for continued care.<sup>51</sup> Today, the majority of states do not explicitly regulate retail clinics, but merely healthcare entities as a whole.<sup>52</sup> An effective management tool is to create regulations expressly for retail clinics so that they may be written as broadly or as narrowly as is necessary to accomplish the specific state policy goals asserted.<sup>53</sup> Massachusetts serves as a model for the development of regulations for retail clinics to avoid fragmentation and instead promote communication and continuous medical care for each patient.<sup>54</sup>

Recognizing the value of communication with primary care physician practices, Massachusetts promulgated regulations explicitly for retail clinics to promote medical homes and mitigate fragmentation of care.<sup>55</sup> Massachusetts' regulations provide that all retail clinics must make referrals to primary care physicians.<sup>56</sup> In doing so, retail clinics and the nurse practitioners that staff them are required to have a list of local primary care

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48. CAL. HEALTHCARE FOUND., *supra* note 13, at 2.

49. Margaret Laws & Mary Kate Scott, *The Emergence of Retail-Based Clinics in the United States: Early Observations*, 27 HEALTH AFF. 1293, 1296 (2008), available at <http://content.healthaffairs.org/content/27/5/1293.full.pdf>.

50. CAL. HEALTHCARE FOUND., *supra* note 13, at 6.

51. *Id.*

52. *Id.* at 2, 7.

53. *Id.* at 7.

54. *See id.*

55. *Id.* at 7, 14.

56. *Id.* at 7.

providers that are accepting new patients.<sup>57</sup> To help manage this initiative, retail clinics are required to create a process to track and limit repeat visitors.<sup>58</sup> Each clinic must employ community health workers who are available to help patients with various administrative health-related tasks such as finding a primary care physician to ensure that each patient seeks any necessary follow-up treatment with the recommended primary care physician.<sup>59</sup>

### *B. The Need for Integration*

A retail clinic that is completely independent of any other health system or provider is less likely to effectively support the patient's continuity of care in a medical home.<sup>60</sup> In this scenario, individual retail clinics are not likely to utilize an EMR system or any other formal mechanisms for communicating with primary care physicians.<sup>61</sup> Medical records are typically sent to the primary care provider by fax or printout.<sup>62</sup> This method often proves unsuccessful because many patients fear that their physician may be upset with them for visiting a retail clinic, so they do not provide the retail clinic with their physician's name or contact information.<sup>63</sup> Also, many retail clinic patients do not have a medical home to which they could have the information sent.<sup>64</sup> While many retail clinics have referral systems for patients who do not already have an established primary care physician, there is less incentive for independent clinics to successfully encourage the

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57. *Id.* at 11.

58. *Id.*

59. *Id.* at 12.

60. *See* Pollack, *supra* note 21, at 1001.

61. *Id.*

62. *Id.*

63. Elliott, *supra* note 25.

64. CAL. HEALTHCARE FOUND., *supra* note 13, at 6.

patient to maintain a relationship with a consistent medical home.<sup>65</sup> A report from the California Academy of Family Physicians said that patients do not always receive any form of record from retail clinics.<sup>66</sup> The patient and the retail clinic are often responsible for continuity of care in that scenario, as most states have very little influence over the communication mechanisms of retail clinics.<sup>67</sup> As a result, the utilization of an EMR system is a strong differentiator that ultimately enables greater continuity of care.<sup>68</sup>

An effective approach to the utilization of an EMR system is through the integration of retail clinics with larger health systems either through ownership or by or a formal partnership.<sup>69</sup> Large health systems such as Allina Health and the Cleveland Clinic already partnered with retail clinics to aid in this integrated care approach.<sup>70</sup> In this scenario, the retail clinic is partnered with a health system and becomes an extension of a larger all-inclusive medical home.<sup>71</sup> The patient can then obtain acute care in the lower-cost, more convenient, setting while at the same time stay connected to a larger healthcare system for chronic issues and ongoing care.<sup>72</sup> When retail clinics are part of a larger integrated system, EMRs are automatically and promptly sent to the patient's primary care physician.<sup>73</sup> This approach improves patient safety and offers a more effective method for providers to

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65. See Pollack, *supra* note 21, at 1001.

66. MARY TAKACH & KATHY WITGERT, ANALYSIS OF STATE REGULATIONS AND POLICIES GOVERNING THE OPERATION AND LICENSURE OF RETAIL CLINICS 8 (2009), available at <http://www.nashp.org/sites/default/files/RetailClinics.pdf>.

67. *Id.*

68. See CAL. HEALTHCARE FOUND., HEALTHCARE IN THE EXPRESS LANE: RETAIL CLINICS GO MAINSTREAM 12 (2006), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareInTheExpressLaneRetailClinics2007.pdf>.

69. See Pollack, *supra* note 21, at 1000-01.

70. See *Special Feature: Retail Clinics Play Growing Role in Health Care Marketplace*, RAND HEALTH (May 22, 2013), <http://www.rand.org/health/feature/retail-clinics.html>.

71. See Pollack, *supra* note 21, at 1000.

72. Andrews, *supra* note 28.

73. *Id.*

identify larger trends outside of acute illnesses treated at retail clinics to ensure optimal preventive and chronic disease screening and care.<sup>74</sup>

## VI. CONCLUSION

Partnerships between healthcare systems and retail clinics help to relieve the severe pressure hospitals face as a result of the primary care shortage in the United States.<sup>75</sup> For this approach to succeed, states must develop regulations, specifically for retail clinics, that promote continuity of care within a consistent medical home through the utilization of formal communication mechanisms with physician practices.<sup>76</sup> States are responsible for the health of their residents and must be vigilant in their regulation of retail clinics so as to promote effective communication with primary care physicians.<sup>77</sup> This communication will support coordinated and continuous care in order to maximize patient safety and effective preventive and chronic disease identification and care.<sup>78</sup>

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74. See generally Pollack, *supra* note 21 (demonstrating that through the increased levels of assimilation, independent, hybrid, and integration, communication and therefore safety improve as integration level increases).

75. ACCENTURE, *supra* note 3, at 1, 3.

76. See *infra* Part IV.

77. See *infra* Part V.

78. *Id.*



The Nurse Practitioner is in: Onsite Health Clinics  
and Their Benefits

*Erica Cribbs\**

I. INTRODUCTION

As our nation moves closer to the full rollout of the Patient Protection and Affordable Care Act (PPACA), two key focuses of healthcare industry players are lowering costs and increasing competition among insurers and providers.<sup>1</sup> As a result, traditional providers are evolving the scope of services they provide in order to fall into more cost-effective options for patients and insurers.<sup>2</sup> In this quickly changing environment, employers in particular face the challenge of complying with the PPACA's coverage mandate at costs that are amenable to running a viable and profitable business.<sup>3</sup> One way employers can control rising healthcare costs is to become more hands-on in how they provide options for care to employees.<sup>4</sup>

This paper will discuss the model of employer-provided, onsite health clinics, their role in expanding affordable access to primary care, and their ability to do so best when they utilize lower-cost nurse practitioners (NPs) instead of physicians.<sup>5</sup> An NP's scope of practice involves not only managing employee health risks, but also focusing on long-term health and

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1. HA T. TU ET AL, THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WORKPLACE CLINICS: A SIGN OF GROWING EMPLOYER INTEREST IN WELLNESS (Res. Brief No. 27, 2010), available at <http://www.hschange.com/CONTENT/1166/1166.pdf>.

2. *Id.*

3. *Id.*

4. *Id.*

5. Onsite health clinic used interchangeable with onsite medical clinic in this paper; sources use the terms interchangeably.

prevention of costly medical care down the line.<sup>6</sup> Part II explains the origin and history of onsite health clinics, while Part III describes why onsite clinics are gaining ground in this era of reform. Parts IV, V and VI offer an argument for why NPs are the better onsite health clinic cornerstone moving forward. Ultimately, with expanded scope of practice for NPs, employer-provided onsite health centers are a viable option to meet employer needs, and work best when they utilize NPs instead of physicians.

## II. WHY ONSITE HEALTH CLINICS

Large-scale employers demand that their insurance providers assume more responsibility for providing care options that better engage employees in good health practices and more comprehensive management of their health conditions.<sup>7</sup> One option for employers who have large coverage plans is to bring providers to the office with an onsite health clinic.<sup>8</sup> These health clinics involve health management services that broadly encompass wellness programs, biometric screenings, condition management, and support for onsite wellness centers or clinics.<sup>9</sup> Several onsite health centers utilize physicians, while others utilize NPs.<sup>10</sup>

Regardless of what model an employer chooses, employers today cite four reasons for choosing to build onsite medical clinics: 1) attracting high-quality workers, 2) cost savings, 3) quality, and 4) workplace safety and

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6. TU ET AL, *supra* note 1, at section 6.

7. Randall Abott & Christine Egan, *Health Plan Vendor Selection in a Post-Reform World: An Updated View*, 27 No. 2 J. OF COMPENSATION & BENEFITS ART 2.

8. See Paula Santonocito, *More Employers Offer Onsite Health-Care Facilities*, 24 No. 17 EMP. ALERT 3, Aug. 9, 2007. Onsite health clinics help employees take responsibility for their health emphasize wellness and condition management; help manage conditions such as diabetes and high blood pressure – resulting in greater productivity and higher employee satisfaction, reduce health care costs. . .onsite health clinics vary in size and services offered, but a full-service clinic generally has physicians on staff, physician’s assistants and nurses, as well as pharmacy services.

9. *Id.*

10. TU ET AL, *supra* note 1, at section 6.

risk management concerns.<sup>11</sup> Employees also benefit, despite potential concerns for the intermingling between work and possibly sensitive and private personal health care.<sup>12</sup> In the past, organizations hesitated to open an onsite health center out of concern that it might be perceived as an intrusion into employees' personal health information.<sup>13</sup> However, employees are becoming more comfortable with health care delivered at their worksite because the benefits outweigh the risk of intrusion.<sup>14</sup>

Achieving a successful onsite health clinic model that wins employee trust is dependent upon the ability to recruit and retain quality providers.<sup>15</sup> NPs bolster an onsite clinic's ability to win employee trust by delivering primary care, as NPs often take the lead in innovative primary care models such as onsite health clinics.<sup>16</sup> Further, the recent shortage of physicians, especially primary care physicians, represents a barrier to establishing successful onsite health clinics, and further highlights a benefit of NP-backed models.<sup>17</sup> Studies repeatedly show that NPs' contribution to high-

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11. Maureen Minehan, *Onsite Health Clinics: Factors that Make 'em or Break 'em*, EMP. ALERT, Aug. 23, 2007, at 1.

12. TOWERS WATSON, 2012 ONSITE HEALTH CENTER SURVEY REPORT 2 (2012), available at <http://www.towerswatson.com/en/Insights/IC-Types/Survey-Research-Results/2012/07/Onsite-Health-Center-Survey-2012>.

13. *Id.* See also Maureen Glabman, *Employers Move Into Primary Care*, Managed Care, June, 2009 (some workers could be deterred from seeking care at a company clinic because of privacy considerations if they perceive that clinicians are working only in the company's interest and not in the interest of employee health).

14. TOWERS WATSON, *supra* note 12, at 2. A significant number of employers intend to offer health services onsite, indicating that organizations believe their employees are becoming comfortable with health care delivered at the worksite; ninety-one percent of companies surveyed with an onsite health center say they offer or plan to offer biometric screening onsite and sixty-one say they provide or plan to provide counseling onsite. *Id.* Ultimately, easy access to care, and careful privacy provisions might assuage any concerns employees have over privacy at the workplace). *Id.*

15. TU ET AL, *supra* note 1 (particularly challenging for areas with provider shortages).

16. *Id.*

17. Mark Naylor and Ellen Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 HEALTH AFFS. 893, 894 (May 2010). The number of medical students and residents entering primary care or pursuing careers in general internal medicine or family practice is steadily declining. *Id.* While at the same time, the nation is benefiting from the relative growth among nurse practitioners (per capita supply is expected to increase annually by an average of nine percent). *Id.*

quality patient outcomes in primary care are often equivalent to that of physicians who see patients in a primary-care setting.<sup>18</sup> Further, patients seeing NPs are more satisfied because they enjoy longer consultation time with the provider, and have more tests administered than when a physician provides care.<sup>19</sup>

### III. THE RETURN OF THE COMPANY “DOCTOR”

Though the onsite health clinic model falls nicely in line with the PPACA-influenced trends of convenience, access, wellness and prevention, onsite health clinics are not a new concept.<sup>20</sup> Traditionally, they existed in the manufacturing and mining industries to treat occupational injuries and minor illnesses that arose on the job.<sup>21</sup> The recent uptick in onsite health clinics, however, stems from a focus on health promotion, wellness and primary care services, rather than occupational or convenience care.<sup>22</sup> Today, onsite health clinics provide a variety of services, including flu shots, screenings, preventative and urgent care, primary care, and more specialized areas such as onsite employee assistance programs, wellness counseling, and chronic condition management.<sup>23</sup> These are all services that NPs can provide in states where scope of practice laws are less restrictive, thus opening the door for clinics to use NPs to provide care in

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18. *Id.* Congressional Office of Technology Assessment (OTA) concluded that “within their areas of competence, nurse practitioners. . .who quality is equivalent to that of care provided by physicians.”

19. *Id.* at 895. Nurse practitioners also provide better results on measures of patient follow-up, consultation time, satisfaction and the provision of screening, assessment and counseling are all important factors to making an onsite health clinic successful to improve employee health long term. *Id.*

20. TU ET AL, *supra* note 1, at Section 6.

21. Lori Thayer Oliphant & Cheryl Camin Murray, *Fit for an On-site Clinic*, HR MAG., Jan. 1, 2012, available at <http://www.shrm.org/publications/hrmagazine/editorialcontent/2012/0112/pages/0112legal.aspx>.

22. TU ET AL, *supra* note 1, at section 1.

23. TOWERS WATSON, *supra* note 12, at 2.

those states.<sup>24</sup>

Present-day onsite health clinics exist in an array of industries and communities, and are mostly undertaken by large, self-insured employers.<sup>25</sup> For instance, in 2008, Toyota Motor (Toyota) built an onsite medical center at its truck factory in San Antonio, Texas, managed by Walgreens' Take Care Health Systems division.<sup>26</sup> As of 2008, Walgreens' Take Care Health Systems division was the largest clinic vendor, with a list of clients including Disney World, Harrah's, and Sprint.<sup>27</sup> Walgreens' Take Care Health Systems operates clinics that use both NPs and physicians; however Toyota's clinic uses the physician-backed model.<sup>28</sup>

Toyota's San Antonio clinic treats around sixty percent of the location's staff; seven thousand employees and families use the clinic for primary care.<sup>29</sup> Toyota's nine million dollar project includes a 20,000 square foot health center with twenty-two exam rooms, blood-draw laboratory, digital radiology, and a high-volume pharmacy dispensing up to 200 prescriptions daily.<sup>30</sup> The Toyota clinic utilizes a physician-backed model, and has the ability to take x-rays, treat broken bones, and handle various emergencies that arise without referring patients to specialists outside the clinic.<sup>31</sup>

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24. Naylor and Kurtzman, *supra* note 17, at 896.

25. TU ET AL, *supra* note 1, at section 1.

26. David Welch, *Health-Care Reform, Corporate-Style*, Bloomberg Businessweek, Jul. 28, 2008, available at <http://www.businessweek.com/stories/2008-07-28/health-care-reform-corporate-style>.

27. Maureen Glabman, *Employers Move Into Primary Care*, Managed Care, June, 2009.

28. Zachary Wilson, *Why Walgreens is Building its own Universal Health-care System*, FAST COMPANY, Jul. 1, 2009, available at <http://www.fastcompany.com/1298100/why-walgreens-building-its-own-universal-health-care-system>. "Walgreen's Take Care Health Systems is now known as Walgreens Health and Wellness Division also operates the retail clinics that are found in Walgreens stores and open to the public. Walgreen's Work-site centers can feature amenities such as x-ray facilities, a pharmacy, and a fitness center. Some have full-time primary care physicians, while others do not. Toyota's clinic has dental care. (San Antonio facility provides about 60% of all primary-care visits for employees and their families.)"

29. Welch, *supra* note 26.

30. Glabman, *supra* note 27.

31. Welch, *supra* note 26; Glabman, *supra* note 27.

Though Toyota's clinic employs physicians, physician-provided care is not a necessary boon for the quality of primary care that employers benefit from in providing onsite clinics.<sup>32</sup> Texas happens to be one of the most restrictive states in terms of granting broad NP scope of practice, as its laws require Texas employers with onsite health clinics to employ a supervising physician.<sup>33</sup> States with less restrictive scope of practice laws allow clinics to provide the same type of care without employing a physician; doing so does not lower quality of care, and employers enjoy overall lower operation costs.<sup>34</sup>

#### IV. THE ONSITE TREND CONTINUES TO GROW

As demonstrated in the Toyota onsite clinic example, employer health plan sponsors are increasingly in search of an all-inclusive solution to health benefit services and health management services.<sup>35</sup> In the fast-changing environment of healthcare reform where industry players are striving to lower costs, onsite medical clinics help employers achieve organizational health goals.<sup>36</sup> When clinics take advantage of lower-cost NPs<sup>37</sup> as opposed to physicians to provide primary care, where state laws allow, they are even more attractive to employers.<sup>38</sup>

While estimates vary as to how many companies currently offer onsite medical centers, a 2008 study indicated that thirty-one percent of employers

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32. Ben Fischer, *All Claims Considered: NPR hopes Onsite Clinic Cuts Insurance Costs*, WASH. BUS. J., APR. 24, 2013, available at <http://www.bizjournals.com/washington/blog/2013/04/all-claims-considered-npr-hopes.html>.

33. Mary Katherine Stout, *COMPARING STATE REGULATION OF NURSE PRACTITIONERS* (Texas Public Policy Foundation, eds., 2007), available at <http://www.texaspolicy.com/center/health-care/reports/comparing-state-regulation-nurse-practitioners>.

34. Naylor and Kurtzman, *supra* note 17, at 895. The average cost of a nurse practitioner visit is twenty to thirty-five percent lower than the average cost of a physician visit. *Id.*

35. Randall Abott & Christine Egan, *supra* note 7.

36. TU ET AL, *supra* note 1

37. Naylor and Kurtzman, *supra* note 17, at 895.

38. TOWERS WATSON, *supra* note 12, at 1.

with 500 or more employees offer such centers, and thirty-three percent of employers with 20,000 employees or more offer onsite clinics.<sup>39</sup> This trend is growing, and could be more prevalent if more onsite clinics utilize NPs as scope of practice laws change.<sup>40</sup>

Onsite clinics work because employers want to focus on preventative medicine in an effort to keep productivity high.<sup>41</sup> Employers want clinics to help employees avoid problems that are expensive to treat, yet are responsible for high rates of absenteeism, like diabetes, hypertension and heart conditions.<sup>42</sup> Onsite clinics are especially beneficial to employees where the holistic approach to patient health and a broad scope of NP services are offered to promote wellness and disease management and prevention.<sup>43</sup>

#### V. THE NURSE PRACTITIONER IS IN

Onsite clinics are most successful when the center integrates services to provide holistic care.<sup>44</sup> Consider an example in which a fifty-eight-year old male employee arrived at an onsite clinic complaining of chronic back pain.<sup>45</sup> In addition to treating that pain, onsite health clinic providers discovered that he was a smoker, hospitalized twice in the past year.<sup>46</sup> By integrating all of the clinic's health management offerings, the onsite center

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39. Patty Murphy, *Onsite Health Clinics: Who Should Consider Them?*, HNI, Aug. 21, 2013, available at [http://hni.com/blog/bid/86379/Onsite-Health-Clinics-Who-Should-Consider-Them?\\_\\_hstc=243918234.c9ce4aa81a7ab405f6fe91a42c9c5e1a.1386709726869.1386709726869.1&\\_\\_hssc=243918234.1.1386709726869&\\_\\_hsfp=439197974](http://hni.com/blog/bid/86379/Onsite-Health-Clinics-Who-Should-Consider-Them?__hstc=243918234.c9ce4aa81a7ab405f6fe91a42c9c5e1a.1386709726869.1386709726869.1&__hssc=243918234.1.1386709726869&__hsfp=439197974).

40. Naylor and Kurtzman, *supra* note 17, at 896.

41. Welch, *supra* note 26. .

42. *Id.*

43. TOWERS WATSON, *supra* note 12, at 3. "More than fifty percent of companies surveyed with onsite medical centers currently allow or are planning to allow spouses of employees to use their centers and forty-six percent currently allow or are planning to allow their children to use them. . .expansion as indication that employers and employees consider the onsite centers to be particularly valuable and successful." *Id.*

44. Minehan, *supra* note 11.

45. *Id.*

46. *Id.*

was able to manage his chronic pain, provide information on preventative care and exercise, refer him for a vocational assessment for a possible job transfer, and finally, discuss nicotine replacement and smoking cessation options.<sup>47</sup> Discovering the causes of various illnesses, in addition to managing care and monitoring employee health in a way that utilizes close proximity, convenience, and long-standing relationships, allows an employer to retain a more productive and healthier workforce.<sup>48</sup> All of these tasks fall under the scope of services that a traditional nurse practitioner provides.<sup>49</sup>

National Public Radio (NPR) recently devoted several thousand square feet on its ground floor to the wellness and health care of its 650 employees in April 2013.<sup>50</sup> NPR's onsite clinic grew out of expanding its partnership with its insurer, Cigna; Cigna supplies resources and manages the onsite clinic while also maintaining its role as the primary insurance provider for employees.<sup>51</sup> An NP staffs two exam rooms, and services are free to any benefits-eligible employee.<sup>52</sup> NPR is still estimating the clinic's benefits in its early stages, but it estimates that it will save \$390,000 in insurance costs over the next three years by avoiding lost work time, switching prescriptions from name-brand to generics at the clinic, and making it easier for workers to stay ahead of illness or disease.<sup>53</sup>

The new NPR clinic is fully NP-staffed, unlike the earlier example of Toyota's physician-backed clinic.<sup>54</sup> However, NPR's onsite health clinic is located in an area where NPs enjoy the least amount of regulatory

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47. *Id.*

48. Oliphant and Murray, *supra* note 21.

49. Naylor and Kurtzman, *supra* note 17, at 893.

50. Fischer, *supra* note 32.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*



oversight, making it possible for NPs to provide primary care independently, and for employees to get the range of care they would expect from a primary care physician.<sup>55</sup>

## VI. CONCLUSION

As the different pieces of the PPACA rollout come into play, employers will continue to make changes to the way they offer care to employees. Worksite health clinics that focus on comprehensive primary care and wellness can do so through either a physician-backed or NP-backed model.<sup>56</sup>

Ultimately, it will be most beneficial to employers to develop NP-backed onsite health clinics so that their employees can access holistic care at a lower cost, with greater satisfaction and accessibility. Further, there is an abundance of evidence that supports passing new state legislation that allows NPs to contribute more towards patient primary care; establishing onsite health clinics is an arena where this could play out to the benefit of employers and employees.<sup>57</sup>

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55. Stout, *supra* note 33. District of Columbia permits fully independent practice and prescriptive authority for nurse practitioners, no provision for physician collaboration or oversight. *Id.* Contrast this to Texas, where regulations impose restrictions on nurse practitioners from working at a site without a physician on the premises at least twenty percent of the time. *Id.*

56. TU ET AL, *supra* note 1, at section 6.

57. Naylor and Kurtzman, *supra* note 17, at 896.

Why the Use of Telemedicine can Alleviate the  
Burden of Current Scope of Practice Norms  
for Nurse Practitioners and the Primary Care  
Shortage in the United States

*Tyler Hanson\**

I. INTRODUCTION

As changes to health care mandated by the Patient Protection and Affordable Care Act (PPACA) begin to come to fruition, questions of how to deliver care continue to arise because of the increasing shortage of primary care physicians.<sup>1</sup> The United States expects an additional twenty-four million citizens to join Medicaid by 2016 under the expansion put in place by the PPACA.<sup>2</sup> Already plagued with a shortage of primary care physicians, leaders in health care are increasingly utilizing the expertise of other care providers, including nurse practitioners, to delivery primary care.<sup>3</sup> However, nurse practitioners in many states are burdened with scope of practice laws, which prevent them from being able to efficiently provide care to patients without the close monitoring of a licensed physician.<sup>4</sup>

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1. Jason Fodeman, *The New Health Law: Bad News for Doctors, Awful for Patients*, THE INST. FOR HEALTHCARE CONSUMERISM, [http://www.theihcc.com/en/communities/policy\\_legislation/the-new-health-law-bad-for-doctors-awful-for-patie\\_gn17y01k.html](http://www.theihcc.com/en/communities/policy_legislation/the-new-health-law-bad-for-doctors-awful-for-patie_gn17y01k.html) (last visted Dec. 12, 2013).

2. CTR. FOR MEDICARE & MEDICAID SERS., DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID PROGRAM; ELIGIBILITY CHANGES UNDER THE AFFORDABLE CARE ACT OF 2010 (2012) 1, 11, *available at* [http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule\\_Regulatory-Impact-Analysis.pdf](http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule_Regulatory-Impact-Analysis.pdf).

3. *See generally* Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235 (2009-2010).

4. *Id.* at 1245-46.

Some states with restrictive scope of practice laws, prevent nurse practitioners from being able to deliver care without close collaboration, and therefore further hinder their ability to reduce the primary care shortage in the United States.

In the midst of this dilemma, more innovative providers in health care consider using advancing technology as a helpful resource in finding a solution to the primary care shortage. Telemedicine is defined as the use of electronic communication and information technology to provide or assist clinical care at a distance.<sup>5</sup> Telemedicine is considered a viable platform for delivering health care to patients in need.<sup>6</sup> The use of this innovative technology can remedy the primary care shortage that will only continue to grow as the PPACA's Medicaid expansion is fully implemented. Coupled with the use of nurse practitioners, telemedicine is a delivery system that can expand access to primary care in anticipation of the dramatic increase in Medicaid patients entering the healthcare market beginning in 2014.

This article will discuss how the combined use of nurse practitioners and telemedicine is a solution to addressing the needs of newly insured individuals. Part II of this article discusses some of the impending changes to health care with the implementation of the PPACA. Part III of this article discusses how nurse practitioners are utilized to fill in the primary care gaps in the United States and why they are an important resource. Part IV discusses some of the obstacles that many nurse practitioners face due to overly restrictive scope of practice laws. Part V defines telemedicine and provides background on its successful uses. Finally, Part VI discusses how nurse practitioners can utilize telemedicine to expand primary care access to

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5. Amy E. Zilis, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, U. Ill. J.L., TECH. & POL'Y. 193, 196 (Vol. 2012).

6. *Id.* at 203-208.

meet the needs of the United States' patient population and its expected increase of Medicaid patients.

## II. CHANGES UNDER THE PPACA THAT WILL FURTHER AFFECT PRIMARY CARE ACCESS

The PPACA became law on March 23, 2010, in an attempt to solve many of the current issues plaguing the United States' healthcare system.<sup>7</sup> Some of its many objectives are to increase access to health care for individuals who could not previously afford healthcare coverage, lower healthcare costs, and improve the quality of care delivered to patients.<sup>8</sup> The passing and subsequent upholding of the PPACA is controversial in both the legal and healthcare fields; it has sparked debate about the individual mandate, PPACA's coverage of controversial women's health issues, and the cumbersome transition process it is predicted to bring.<sup>9</sup>

In 2014, the Medicaid program will expand to include populations that were previously ineligible for coverage under Medicaid.<sup>10</sup> Traditionally, Medicaid was a program that provided medical coverage for a very specific group of people: children, pregnant women, some parents of Medicaid-eligible children, and seniors, who met a certain income requirements.<sup>11</sup> After the PPACA is completely implemented in 2014, Medicaid eligibility will expand to include all citizens with an income up to 133 percent of the

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7. Zilis 2012, *supra* note 44 at 197.

8. CTR. FOR MEDICARE & MEDICAID SERVS., ASSURING ACCESS TO AFFORDABLE COVERAGE: MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM FINAL RULE (2012), *available* at <http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidCHIP-Eligibility-Final-Rule-Fact-Sheet-Final-3-16-12.pdf>.

9. Roy G. Spece, Jr., *Constitutional Attacks Against the Patient Protection and Affordable Care Act's "Mandating" That Certain Individuals And Employers Purchase Insurance While Restricting Purchase By Undocumented Immigrants and Women Seeking Abortion Coverage*, 38 N. KY. L. REV. 489, 497-98 (2011).

10. CTR. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 1 at 11.

11. *Id.* at 5.

federal poverty line.<sup>12</sup> By 2016, it is estimated that an additional twenty-four million people will be enrolled in Medicaid.<sup>13</sup>

Opponents of the PPACA believe that an increased cost, a shortage of healthcare providers, and a drop in quality of care will accompany the new spike in patients seeking basic medical treatment under the Medicaid expansion.<sup>14</sup> Many of the individuals that will be newly eligible for Medicaid coverage under the PPACA are the same individuals that typically avoided primary care appointments because they could not afford to visit a doctor solely for preventative care. This expansion in coverage, along with the individual mandate, will provide this large group of previously uninsured individuals the opportunity to receive general checkups, preventive screenings, and early diagnoses.<sup>15</sup> Previously uninsured individuals will also be able to monitor their health conditions with the help of a care provider.<sup>16</sup> With the upcoming influx of new individuals that will have access to preventive and primary care services under the PPACA, experts in the health fields are debating about how the increase in needed care will be delivered.<sup>17</sup> The use of telemedicine coupled with skilled nurse practitioners can provide this much needed care

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12. *Id.* at 7. Individuals must also meet citizenship requirements and must be under the age of 65. *Id.*

13. *Id.* at 11.

14. Fodeman, *supra* note 1, [http://www.theihcc.com/en/communities/policy\\_legislation/the-new-health-law-bad-for-doctors-awful-for-patie\\_gn17y01k.html](http://www.theihcc.com/en/communities/policy_legislation/the-new-health-law-bad-for-doctors-awful-for-patie_gn17y01k.html). (last visited Dec. 12, 2013).

15. See CTR. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID PROGRAM; ELIGIBILITY CHANGES UNDER THE AFFORDABLE CARE ACT OF 2010 (March 2012), [http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule\\_Regulatory-Impact-Analysis.pdf](http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule_Regulatory-Impact-Analysis.pdf).

16. See CTR. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID PROGRAM; ELIGIBILITY CHANGES UNDER THE AFFORDABLE CARE ACT OF 2010 (March 2012), 4-6, [http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule\\_Regulatory-Impact-Analysis.pdf](http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule_Regulatory-Impact-Analysis.pdf).

17. Fodeman, *supra* note 1, [http://www.theihcc.com/en/communities/policy\\_legislation/the-new-health-law-bad-for-doctors-awful-for-patie\\_gn17y01k.html](http://www.theihcc.com/en/communities/policy_legislation/the-new-health-law-bad-for-doctors-awful-for-patie_gn17y01k.html). (last visited Dec. 12, 2013).

effectively.

### III. NURSE PRACTITIONERS AND SCOPE OF PRACTICE

Due to the shortage of primary care physicians, nurse practitioners are currently utilized as a quality source of primary care for patients.<sup>18</sup> While the number of practicing physicians was only increasing at an annual rate of 1.17% in 2008, the number of practicing nurse practitioners increased at 9.5%.<sup>19</sup> Nurse practitioners are registered nurses that have completed additional schooling and clinical training beyond a traditional nursing degree.<sup>20</sup> Nurse practitioners are afforded more responsibilities than registered nurses, including, but not limited to, the ability to diagnose conditions, treat health conditions, order and interpret x-rays and other diagnostic tests, prescribe medications, and administer immunizations.<sup>21</sup> Additionally, a licensed nurse practitioner can choose to specialize his or her practice and become further trained in a variety of specialties ranging from pediatrics to oncology.<sup>22</sup> Although nurse practitioners have expert credentials and are afforded great responsibilities, they are still stifled by state scope of practice laws.<sup>23</sup> These restrictions burden nurse practitioners,

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18. Hansen-Turton 2010, *supra* note 3 at 1244 (“A 2000 study found that physicians and nurse practitioners practicing in community-based primary care clinics achieved similar patient outcomes when the nurse practitioners employed a medical mode of care and had the same degree of authority.”).

19. Hansen-Turton et al. 2010, *supra* note 3 at 1240.

20. *Id.* at 1243. Nurse practitioners typically have either a master’s degree and some have even earned doctorates in the field of nursing. *Id.*

21. *Id.* at 1243-44. Additionally nurse practitioners can provide prenatal care, childcare, family planning services, gynecological services, and perform physical examinations. *Id.*

22. AM. MED. ASS’N, AMA SCOPE OF PRACTICE DATA SERIES: NURSE PRACTITIONERS, 55-57 (2009) available at <http://www.aanp.org/images/documents/state-leg-reg/08-0424 SOPNurseRevised%2010-09.pdf> (“Today NPs specialize in such areas as acute care pediatrics, cardiology, critical care, diabetes management, dermatology, emergency medicine, home health, holistic nursing, gastroenterology, long-term care, neonatology, nephrology, neuroscience, occupational health, oncology, psychiatrics and mental health, school health, surgery and wound, ostomy, and continence care.”).

23. 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

despite studies that show nurse practitioners produce similar or equal patient outcomes as licensed primary care physicians.<sup>24</sup>

Generally, scope of practice laws define a particular practice or profession. These laws create boundaries and limit the practice of that profession to individuals who have acquired certain credentials, completed required training, or passed specific examinations.<sup>25</sup> The correct scope of practice boundaries for nurse practitioners is greatly debated.<sup>26</sup> Proponents of strict scope of practice laws want to severely limit what care nurse practitioners can provide for a patient, leaving the practice of medicine and the medical community inherently reliant on physicians.<sup>27</sup> Opponents, on the other hand, argue that the scope of practice of nurse practitioners should be expanded to increase access for patients and to decrease overall costs.<sup>28</sup> These opponents also focus on potential quality of care issues, a decrease in physician salaries, and the need for collaborative agreements when utilizing nurse practitioners for primary care services.<sup>29</sup>

Those that argue for an expanded scope of practice for nurse practitioners believe that the use of advanced practice nurses is an answer for the shortage in primary care physicians and general lack of access to

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(2002).

24. Hansen-Turton 2010, *supra* note 3 at 1244 (“A 2000 study found that physicians and nurse practitioners practicing in community-based primary care clinics achieved similar patient outcomes when the nurse practitioners employed a medical mode of care and had the same degree of authority.”).

25. Safriet 2002, *supra* note 24 at 206.

26. *Id.*

27. See AM. MED. ASS’N, AMA SCOPE OF PRACTICE DATA SERIES: NURSE PRACTITIONERS, 55-57 (2009), available at <http://www.aanp.org/images/documents/state-leg-reg/08-0424SOPNurseRevised%2010-09.pdf>.

28. Safriet 2002, *supra* note 25, at 323. Opponents to strict scope of practice laws want restrictions lifted off of practitioners so that they can provide more care and opponents also want the medical field to evolve into one that allows overlaps among different medical professionals. *Id.* Simplifying scope of practice and obtaining a greater understanding of professional roles will give consumers more options for care, increase mobility of providers, and will optimally utilize healthcare resources available in the United States. *Id.*

29. *Id.* at 323.

health care.<sup>30</sup> This year, the World Health Organization found that there are only twenty-four physicians for every 10,000 people in the United States.<sup>31</sup> Not only is there an overall shortage of licensed physicians in the United States, but there is an even greater shortage of primary care physicians.<sup>32</sup> In 2008, a survey of medical students revealed that only two percent of medical school graduates aimed to become a primary care physician.<sup>33</sup> This statistic is not shocking considering the dramatic difference in earnings of a primary care physician compared to that of a physician who chooses specialize in a particular field.<sup>34</sup> There are a higher number of advanced practice nurses entering into the workforce compared to physicians, and their salaries are lower than physicians, allowing them to charge less for services.<sup>35</sup> Nurse practitioners not only provide more primary care supply, but they can do so at a lower cost.

Today, the majority of states require a collaborative agreement between a nurse practitioner and a physician in order for a nurse practitioner to provide care to patients.<sup>36</sup> Through these agreements, a nurse practitioner is required to meet with a physician to have his or her work reviewed, to ensure that certain protocol is followed, and to get approval to write prescriptions.<sup>37</sup> The intensity of this relationship varies from state to state;

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30. See generally Hansen-Turton et al. 2010, *supra* note 3 at 1235-1262.

31. WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS 2013, at 126 (2013), available at [http://www.who.int/gho/publications/world\\_health\\_statistics/EN\\_WHS2013\\_Part3.pdf](http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Part3.pdf).

32. Hansen-Turton et al. 2010, *supra* note 3, at 1238.

33. *Id.* at 1239 (citing Karen Hauer et al., *Factors Associated with Medical Students' Career Choices Regarding Internal Medicine*, 300 JAMA 1154, 1157 (2008)).

34. *Id.* at 1238. The median income for a specialized doctor is about two times the salary of a primary care physician; this is a figure that continues to increase. Thomas Bodenheimer, *Primary Care-Will It Survive?*, NEW ENG. J. MED. 861, 862 (2006).

35. *Id.* at 1240; Stephanie Gunselman, *The Conrad "State-30" Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain?*, 5 J. HEALTH & BIOMEDICAL L. 93, 110 (2009).

36. Hansen-Turton et al. 2010, *supra* note 3 at 1245.

37. Ann Ritter, et al., *The Primary Care Paradigm Shift: An Overview of the State-Level*



some states require more frequent and in-depth reviews than others.<sup>38</sup> Twenty-five states prohibit a nurse practitioner from writing a prescription for a patient without the consent of a collaborating physician.<sup>39</sup> Some states even restrict the scope of practice of nurse practitioners to certain practice sites, areas, and facilities.<sup>40</sup>

Complying with these types of standards can be especially difficult for a nurse practitioner that is treating patients in a rural area or in other situations where physician oversight is not readily accessible. Restrictive scope of practice laws can hinder the ability to utilize nurse practitioners as primary care providers while the United States continues to experience a shortage in primary care physicians.<sup>41</sup> Although scope of practice laws for nurse practitioners are seemingly contradictory to the government's goal of improving access to health care, the use of telemedicine is a tool that can mitigate these laws' negative effects while providing the supervision the laws aim to achieve. Telemedicine gives healthcare providers the ability to communicate, share records, provide feedback, and see test results quickly, making it a viable tool to alleviate scope of practice issues.

#### IV. WHAT IS TELEMEDICINE AND CAN IT HELP?

Telemedicine is defined as the use of electronic communication and information technologies to provide or support clinical care at a distance.<sup>42</sup> Telemedicine gives a healthcare provider the ability to consult with patients, diagnose disease, deliver treatment, conduct examinations, review

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*Legal Framework Governing Nurse Practitioner Practice*, 20 THE HEALTH LAW., 21, 23-25 (April 2008).

38. *Id.* at 23.

39. *Id.* at 24.

40. Safriet 2002, *supra* note 25 at 314.

41. *Id.*

42. Zilis 2012, *supra* note 44, at 196.

patient records, and watch live radiology scans from a remote location.<sup>43</sup>

Since the late 1950's,<sup>44</sup> telemedicine has been successfully implemented by university hospitals to help deliver quality care,<sup>45</sup> by the United States Department of Justice for inmate care, and in impoverished countries around the world to reach patients in rural areas.<sup>46</sup> In 1959, the University of Nebraska was one of the first entities to successfully use telemedicine.<sup>47</sup> It did so by utilizing a closed-circuit television to deliver care and educate at a distance.<sup>48</sup> In the 1960's, the National Aeronautics and Space Administration (NASA) developed its own telemedicine system, specifically designed to monitor the health of astronauts while in space.<sup>49</sup> NASA continued to develop its telemedicine use and subsequently used it to deliver health care to Arizona's rural Papago Indian Reservation.<sup>50</sup> The use of telemedicine began to facilitate remote surgeries in 2001, when a surgeon stationed in New York performed a gallbladder surgery on a patient in Strasbourg, France.<sup>51</sup> Today, the use of telemedicine continues to advance and gain acceptance; it is now a healthcare method that is reimbursable by government health programs.<sup>52</sup>

The use of telemedicine is successfully used in several different

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43. *What is Telemedicine?* AM. TELEMEDICINE ASS'N, <http://www.americantelemed.org/learn> (last visited Oct. 27, 2013).

44. Zilis 2012, *supra* note 5 at 197.

45. *Id.* at 203-08.

46. Paul Spradley, "Telemedicine: The Law Is the Limit", 14 TUL. J. TECH. & INTELL. PROP. 307, 308 (2011).

47. Zilis 2012, *supra* note 44, at 196.

48. *Id.* at 196 (quoting William J. Crump, *A Telemedicine Primer: An Introduction to the Technology and an Overview of the Literature*, 4 ARCH. FAM. MED. 796, 797 (Sept. 1995), available at <http://archfami.ama-assn.org/cgi/reprint/4/9/796.pdf>).

49. Spradley 2011, *supra* note 46 at 310.

50. *Id.* The project, known as STARPHAC (Space Technology Applied to Rural Papago Advanced Health Care), was a collaboration of NASA and the Department of Health, Education, and Welfare. It utilized a van equipped with medical equipment and two native paramedics to deliver care to patients with the help of telemedicine. *Id.*

51. *Id.* at 313.

52. Zilis 2012, *supra* note 44 at 196.

environments and is praised for its ability to deliver quality care to developing countries that would not otherwise have access to specialized medicine.<sup>53</sup> California applies this benefit of telemedicine by using it to deliver care to rural California residents.<sup>54</sup> California successfully connects specialized physicians at the University of California Davis Medical Center with general physicians at over 170 clinics and hospitals in rural areas of the state.<sup>55</sup>

V. HOW THE USE OF TELEMEDICINE CAN TRANSFORM  
THE CARE DELIVERED BY A NURSE PRACTITIONER DESPITE  
SCOPE OF PRACTICE REGULATIONS

Providing nurse practitioners the ability to deliver primary care to patients, with remote supervision of a physician can result in greater access to care, while satisfying a nurse practitioner's scope of practice requirements. Imagine an all-nurse practitioner primary care practice comprised of three to four practitioners who provide traditional primary care services to patients. This facility is able to meet its state's scope of practice requirements because it is connected to a licensed physician who is able to remotely monitor the work of the practitioners at this site. Physicians involved in this type of off-site collaborative agreement are able to monitor several practices, vastly increasing the amount of nurse practitioners delivering care to patients in need. Through use of this model, nurse practitioners will be able to efficiently utilize their skills and in turn

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53. See generally Nancy Lugan, *A Piece of the Puzzle: Telemedicine as an Instrument to Facilitate the Improvement of Healthcare in Developing Countries?*, 18 EMORY INT'L. L. REV. 151, 151-189. (2004).

54. Zilis 2012, *supra* note 44, at 203-05.

55. *Id.* at 204. Other successful uses of telemedicine include Illinois' Children's Memorial Hospital's telecardiology department, which delivers the care of its congenital heart specialists to other hospitals in the state which do not have the same access to those types of specialized experts. *Id.* Telemedicine is even successful in state prisons, where physicians can provide care to prisoners with more safety at a lower cost than traditional delivery of care. *Id.*

deliver care efficiently and cost-effectively. This technology driven model will allow nurse practitioners to be supervised by a licensed physician and will conform to the requirements of states' collaborative agreements.

Adopting a system that relies more heavily on nurse practitioners and telemedicine to deliver primary care can help transform the United States' healthcare system into one with enough healthcare providers to adequately serve the current population, and even accommodate the new influx of patients to come. In order to successfully serve the current population seeking primary care services and the additional twenty-four million expected to join the Medicaid program by 2016, the United States should utilize nurse practitioners through telemedicine. This method would help alleviate the primary care physician shortage of 66,000 that is predicted to be in the United States by 2025.<sup>56</sup> Similar models of care such as retail health clinics have utilized nurse practitioners and telemedicine on a smaller scale and are successful in delivering quality care and expanding access to care.<sup>57</sup>

## VI. CONCLUSION

The PPACA will bring many changes to the healthcare system including the addition of millions of individuals that will need primary care services.<sup>58</sup>

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56. STEPHEN ISAACS & PAUL JELLINEK, THE PHYSICIANS FOUNDATION, ACCEPT NO SUBSTITUTE: A REPORT ON SCOPE OF PRACTICE, 41 (2012).

57. See generally Kristin E. Schlieter, *Retail Medical Clinics: Increasing Access to Low Cost Medical Care Amongst a Developing Legal Environment*, 19 ANNALS HEALTH L. 527 (2009-2010). Non-traditional "retail medical clinics" are used to provide lower cost care to patients who may not have access to a primary care physician. *Id.* The model utilizes nurse practitioners and physicians assistants to deliver care with the supervision of a licensed physician. *Id.* They provide care to a limited number of common medical conditions in an easy, quick, convenient way by setting up practice in retail stores and providing more "transparent pricing." *Id.*

58. CTR. FOR MEDICARE & MEDICAID SERS., DEP'T OF HEALTH AND HUMAN SERVS., MEDICAID PROGRAM, *supra* note 2, at 11, available at [http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule\\_Regulatory-Impact-Analysis.pdf](http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidEligibilityFinalRule_Regulatory-Impact-Analysis.pdf)

With the growing shortage of primary care physicians, the new Medicaid population will only exacerbate this problem unless new measures are put in place to delivery a greater supply of primary care. In order to counteract this influx of patients, there needs to be a viable solution to the physician shortage to assure a smooth transition into the new health system mandated by the PPACA. The combined use of nurse practitioners and telemedicine is a likely solution.

Changes in states' nurse practitioner scope of practice laws already expanded the profession's healthcare responsibilities.<sup>59</sup> However, there is a continued restriction on a nurse practitioner's independence in delivering care that prevents the United States from taking full advantage of their education and skills. To alleviate the problems caused by nurse practitioners' lack of independence in the healthcare community, the use of telemedicine can open the door for nurse practitioners to operate their own practices with the remote monitoring of a licensed physician. This healthcare delivery model will help close the primary care access gap and provide quality primary care to patients across the country. The ability for a physician to supervise groups of nurse practitioners off-site allows the amount of primary care being delivered to dramatically increase. For every primary care physician providing care to a set group of patients today, there could be a single physician in his or her place who is supervising several nurse practitioners off-site, monitoring their work and making sure that they are delivering quality care to a much larger group of patients. While expanding the scope of practice for nurse practitioners is ideal, there is great resistance from physician organization and other pro-regulation groups.<sup>60</sup> Taking complete advantage of the scope of practice for both physicians and

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59. This citation is empty

60. See generally AM. TELEMEDICINE ASS'N, *supra* note 22.

nurse practitioners, while successfully providing care to the incoming influx of patients is an accomplishable feat through the use of telemedicine.

Acupuncture Licensing and the Patient Protection  
and Affordable Care Act: An Opportunity for  
Greater Access to Alternative Medicine in  
America's Changing Healthcare System

*Katie Witham\**

I. INTRODUCTION

Over the past few decades, interest and demand for alternative medicine increased and continues to increase today.<sup>1</sup> Alternative medicine, including acupuncture, can no longer be considered a fleeting trend in the United States.<sup>2</sup> The Patient Protection and Affordable Care Act (PPACA) generated more discussion of the scope of alternative medical practice because it addressed important aspects of the practice and regulation of alternative medicine.<sup>3</sup> Although the PPACA affects the way states regulate alternative medicine, states may define practitioners' scopes of practice through licensing and the state essential benefits plan.<sup>4</sup> States currently take different approaches to acupuncture regulation.<sup>5</sup> The majority of states require licensing under the National Certification Commission for Acupuncture and Oriental Medicine's (NCCAOM) licensing board, while a

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1. Peter J. Van Hemel, *A Way Out of the Maze: Federal Agency Preemption of State Licensing and Regulation of Complementary and Alternative Medicine*, 27 AM. J.L. & MED. 329, 329 (2001).

2. *Id.*

3. Ankita Rao, *Affordable Care Act Boosts Status of Alternative Medicine – At Least On Paper*, Kaiser Health News (July 26, 2013), available at <http://www.kaiserhealthnews.org/stories/2013/july/26/alternative-medicine-boosted-from-health-law-on-paper.aspx>.

4. *Id.*

5. Van Hemel, *supra* note 1, at 334.

minority of states does not have a state licensing boards at all.<sup>6</sup>

Implementation of licensing boards using the NCCAOM in the six states<sup>7</sup> that do not currently have a licensing board as well as adherence to the legislative spirit of the PPACA's approach to alternative medicine may encourage increased access and legitimization of acupuncture and other alternative medicines in the United States. California is a model of a successful licensure program and legislature that encourages the growth of alternative treatment availability. This article will first give an overview of alternative medicine, followed by a discussion of the current state of acupuncture regulations, demonstrated by the legislative and medical trajectories of acupuncture over the past few decades, including resistance from physician organizations and governmental agencies. Subsequently, this article will discuss the implications of the PPACA for acupuncture and alternative medicine and the opportunity the PPACA creates for states to embrace alternative treatments. Finally, this article will contend that acupuncture licensing boards in every state and adherence to the legislative spirit of the PPACA would be a positive step for access and choice of treatment, citing California as a model for successful state facilitation of growth in access to alternative medicine.

## II. UNDERSTANDING ALTERNATIVE MEDICINE

Alternative treatments, or complementary and alternative medicine (CAM), encompass a variety of practices outside mainstream medicine.<sup>8</sup> These treatments are called complementary because they have not

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6. NCCAOM, 2013 NCCAOM JOB ANALYSIS; NUMBER OF ACUPUNCTURISTS PROVIDED BY STATE LICENSING BOARDS (2013), available at <http://www.nccaom.org/regulatory-affairs/state-licensure-map> (2013).

7. *States that Recognize NCCAOM Certification or Examination for Licensure*, NAT'L CERTIFICATION COMM'N FOR ACUPUNCTURE & ORIENTAL MED., <http://www.nccaom.org/regulatory-affairs/state-licensure-map> (last visited Dec. 7, 2013). (Alabama, North Dakota, Kansas, Oklahoma, South Dakota, Wyoming).

8. Van Hemel, *supra* note 1, at 330.



conventionally been a part of health care in the United States.<sup>9</sup> In contrast to traditional or allopathic medicine, which is based on scientifically researched treatments, alternative medicine takes a holistic approach integrating concepts of balance, energy, biology and other factors.<sup>10</sup> Alternative medical providers are a growing proportion of the healthcare field.<sup>11</sup> This growth is due to increased consumer demand for alternative care services.<sup>12</sup> Consumer demand in health care is driven by a variety of factors including personal and cultural treatment preferences, greater accessibility, and lower cost.<sup>13</sup> Many patients choose alternative care because they want to take a more holistic approach to their health rather than treating illness with more conventional medical interventions.<sup>14</sup>

Alternative medicine offers quality treatment;<sup>15</sup> alternative providers face proportionally fewer malpractice suits than physicians,<sup>16</sup> and a significant number of scientific studies attest to the effectiveness and safety of alternative treatment.<sup>17</sup> Alternative treatments, particularly acupuncture, which has been part of the Eastern tradition of medical treatment for 2,500 years, is often at least as time tested as conventional physician practices.<sup>18</sup>

Acupuncture is a traditional Chinese medicine.<sup>19</sup> The word acupuncture literally means to puncture with a needle and involves insertion of thin needles through the patient's skin on specific points along the meridians, or

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9. *Id.*

10. *Id.* at 331

11. Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273, 1274 (1996)

12. *Id.*

13. *Id.* at 1276.

14. *Id.* at 1280.

15. *Id.* at 1283.

16. *Id.* at 1281.

17. *Id.* at 1283-84.

18. WHO, ACUPUNCTURE: REVIEW AND ANALYSIS OF REPORTS ON CONTROLLED CLINICAL TRIALS 1 (2003), available at <http://apps.who.int/medicinedocs/pdf/s4926e/s4926e.pdf>.

19. Acupuncture Definition, MAYO CLINIC (Jan. 25, 2012), <http://www.mayoclinic.com/health/acupuncture/MY00946>.

pathways, for energy flow.<sup>20</sup> In the traditional Eastern view, acupuncturists believe that when these needles are inserted, the patient's energy flow will achieve balance.<sup>21</sup> Many Western practitioners view the acupuncture points as stimulation points for the nerve, muscle, and connective tissue, which increase blood flow and boost activity of natural painkillers.<sup>22</sup> Acupuncture is used primarily to relieve pain;<sup>23</sup> however, it can be used as a treatment for several conditions including hypertension, depression, and rheumatoid arthritis.<sup>24</sup> Some question acupuncture's efficacy, suggesting that it only works through the placebo effect, but scientific evidence attests to the success of acupuncture treatment.<sup>25</sup> A study in the Archives of Internal Medicine used a sham acupuncture placebo control group to demonstrate that the patients who received actual acupuncture treatment enjoyed greater relief of chronic pain than the control group patients.<sup>26</sup>

Some theorize that acupuncture, along with other alternative medicines, became more prevalent in the United States because the modern lifestyle is sedentary and often includes consumption of unhealthy foods.<sup>27</sup> Many people are more open to holistic approaches that address the health concerns that go along with the modern lifestyle.<sup>28</sup> Alternative medicine practitioners emphasize embracing and encouraging the body's natural ability to restore itself by supporting, instead of inhibiting, its healing

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20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

24. WHO, *supra* note 18, at 23-24.

25. *Id.* at 31.

26. Andrew J. Vickers et al., *Acupuncture for Chronic Pain: Individual Patient Data Meta-analysis*, 172 ARCH. INTERN. MED. 1444, 1444 (2012).

27. Phil Veneziano, *Acupuncture in the U.S. and the Hospital of the Future*, HUFFINGTON POST HEALTHY LIVING BLOG (June 6, 2012, 5:49 PM), [http://www.huffingtonpost.com/phil-veneziano-ms-lac/acupuncture-\\_b\\_1572036.html](http://www.huffingtonpost.com/phil-veneziano-ms-lac/acupuncture-_b_1572036.html).

28. *Id.*

abilities.<sup>29</sup> Openness to this approach makes alternative medicine an increasingly popular choice among consumers.<sup>30</sup> In the healthcare system, it is important to consider different viable approaches to health rather than remaining restricted to one manner of treatment, and to make those approaches available to patients if they have been proven effective.<sup>31</sup> Many patients are seeking alternative treatment options and finding them effective, and the healthcare system can best serve those patients by making alternative medicine more accessible.<sup>32</sup>

### III. LEGISLATIVE BACKGROUND AND REGULATION

While acupuncture and other alternative medicines continue to gain popularity in the United States, these practices must navigate a medical field with stringent definitions of medical practice.<sup>33</sup> Mainstream medical organizations and practitioners have resisted the growth of alternative medicine, citing concerns that some alternative medicines may be harmful to uninformed patients.<sup>34</sup> The American Medical Association lobbies for state legislatures to restrict recognized medicine to mainstream techniques.<sup>35</sup> Case law has not always been favorable toward alternative medicine either.<sup>36</sup> In *Pinkus v. MacMahon*, the New Jersey Supreme Court convicted the defendant store proprietor of violating medical practice law when he told customers what and what not to eat after they described their ailments to him.<sup>37</sup> Decisions such as that in *Pinkus* gave courts the opportunity to define medical practice and demonstrate the necessity for

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29. Rao, *supra* note 3.

30. *See Id.* (citing an increased interest in alternative medicine).

31. *See Id.* (stating that holistic treatments are an effective choice for some patients).

32. *See Id.*

33. Van Hemel, *supra* note 1, at 332.

34. *Id.* at 338.

35. *Id.*

36. *See Id.* at 335-336 (noting Supreme Court recognition of a state's power to mandate licensure of medical practitioners).

37. *Pinkus v. MacMahon*, 29 A.2d 885, 886-87 (N.J. 1943)

licensing of nontraditional medical treatments lest their practitioners face legal repercussions.<sup>38</sup> States, like New Jersey, enacted practice of medicine statutes in an effort to ensure unlicensed practitioners were not able to hold themselves out as medical doctors to the detriment of the people who trusted them with their health, which subsequently created barriers for acupuncturists.<sup>39</sup> In *Andrews v. Ballard*, a Texas district court removed this barrier, holding that the constitutional right of privacy encompasses the decision to obtain acupuncture treatment and, therefore, the medical practice act limiting acupuncture to licensed physicians was unconstitutional.<sup>40</sup> The court's interpretation of the right to privacy was favorable for the acupuncturist defendant in *Andrews*, but, in order to achieve increased access to legitimate and quality acupuncture treatment, all states need to develop a licensing regime.<sup>41</sup>

The medical profession assures that standards of treatment and qualification are maintained through licensing requirements for healthcare providers.<sup>42</sup> There are three categories of professional licensure: mandatory licensure, title licensure, and registration.<sup>43</sup> There are six states lacking licensure requirements for acupuncturists, in contrast to physicians of Western medicine who are subject to a rigid and difficult qualification and licensing regime in every state.<sup>44</sup>

The majority of states have a mandatory licensing regime under the national standards set by the NCCAOM.<sup>45</sup> Established in 1982, the

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38. *Id.*

39. *See Id.* (When there is no licensing board, it becomes difficult for acupuncturists to legitimize their practice).

40. *Andrews v. Ballard*, 498 Fed. Supp. 1038, 1051, 1057 (S.D. Tex. 1980)

41. *Andrews*, 498 F. Supp. at 1057; Van Hemel, *supra* note 1, at 332.

42. Van Hemel, *supra* note 1, at 333.

43. *Id.* at 333.

44. *Id.* at 332.

45. *History and Overview*, NAT'L CERTIFICATION COMM'N FOR ACUPUNCTURE & ORIENTAL MED., [hereinafter NCCAOM History], <http://www.nccaom.org/about/history> (last visited Sept. 29, 2013).

NCCAOM's mission is to establish, assess, and promote recognized standards of competence and safety in acupuncture.<sup>46</sup> The National Commission for Certifying Agencies (NCCA) accredits the NCCAOM's certification programs.<sup>47</sup> The NCCAOM provides supporting data to the Bureau of Labor and Statistics in order to create a job classification code for acupuncturists, which furthers government recognition of its certification program.<sup>48</sup> Since its foundation, the NCCAOM certified more than 21,000 acupuncture and oriental medicine practitioners.<sup>49</sup>

The NCCAOM created an avenue for states to ensure that acupuncturists are properly licensed to the highest standard of practice.<sup>50</sup> If state legislatures without licensing boards enacted the NCCAOM licensing regime, each state would be able to achieve consistent quality, credibility, and greater access for their acupuncturists matching the rigidity of the licensing qualifications required for traditional Western physicians.<sup>51</sup>

#### IV. THE PPACA'S IMPLICATIONS FOR ACUPUNCTURE AND OTHER ALTERNATIVE MEDICINE

The PPACA contains sections that will impact the accessibility of alternative medicine.<sup>52</sup> Section 2706, Non-discrimination in Health Care states, in part, that a group health plan and a health insurance issuer offering group or individual health insurance coverage cannot discriminate against healthcare providers is acting within the scope of that provider's license or

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46. *Id.*

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. *See Id.* ("NCCAA certification indicates to employers, patients, and peers that one has met national standards for safe and competent practice of acupuncture as defined by the profession.")

52. *Acupuncture and the Affordable Care Act*, OREGON COLLEGE OF ORIENTAL MEDICINE, <http://ocom.edu/index.php/News/affordablecareact.html> (last visited Sept. 29, 2013).

certification under applicable state licensing law.<sup>53</sup> The legislative goal of this section is to prohibit health insurance plans from discriminating against practitioners who are providing services within their state-defined scope of practice.<sup>54</sup> It will ensure that, in most cases, health plans cannot require that only a medical doctor perform acupuncture services, rather than a licensed acupuncturist.<sup>55</sup> Licensed acupuncturists will be reimbursed just as a medical doctor would for acupuncture services.<sup>56</sup> However, the section will not apply to acupuncture providers who are not licensed in the state where they practice.<sup>57</sup> This section of the PPACA will go into effect in 2014 and covers virtually all individual and group insurance market policies, although it is not clear whether it will apply to existing policies grandfathered in 2010.<sup>58</sup> This section will ideally promote access to acupuncture treatment in more health plans while maintaining high quality acupuncture.<sup>59</sup>

The language of the PPACA Section 5101 is another important boon for legislative inclusion of alternative medicine in the United States' healthcare system.<sup>60</sup> Under federal law, the healthcare workforce was originally defined federally as Doctors of Medicine (M.D.s), Doctors of Osteopathic Medicine (D.O.s), and Allied Health Professionals.<sup>61</sup> Section 5101 modifies the definition to include *all* licensed healthcare professionals.<sup>62</sup>

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53. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § 2706, 124 Stat. 119, (2010).

54. OREGON COLLEGE OF ORIENTAL MEDICINE, *supra* note 52.

55. *Id.*

56. Bill Reddy, A Closer Look at the Affordable Care Act: How it Will Affect Your Practice, 14(10) ACUPUNCTURE TODAY (October, 2013), <http://www.acupuncturetoday.com/mpacms/at/article.php?id=32794>.

57. PPACA, *supra* note 53.

58. Reddy, *supra* note 56.

59. *Id.*

60. See OREGON COLLEGE OF ORIENTAL MEDICINE, *supra* note 52. (federal and state interpretation of the new language will be legally favorable for alternative practitioners).

61. Reddy, *supra* note 56.

62. *Id.*

This more inclusive language opens the door for officially encompassing of acupuncture and other licensed alternative medicine professionals in the health care system.<sup>63</sup> Both of the aforementioned PPACA sections have the potential to lead to an increase in the accessibility of acupuncture services and, therefore, an increase in the number of acupuncture patients.<sup>64</sup>

Neither of these sections guarantees that individual states will enforce the inclusion of acupuncture.<sup>65</sup> Insurers may try to cap the number of visits, lower reimbursement rates, remove the service altogether, or use other strategies to limit the implementation of non-discrimination policies.<sup>66</sup> These sections of the PPACA allow group health plans, health insurers, or the individual state's Secretary of State to establish their own reimbursement rates for alternative services without federal intervention based on quality and performance measures.<sup>67</sup> Coverage of services offered by licensed alternative medical practitioners is another potential limiting factor to the increased accessibility of alternative medicine.<sup>68</sup> Some acupuncture services that can be rendered by an acupuncturist may not be covered under every insurance plan.<sup>69</sup> While these sections of the PPACA are intended to increase accessibility to alternative medicine, the language is not binding enough to exclude the possibility of insurers using strategies to limit implementation of its goals.<sup>70</sup> Alternative providers hope that states will act within the spirit the legislation was intended to provide greater

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63. *Id.*

64. *See* OREGON COLLEGE OF ORIENTAL MEDICINE, *supra* note 52. (the non-discrimination clause has the potential to have far-reaching effects on acupuncture practice)

65. *Id.*

66. *Id.*

67. Reddy, *supra* note 56.

68. *requently Asked Questions about Section 2706*, INTEGRATIVE HEALTHCARE POLICY CONSORTIUM, <http://www.ihpc.org/section2706/section-2706-faqs-and-facts.shtml> (last visited September 29, 2013).

69. *Id.*

70. *Id.*

access to acupuncture.<sup>71</sup>

State licensing statutes governing acupuncture provide a framework in which acupuncture providers can operate in a quality, accessible scope of practice and avail themselves of the benefits of the PPACA.<sup>72</sup> If the legislative spirit of the PPACA sections is manifested in the actions of state legislatures and insurers as it is in states like California, and states without licensing systems adopt the NCAOMM licensing system, practitioners will benefit from these PPACA sections and quality and access will increase to their fullest extent.<sup>73</sup>

#### V. ACUPUNCTURE REGULATION IN CALIFORNIA: A MODEL FOR STATE LICENSING LAWS

California was one of the first states to license acupuncturists and also can be used as a state model of accessible acupuncture services.<sup>74</sup> There are over 10,000 licensed acupuncturists in California, more than in any other state.<sup>75</sup> A 1995 poll of the San Francisco Bay area found that, while thirty-one percent of respondents saw a physician in the past year, forty-one percent tried alternative treatments such as seeing a chiropractor, acupuncture, and biofeedback.<sup>76</sup> This statistic, along with other factors, demonstrates overwhelming acceptance of and access to alternative medicine in California.<sup>77</sup>

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71. *Id.*

72. *See Id.* (stating that the PPACA provides a unique opportunity to create affordable access to CAM providers for their patients).

73. *See Id.* (stating that making access to CAM providers difficult violates the letter and spirit of the nondiscrimination provision).

74. *See History*, STATE OF CAL. DEPT. OF CONSUMER AFFS. ACUPUNCTURE BOARD [*hereinafter* DEPT. OF CONSUMER AFFS.], *History*, [http://www.acupuncture.ca.gov/about\\_us/history.shtml](http://www.acupuncture.ca.gov/about_us/history.shtml) (last visited Sept. 29, 2013). (explaining how California ensure quality of treatment and have created an environment of growth for acupuncture practices).

75. NCCAOM, *supra* note 6.

76. Andrews, *supra* note 11, at 1274

77. *See generally* Andrews, *supra* note 11 (demonstrating that rather than representing a tiny adjunct to traditional health care, the services of alternative providers represent a major and growing proportion of health care as a whole).



Although acupuncture licensing in California is not within the NCCAOM licensing structure, the California licensing board was formed before the NCCAOM and the increase in professional acupuncture licensing.<sup>78</sup> The Board of Medical Examiners of California began regulating acupuncture in 1972, putting California at the forefront of acupuncture regulation.<sup>79</sup> In 1975, the California legislature formed the Acupuncture Advisory Committee, which eventually became the Acupuncture Board.<sup>80</sup> In 1978, California established acupuncturists as primary health care providers by eliminating the requirement for prior diagnoses or referral by a doctor, dentist, podiatrist or chiropractor in order to get treatment from acupuncturists.<sup>81</sup> The Acupuncture Board is now an autonomous licensing body with a fully developed examination system to ensure quality acupuncturists.<sup>82</sup> The Acupuncture Board also has the power to adopt state regulations for acupuncture practitioners, pursuant to Title 16 of the California Code of Regulations, Chapter 13.7.<sup>83</sup>

The California legislature recently proposed a bill regulating use of the title of doctor.<sup>84</sup> If passed, the bill would make it unprofessional conduct for an acupuncturist to use the title of doctor without indicating that he or she has the proper credentials and licensure to practice acupuncture.<sup>85</sup> It would serve to further legitimize licensed acupuncture practitioners.<sup>86</sup> Regulations like this also further integrate acupuncture into the healthcare

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78. DEP'T OF CONSUMER AFFS., *supra* at note 74.

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. *California Proposes Legislation Regulating Acupuncturist's Use of Title "Doctor,"* CAMLAW <http://www.camlawblog.com/articles/new-regulation/california-proposes-legislation-regulating-acupuncturists-use-of-title-doctor/> (last visited Oct 27, 2013).

85. *Id.*

86. *See generally Id.* (claiming that the title "Doctor" is an important signifier for quality treatment in the medical field).

landscape of California.<sup>87</sup>

Out of the three largest state employee health plans in California, two include acupuncture coverage.<sup>88</sup> Of the three largest small group plans, two provide coverage of acupuncture services including Kaiser HMO.<sup>89</sup> According to the PPACA, in 2014, all health plans offered in the individual and small group markets, exchange plans, and all state Medicaid plans will be required to offer a comprehensive package of items and health services known as Essential Health Benefits package.<sup>90</sup> The California legislature has introduced two bills defining the Essential Health Benefit package benchmark for the state that would establish Kaiser HMO as the benchmark health plan.<sup>91</sup> If these bills pass, individual and small group market plans, plans within the California Health Benefit Exchange, and Medicaid plans will be required to cover acupuncture as Kaiser HMO does in its health plan.<sup>92</sup> These bills were introduced in response to the PPACA requirements and, if passed, will make acupuncture an integrated and more easily accessible part of the new health care system.<sup>93</sup>

California established a standard of acupuncture access, coverage, and quality that other states can draw from to form or improve patient care and provide more options to patients.<sup>94</sup> The PPACA offers an opportunity for states to incorporate alternative medicines further into the health care system promoting greater access as California demonstrates through its

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87. *See generally Id.*

88. Supreme Court Decision Paves the Way for Acupuncture Parity, CAL. STATE ORIENTAL MED. ASS'N, [hereinafter CSOMA], <http://www.aaaomonline.org/?page=supremecourt> (last visited Sept. 28, 2013).

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *See CSOMA supra* note 88.

recent proposed legislation.<sup>95</sup>

## VI. CONCLUSION

In order to establish access to quality acupuncture services throughout the United States, states must take initiative to regulate and license acupuncturists. This initiative will lend credibility and quality assurance to the practice as well as increased access through the PPACA.<sup>96</sup> There are acupuncturists in every state, but the licensing procedures in each state are not uniform or nonexistent.<sup>97</sup> For states that do not currently have licensing programs, adhering to the NCCAOM acupuncture licensing qualifications would create a solid, tested foundation to establish an effective licensing board.<sup>98</sup> Lack of licensing presents challenges in providing access through health insurance plans, specifically, the Essential Health Benefit package opportunity created by the PPACA.<sup>99</sup> On a federal level, the nondiscrimination clause of the PPACA is a positive step towards inclusiveness of acupuncture in the health care landscape, but it can only be effective if state legislatures also embrace licensing of acupuncture and other alternative medicines as California's has done effectively.<sup>100</sup> Access to health care is an essential right and more quality choices in our health care, including acupuncture, allow American citizens to maximize this right.

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95. *See Id.* (stating that this ruling, coupled with legislation currently under consideration in the California legislature, will likely mean that the vast majority of California's 38 million residents will have a basic level of acupuncture coverage starting in 2014).

96. *See Id.*

97. Van Hemel *supra* note 1, at 334.

98. *See* NCCAOM, *supra* note 6.

99. *See* CSOMA *supra* note 88.

100. *Id.*

Closing the Gap Between Military Medical  
Personnel and their Civilian Counterparts:  
A Possible Solution to the Expanding Nurse  
Shortage in the United States

*Spencer Lickteig\**

I. INTRODUCTION

For more than a century, the exemplary performance standards and heroic personnel of the United States Navy's Hospital Corps has made it the most decorated institution in the United States military.<sup>1</sup> The training that the enlisted individuals undergo in order to develop their skills is stanch and brutal;<sup>2</sup> yet, battlefield medicine, as vital as it may seem in the fog and chaos of war, does not typically find itself present and applicable in everyday civilian life.<sup>3</sup> Due to the limited overlap between the training that

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1. See Jason Kelly, *Navy Hospital Corps Celebrates 115 Years of Service*, NAVY LIVE (June 17, 2013, 12:20 PM), <http://navylive.dodlive.mil/2013/06/17/navy-hospital-corps-celebrates-115-years-of-service/> (providing facts about the Navy Hospital Corps, including that 178 corpsmen have received the Navy Cross); U.S. Navy Bureau Med. & Surgery Pub. Affairs, *Navy Surgeon General Honors Hospital Corps' 113th Birthday*, AMERICA'S NAVY (June 15, 2011), [http://www.navy.mil/submit/display.asp?story\\_id=61029](http://www.navy.mil/submit/display.asp?story_id=61029) ("The Hospital Corps is the largest rating in the Navy and the most decorated in the U.S."); e.g., See Mark T. Hacala, *The U.S. Navy Hospital Corps: A Century of Tradition, Valor, and Sacrifice*, NAVY MED., May-June 1998, at 25-26, available at <https://archive.org/stream/NaVymedicineVol.89No.3May-june1998/NavyMedicine1998-05#page/n1/mode/2up/search/Hacala> ("Today, the 23,000 regular and 6,000 reserve members of the Navy Hospital Corps continue to serve around the globe. . . . They maintain constant battle readiness with Marine Corps units and SEAL teams.").

2. See *infra* text and accompanying notes 29-30 (outlining the basic training that corpsmen and other military medical personnel complete).

3. E.g., MOST FREQUENCY PROCEDURES PERFORMED IN U.S. HOSPITALS, 2010, AGENCY FOR HEALTHCARE RESEARCH & QUALITY 2-3 (2010), available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb149.pdf> (stating the top medical and surgical procedures performed in the U.S. in 2010, most of which would not be considered battlefield medicine).

corpsmen obtain while in service and the treatment that civilian medical personnel are expected to provide, many of these soldiers return home from service, hoping to apply their skills and medical knowledge to a permanent profession, but find their qualifications lacking.<sup>4</sup> Meanwhile, the United States faces a continuous shortage of nurses and additional general medical care providers to treat a rapidly aging population.<sup>5</sup>

The issue of veterans struggling to find work once they have completed their military service is far from a new matter for the United States,<sup>6</sup> but it does not mean that the problem is impossible to fix.<sup>7</sup> Both Congress and many state legislatures recognize the issues facing our veterans returning to the work force, and they continue to attempt to put forth strategies ranging from increasing the hiring rates of veterans,<sup>8</sup> to providing better training and education to soldiers while in the military in order to smooth the transition from active service.<sup>9</sup> Of these governmental bodies, the state of California

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*But see* Sandra Basu, *Military Trauma Advances Also Help Civilians, Must be Maintained*, U.S. MED., (Sept. 2013), <http://www.usmedicine.com/articles/military-trauma-advances-also-help-civilians-must-be-maintained.html#.Up9qucRDskQ> (discussing the many major advancements in civilian trauma treatment that can be attributed to military medicine training and procedures).

4. *See* Ed Michaud, et al., *Assessment of Admissions Policies for Veteran Corpsmen and Medics Applying to Physician Assistant Educational Programs*, 23 J. PHYSICIAN ASSISTANT EDUC. 4, 6 (2012) (conducting research that showed that out of 110 PA programs, military veterans were admitted to 83.6% of them during 2008–2010, resulting in 2.7% of the total enrollment in these PA programs in 2009; 2.3% in 2009; and 2.8% in 2010).

5. *See Nursing Shortage*, AM. NURSING ASS'N, <http://www.nursingworld.org/nursingshortage> (last visited Dec. 4, 2013) (discussing the reasons for the continual shortage of nurses and the potential positive and negative consequences of the shortage).

6. *E.g.*, Joan Goldstein, *Medical Corpsmen as a Source of Civilian Health Manpower for New Jersey*, 8 MED. CARE 254, 254, 256–258 (explaining the recognition of the need to help employ veteran corpsmen after the Vietnam War in New Jersey as well as several of the programs that were set forth as a result).

7. *See infra* Part IV (describing many of the established programs that attempt to resolve issues surrounding the transition of medical veterans into civilian care positions).

8. *See infra* Part IV (explaining some of the current legislation and bills in both the federal government and state governments respectively).

9. *See* William L. Kissick, *Health Manpower in Transition*, 46 MILBANK MEM'L FUND Q. 53, 83 (1968), *available at* <http://www.jstor.org/discover/10.2307/3349149?uid=3739256&uid=2&uid=4&sid=21102706902113> ('The experience of the armed forces in preparing hospital corpsmen, laboratory technicians and personnel for other health

has taken the most prominent steps in this area.<sup>10</sup> The steps that California took and the laws and policies enacted provide a surmountable template for other states to follow in the quest to support returning veterans of the Hospital Corps.

The goal of this article is to propose a strategy for states to provide opportunities for these specific veterans by following in the footsteps of California's legislation and policies. In Section II, this article will provide a brief history of the United States Hospital Corps and its progression towards present day standards.<sup>11</sup> Then, Section III will explain the modern medical training and scopes of practice of corpsmen, their civilian counterparts, and the issues arising from the discrepancies between the two.<sup>12</sup> Finally, Sections IV and V advocate that this system will provide a reasonable and helpful solution to the shortage of nurses and other medical providers, and will allow this country to take care of the individuals that it owes the most to: the brave men and women of the military forces.<sup>13</sup>

## II. BACKGROUND<sup>14</sup>

The first military medical positions were remarkably simple and left

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occupations suggests that career ladders in health are feasible . . . ."); *see also infra* notes **Error! Bookmark not defined.** and accompanying text (providing examples of educational institutions that have already begun to adapt to corpsmen education levels and are changing their programs to accommodate for them).

10. *See infra* Part IV (describing several of the progressive steps taken by California in easing the transitions of medical veterans).

11. *See infra* Part II (summarizing the historical development of the Navy medical personnel).

12. *See infra* Part III (discussing the scopes of practice of both modern corpsmen and several common medical provider positions, and the discrepancies between the two).

13. *See infra* Part IV–V (proposing a system, primarily based on California, for states to follow in order to provide adequate opportunities to veteran corpsmen).

14. While this section will primarily focus on the history of the Navy's medical personnel and corpsmen, stories of other military medical personnel that could not be included in this article can be found elsewhere. For example, for a description of the history of the Army nurse, *see generally* MARY T. SARNECKY, A HISTORY OF THE U.S. ARMY NURSE CORPS 1 (University of Pennsylvania Press, 1999).

more to luck than to the actual application of treatment.<sup>15</sup> While these individuals were technically enlisted in the military, there was not an official title or description of enlisted medical personnel.<sup>16</sup> During this time, the range of possible care, either in the medical ward or on the battlefield, was incredibly limited by the available technology and the lacking of anatomical and physiological knowledge.<sup>17</sup> With the start of the American Civil War, the Navy demanded an increase in its medical sectors to provide care to its rapidly increasing number of soldiers.<sup>18</sup> After the conclusion of this war, the Navy reduced and concentrated its medical corps and also increased the required qualifications for enlistment as medical staff personnel.<sup>19</sup> Ultimately, due to tremendous pressure from naval physicians, as well as the impending Spanish-American War, President William

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15. HACALA, *supra* note 1, at 12. These original positions were created out of necessity during the Revolutionary War, and generally consisted of three person groups that were made up of a surgeon, a surgeon's mate, and usually an enlisted soldier. *Id.* A practicing physician held the surgeon position, while the surgeon's mate would be more comparable to that of a modern day corpsmen in responsibilities and knowledge. *Id.*

16. HACALA, *supra* note 1, at 12. The first recorded title for an enlisted military medical provider was "loblolly boy," which described the non-professional assistant to the unit's surgeon. *Id.* The title originated from one of the primary duties of these individuals, which was to serve the patients loblolly—a thick porridge with meat or vegetables. *Id.*

17. *Id.* There was realistically a minimal advancement, if any at all, in medical treatment and techniques between the end of the Revolutionary War and the first decades of the nineteenth century. *Id.* In fact, medical tents, buildings, and wards were considered more of a place to die than as a place to heal. *Id.* The most common "care" that was provided to the wounded and sick was a daily ration of porridge or "loblolly." *Id.* (describing the extremely limited options for treatment and care by medical personnel in the late 1700's).

18. *Id.* The Navy's answer for this new demand was the allowance of a new position on ships and smaller vessels: the military nurse. *Id.* at 13 ("In addition to a surgeon's steward, 1 nurse would be allowed for ships with a complement of less than 200; 2 nurses would be allowed for ships with a complement of more than 200; and sufficient nurses would be allowed on receiving ships in a number proportionate to the necessities of the vessel.") (quoting *Hospital Corps, U.S. Navy*, Hosp. Corps Q., April–June 1948, at 21(2):2.)).

19. *Id.* at 16. This increase of educational standards continued into the final decades of the nineteenth century, eventually challenging the Navy to keep up with the Army, who had officially established its own Hospital Corps in 1887 and began training its medics in civilian hospitals. *Id.* Along with the advancement of qualifications, the Navy changed the titles of personnel, including the surgeon's steward into three separate grades of apothecaries in 1866, all of which were required to have a basic knowledge of pharmacy, and making and dispensing all medication necessary for a specific ship. *Id.* at 15.

McKinley signed into law the creation of the Navy Hospital Corps on June 17, 1898.<sup>20</sup>

The newly established Hospital Corps brought with it a new degree of educational and procedural standards.<sup>21</sup> The end of World War I led Congress to enact a new law that refined the classes of the corps, and increased the overall size of the Navy Hospital Corps five-fold.<sup>22</sup> This increase in medical personnel hit its peak in World War II, when the number of enlisted Hospital Corps members reached a staggering 132,000 individuals.<sup>23</sup>

After World War II, the modern day Hospital Corps began to take shape as new legislation brought large changes to the organization.<sup>24</sup> The practice

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20. *Id.* at 16 (explaining the process of forming the Navy Hospital Corps). The system of identification of medical personnel as corpsmen, and the separation of that title into three separate classes, which was set forth in that law still stands to the present day. *See id.* (explaining the hospital apprentice, hospital apprentice first class, and the hospital steward positions).

21. *E.g. id.* at 17 (“[The new] curriculum included anatomy and physiology, bandaging, nursing, first aid, pharmacy, clerical work, and military drill. . . . Development of the Navy’s hospital corps training courses would prepare the first generation of hospital corpsmen for arduous duty, both in peace and war.”). To fulfill these new standards, the Navy founded the first “school of instruction” as a part of the U.S. Naval Hospital Norfolk. *Id.* at 16–17.

22. *Id.* at 17, 19 (stating that by the end of World War I, the number of enlisted soldiers in the Hospital Corps would peak at 17,000). The Navy’s corpsmen became so prevalent, that they were even sent to help in other branches of the military, including the front-lines with the Marine Corps. *Id.* at 19. Those corpsmen specially trained in the practice of treating trauma victims for as long as it took before they transportation to proper health care facilities was available. *Id.*

23. *Id.* at 20. Along with the growth in sheer man power, corpsmen were also continuously applying the most recent medical technology and treatment methods to their patients, sometimes even before they had been performed in civilian medicine in the United States. *See generally* Keely Grasser, *Military Medicine: A History of Innovation*, PHOENIX PATRIOT, Winter 2012, <http://phoenixpatriotmagazine.com/article/winter12/> (describing the many medical advancements achieved by the military).

24. *E.g., id.* at 21 (discussing the consequences of the legislative acts after World War II, including the establishment of the Department of Defense, the removal of commissioned allied health and medical officers from the Army and Navy Hospital Corps, creation of a separate dental technician class, and finally another change to the titles and rankings of the Hospital Corps). This movement was highlighted by the allowance of women to enlist in military service and become active medical corpsmen. *Id.* Although women were not officially allowed to enlist in military service, many women were enrolled in the Women’s Reserve, or “WAVES”, of the Hospital Corps. *Id.* at 21–22.



capabilities of corpsmen continued to advance and become more sophisticated during the Vietnam War, eventually to the extent that civilian hospitals began to recognize the benefit of having an individual with this extensive medical knowledge available, even without a medical school degree.<sup>25</sup> Veteran corpsmen came back to the United States after the Vietnam War and started working as a new type of medical provider, known today as a physician's assistant.<sup>26</sup>

However, the days of corpsmen leading the way in the practice of innovative techniques and use of advanced technology quickly vanished as the demands within the field of medicine and the knowledge of new treatment and sciences exploded over the remaining decades of the twenty-first century.<sup>27</sup>

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25. See *infra* note 26 and accompanying text (claiming that, regardless of the fact that they did not have a formal medical education, military corpsmen were the ideal candidate on which to base the new physician assistant position).

26. Reginald Carter, *Physician Assistant History*, 12 PERSP. ON PHYSICIAN ASSISTANT EDUC. 130, 130–32 (2001). The idea of utilizing corpsmen in civilian hospitals originated at Duke University by Dr. Charles L. Hudson, who had the idea of quelling the shortage of medical providers by creating two new types of assistants in medical institutions. *Id.* The first would be trained on-the-job to “serve in medical and surgical inpatient divisions, the operating room, and emergency ward,” and whose duty was compared directly to that of a corpsmen. *Id.* The second assistant was expected to have more specialization and education, and in practice would be considered more of an intermediate between a physician and a technician. *Id.* The first wave of these new assistants was made up entirely of veteran corpsmen. *Id.* The position soon received the recommendation of the American Medical Association, as several States began to incorporate the assistants into the medical field. *Id.* However, issues arose regarding the extent of treatment and practice that these ex-corpsmen could legally have and still loom today as the practice of medicine continues to become more precise while the population, and thus the demand for healthcare providers, grows. *Id.*

27. Cf. *The 1960s: Medicine and Health: Overview*, ENCYCLOPEDIA.COM, <http://www.encyclopedia.com/doc/1G2-3468302401.html> (discussing the transformation in medical knowledge and treatment, mostly by researchers in civilian care, after World War II). These new standards for civilian medical providers would limit the options of veteran corpsmen returning from service as they demanded higher education for the same positions that were at one point based on the corpsmen position. *Id.* The gap of knowledge and skill between civil medical personnel and their military counterparts had officially been established and has been widening at a remarkable rate ever since. See *infra* Part III (comparing the scopes of practice of modern corpsmen and several common healthcare positions).

## III. DISCUSSION

The modern scopes of practice for military medical personnel provide clear discrepancies in knowledge, skill, and priority between them and their civilian counterparts.<sup>28</sup> However, before any changes can be proposed on either the state or federal level to remedy these discrepancies, it is first essential to understand the current training and scopes of practice of medical corpsmen, as well as recognize the variance between these military medical personnel and their civilian counterparts.

Individuals that enlist in the Hospital Corps must complete a demanding curriculum and training in order to become licensed medical personnel in the military.<sup>29</sup> However, the present day Navy or Army corpsman possess a limited scope of practice consisting primarily of battlefield treatment

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28. See e.g. Kathryn J. Krause, *An Analysis of First Duty Station Placement and New Graduate Transition Education and Retention in the Navy Nurse Corps* (March 2010), (unpublished M.A. thesis, Naval Postgraduate School), available at <http://hdl.handle.net/10945/5408>). Other than a two-year course and the experience obtained from actual practice, military medical personnel do not receive any other form of medical training, especially in connection with civilian care. E.g., *id.* at xiii (“Nursing research indicates that new graduate nurses . . . do not possess the clinical abilities, critical thinking skills, and professional acumen to perform at the level of an experienced nurse.”); *id.* at 73 (“There is no standardized . . . transition program throughout the Navy. . . . None of the programs contain all of the essentials recommended in nursing research and professional literature.”).

29. See MELISSA KNOX, CATHERINE DOWER, & EDWARD O’NEIL, *US MILITARY AND CALIFORNIA HEALTH PERSONNEL: SELECT COMPARISONS 5–6* (2008) [hereinafter *COMPARISONS*], available at [http://futurehealth.ucsf.edu/Content/29/2008-02\\_US\\_Military\\_and\\_California\\_Health\\_Personnel\\_Select\\_Comparisons.pdf](http://futurehealth.ucsf.edu/Content/29/2008-02_US_Military_and_California_Health_Personnel_Select_Comparisons.pdf) (describing the common training provided to military medical recruits). After graduating high school, individuals are required to complete a two-year program consisting of a brief overview of anatomy and physiology, medical treatment techniques, methodology of administering certain drugs, and emergency and trauma care; all to the limited extent that future military medical personnel will need to be successful in service. *Id.* After this course, the recruits attend a year of regular soldier protocol and physical training. *Id.* Finally, the recruits are distributed to chosen or assigned locations and begin to accumulate clinical experience in their specific fields. Cf. *Veterans’ Employment: Improving the Transition from the Battlefield to the Workforce Before S. Veterans Affairs Comm.*, 112th Cong. (2011) (testimony of Eric Smith, Iraq and Afghanistan Veterans of America) [hereinafter *Eric Smith Testimony*], available at [http://www.veterans.senate.gov/hearings.cfm?action=release.display&release\\_id=4983bc21-69b3-4024-9558-3bf2ad6df9ac](http://www.veterans.senate.gov/hearings.cfm?action=release.display&release_id=4983bc21-69b3-4024-9558-3bf2ad6df9ac) (“As a Navy Corpsman, I carried enormous responsibility and acquired a wide range of technical and leadership skills that should translate into a good job in the civilian workforce. . . . By age 19, I had skills, training and responsibilities far beyond those of my civilian peers in the medical field.”).

techniques, basic trauma surgery, and a narrow range of knowledge involving prescription drugs, mainly focusing on pain inhibitors and trauma medication.<sup>30</sup> The level of care which corpsmen can provide depends on local regulations and guidelines, and it is generally very restricted.<sup>31</sup> The limitations of a corpsman's scope of practice lies directly with the fact that the medical education that these soldiers receive is deficient in regards to civilian healthcare education, both in the specific content and extent of experience.<sup>32</sup>

The gap of treatment, technique, and knowledge between civilian and military care providers is the primary inhibitor of veteran medical personnel obtaining healthcare careers when they leave the service.<sup>33</sup> This discrepancy becomes more apparent when the scope of practice of corpsmen is directly compared to the civilian positions in which medical veterans pursue.<sup>34</sup> Corpsmen veterans that wish to transition to civilian

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30. NAVY MEDICINE MANPOWER, PERSONNEL, TRAINING, AND EDUCATION COMMAND, HOSPITAL CORPSMAN: NAVEDTRA 14295B: NON-RESIDENT TRAINING COURSE 1-1 (2010) [hereinafter NRTC], available at <http://www.navybmr.com/study%20material/NAVEDTRA%2014295B.pdf>.

31. See NRTC, *supra* note 30, at 11-2 (outlining the professional aspects to the corpsmen profession, including the professional responsibilities and limitations). Even in the military's own hospitals, corpsmen take on more of an assistant role in the clinical setting. *Id.* They are generally confined to "administering medication, performing treatments, and providing individual patient care in compliance with the orders of the senior healthcare provider." *Id.* Even though they are only assistants to the overall procedure, hospital corpsmen are still held to the highest standard of responsibility for their actions during the medical procedure. *Id.* at 11-2 to 11-3.

32. Compare *A Brief Synopsis of Medical School—Medical School Requirements*, PETERSON'S (Jan. 30, 2013), <http://www.petersons.com/graduate-schools/synopsis-medical-school-requirements.aspx> (summarizing the modern medical school experience and demands), with *supra* note 29 and accompanying text (summarizing the general requirements for corpsman education). The educational differences between corpsmen and civilian medical providers are a clear show the tremendous gap between the material and treatments taught to corpsmen compared to those civilian positions. *Id.*

33. See COMPARISONS, *supra* note 29, at 9-10 ("Despite the numerous potential opportunities for individuals separating from the military . . . many differences exist between the military and civilian health care sectors that may have an impact on career transitions . . .").

34. Compare *supra* Part III (describing the scope of practice and required training for modern corpsmen) with *infra* notes 36-40 and accompanying text (summarizing the scopes

health care generally favor positions that have similar responsibilities to those they had as a corpsman.<sup>35</sup> These positions mainly consist of emergency medical technicians (EMTs),<sup>36</sup> licensed vocational nurses (LVNs),<sup>37</sup> registered nurses (RNs),<sup>38</sup> nurse practitioners (NPs),<sup>39</sup> and

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of practice for the most prevalent professions for medical veterans in civilian healthcare).

35. Cf. AM. ACAD. PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANT CENSUS REPORT: RESULTS FROM THE 2010 AAPA CENSUS 12 tbl.11 (2010), *available at* [http://www.aapa.org/uploadedFiles/content/Research/2010%20Census%20Report%20National%20\\_Final.pdf](http://www.aapa.org/uploadedFiles/content/Research/2010%20Census%20Report%20National%20_Final.pdf) (showing that approximately 4.4% of current practicing PAs have some affiliation with a military entity or the VA).

36. See, e.g., NATION EMS SCOPE OF PRACTICE MODEL, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN. 23–24 (February 2007), *available at* <http://www.nremt.org/nremt/downloads/Scope%20of%20Practice.pdf> (“[An EMT’s] scope of practice includes basic, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, [EMTs] provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.”).

37. E.g., LICENSED VOCATIONAL NURSE SCOPE OF PRACTICE STANDARDS, CAL. CORR. HEALTH SERV. 5-5-1 to 5-5-6 (January 2002), *available at* <http://www.cphcs.ca.gov/docs/imspp/IMSPP-v05-ch05.pdf>. Compared to the more independent positions, LVNs are expected to have a different role in the patient treatment, mainly centered on obtaining an assessment of the patient’s basic physical and mental states. *Id.* (defining what a “basic” assessment of assigned patients would consist of for an LVN, including the collection of “subjective and objective [physical] data and recognition of problems or abnormal conditions,” and a psychosocial assessment of a patient). The degree of this assessment is not allowed to include any aspect that could be considered medical treatment. See *id.* at 5-5-2 to 5-5-6 (describing the basic allowances for LVN practice in a hospital, specifically in California).

38. E.g., CAL. DEP’T. CONSUMER AFFAIRS BOARD OF REGISTERED NURSING, AN EXPLANATION OF THE SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES 1 (January 2011), *available at* <http://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf> (explaining the scope of practice of California RNs according to the Nursing Practice Act, Business and Professions Code § 2725). The ability to provide actual medical treatment does not truly begin until an individual reaches the point of RN. *Id.* In general, RNs are legally allowed to diagnose mental and physical conditions, administer pharmaceuticals to patients, perform the most basic forms of surgery that breach the tissue of patients in order to treat conditions, and to perform most any additional actions in order to insure the safety and comfort of the patient during their stay. See *id.* at 2 (providing a list of the common functions that RNs are permitted to perform).

39. See SCOPE OF PRACTICE FOR NURSE PRACTITIONERS, AM. ASS’N NURSE PRAC. 1 (2013), *available at* <http://www.aanp.org/images/documents/publications/scopeofpractice.pdf> (outlining the general guidelines and recommendations for States to consider when enacting their own scope of practice laws for NPs). An NP’s scope of practice includes full diagnosis and disease management of acute and some chronic illnesses, laboratory test ordering and interpretation, and even the ability to prescribe certain medications and non-pharmacologic therapies. *Id.* NPs are technically capable of prescribing certain pharmaceuticals, but they must first register with the United States Drug

physician assistants (PAs).<sup>40</sup>

This gap is even more prevalent in the licensure requirements for civilian medical personnel, which do not recognize the experience and education that the military provides corpsmen.<sup>41</sup> Moreover, veterans that attempt to seek licensure to practice medicine as any of the professions mentioned below, find that the information and knowledge required by the state licensing exams is far from that which they learned through the Hospital Corps.<sup>42</sup> These individuals are inevitably forced to undergo the same level

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Enforcement Administration, and even then, are usually only allowed to prescribe Schedule II controlled substances. See Board of Registered Nursing, *General Information: Nurse Practitioner Practice*, CAL. DEP'T. CONSUMER AFF. 2-3 (April 2011), available at <http://www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf> (describing the controlled substance furnishing policies for NPs).

40. See 263 MASS. CODE. REGS. 5.04 (2013), available at <http://www.mass.gov/eohhs/docs/dph/regs/263cmr005.pdf> (stating the regulations of PAs for Massachusetts); e.g., AM. ACAD. PHYSICIAN ASSISTANTS, PROFESSIONAL ISSUES: PHYSICIAN ASSISTANT SCOPE OF PRACTICE 1 (October 2011), available at [http://www.aapa.org/uploadedFiles/content/The\\_PA\\_Profession/Federal\\_and\\_State\\_Affairs/Resource\\_Items/PI\\_PAScopePractice\\_1108\\_11\\_Final.pdf](http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/PI_PAScopePractice_1108_11_Final.pdf) ("The boundaries of each PA's scope of practice are determined by four parameters: education and experience; state law; facility policy; and the supervising physician's delegatory decisions."). The general scope of practice for PAs consists of the performance of any medical procedure that is deemed permissible by the supervising physician and is within the competency of the PA, the treatment of any patient, regardless of age and condition, as deemed acceptable by the supervising physician, and any treatment or procedure within a PA's designated specialty that is consistent with the first two components. *Id.* PAs also have the ability prescribe controlled substances to patients with the authorization of the supervising physician, but unlike NPs, PAs can become authorized to prescribe up to Schedule V drugs depending on the state's allowance. See AM. ACAD. PHYSICIAN ASSISTANTS, PA PRESCRIBING AUTHORITY BY STATE (July 2013), available at [http://www.aapa.org/uploadedFiles/content/The\\_PA\\_Profession/Federal\\_and\\_State\\_Affairs/Resource\\_Items/Rx%20Chart%207-13.pdf](http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/Rx%20Chart%207-13.pdf) (providing the range of controlled substances that many states allow PAs to prescribe).

41. See COMPARISONS, *supra* note 29, at 10 (stating that civilian health institutions and state licensing boards do not recognize education, training, and experience obtained in the military); e.g., *Eric Smith Testimony*, *supra* note 29 (stating that Navy corpsmen, even if they believe they are overqualified for the position, are not able to obtain positions as civilian nurses and thus consider their "graduation from Naval Hospital Corps school and years worth of experience" resulted in "no certifications that translated into the civilian world").

42. See, e.g., Philip K Ireland, *MiraCosta Class Targets Military Folks in Transition*, SAN DIEGO UNION-TRIB., Mar. 4, 2008, <http://www.utsandiego.com/news/2008/mar/04/miracosta-class-targets-military-folks-in/all/?print> (describing a course offered by MiraCosta College in California that prepares medical veterans to challenge the LVN examination to become a licensed LVN). Another large hindrance for veterans seeking to obtain their

of education and clinical experience as regular civilians that enter the field without any medical exposure.<sup>43</sup> California is one of the few states that is leading a change to not only recognize the military experience of these medical personnel when considering licensure, but to provide these veterans an accelerated path based on their experience.<sup>44</sup> Other states must look towards the progressive steps taken by California in providing a more accommodating transitory environment for corpsmen.

#### IV. ANALYSIS

Between the inconsistency in medical education and the absence of recognition for military experience, a vast majority of veterans find themselves back to square one in their paths of becoming civilian medical providers.<sup>45</sup> While these obstacles for United States' veterans caught the

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medical license is the excessively varied requirements and expectations from different states in their licensure measures. *Id.* Furthermore, because these licensing standards are set by the states themselves, the military cannot replicate them for their own standards, thus creating an even smaller consistency between civilian and military care. *Id.* For an overview of the licensing requirements for LVNs, RNs, NPs, and other medical professions, see CAREERONESTOP, [http://www.careerinfonet.org/LicensedOccupations/lois\\_agency.asp?stfips=99&nodeid=16&by=occ&jobfam=29&onetcode=29-2061.00&onetcode=29-1071.00&onetcode=29-1141.00](http://www.careerinfonet.org/LicensedOccupations/lois_agency.asp?stfips=99&nodeid=16&by=occ&jobfam=29&onetcode=29-2061.00&onetcode=29-1071.00&onetcode=29-1141.00) (last visited Sept. 28, 2013).

43. See Mary Wakefield, *Helping Veterans Transition to Careers in Nursing*, VANTAGE POINT: DISPATCHES FROM THE U.S. DEP'T VETERANS AFFS. (September 21, 2011), <http://www.blogs.va.gov/VAntage/4668/helping-veterans-transition-to-careers-in-nursing/> (“[V]eterans have found that their training in medic and certain other health care roles do not fully meet the standards of academic training for nursing programs. As a result, Veterans have encountered difficulty gaining academic credit for their health care training while enlisted.”). But see Patricia Allen et al., *Returning Enlisted Veterans—Upward (to) Professional Nursing: Not All Innovative Ideas Succeed*, 28 J. PROF. NURSING 241, 243 (2012) (“U.S. Army LVNs are often able to readily find employment soon after leaving the military. . . . The military LVN is often overqualified for the civilian LVN position, yet underqualified for other health care positions.” (citing COMPARISONS, *supra* note 29)).

44. *E.g.*, CAL. BD. OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS, INSTRUCTIONS TO APPLICANTS FOR LICENSURE AS A LICENSED VOCATIONAL NURSE 3 (2009), available at <http://www.bvnpt.ca.gov/pdf/method4.pdf> (permitting individuals to present record of military service in order to qualify to challenge the LVN exam); *supra* note 42 and accompanying text (discussing the college course offered by MiraCosta College which prepares veteran corpsmen to prepare to challenge the LVN exam and become licensed in California).

45. See, e.g., COMPARISONS, *supra* note 29, at 10 (explaining that the because the scopes of practice differ so dramatically between civilian care and military care, veterans struggle to

attention of the federal government and a few states, resulting in limited programs and legislation, the state of California went a step further by enacting a true change to this transitory process.<sup>46</sup>

On the federal level, several bills were proposed that include a strong motivation to increase the number of jobs available to veterans as well as to help train them, either during their service or afterwards, to be successful in their chosen careers.<sup>47</sup> Furthermore, President Barack Obama takes a strong stand for veteran transitional efficiency,<sup>48</sup> and has created a new executive body to help train and place veterans into a variety of careers, including healthcare positions.<sup>49</sup> President Obama's effort has been bolstered by many

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should that they're qualified); *Eric Smith Testimony*, *supra* note 29 ("In the military I was more than qualified for the positions I applied for in the civilian workforce. But in the civilian world, my military education and training did not translate because I didn't have a piece of paperwork saying so.").

46. See *infra* Part IV (explaining several recent laws and programs that are promoting efficient transitions for corpsmen, nurses, and medics into equivalent civilian healthcare professions).

47. See, e.g., 10 U.S.C. § 1144 (2011) (authorizing funding and program development for the Secretary of Labor, Defense, Homeland Security, and of Veteran Affairs to promote more efficient veteran transitions in the civilian work force); National Defense Authorization Act for Fiscal Year 2010, H.R. 2647, 111th Cong. § 933 (2009) (proposing the establishment of a Department of Defense School of Nursing to help produce "military health professionals" in order to quell the civilian nurse shortage, and to encourage medics and corpsmen to obtain Bachelor of Science degrees in Nursing, perhaps even continuing on to the Department of Defense's Physician Assistant program); H.R. 6339, 111th Cong. § 2(a) (2010) (proposing a bill that would allow the Secretary of Veterans' Affairs to create a program that would provide aid to military medics and corpsmen that attempt to transition from military medicine to civilian physician assistant positions); Hiring Heroes Act of 2011, S. REP. NO. 112-36, §§ 10, 13-14 (2011) (promoting changes within the Federal Government, including the Department of Defense, Department of Labor, the Veterans Association, and the Department of Homeland Security, to allow for better transitional training and opportunities for veterans).

48. See NAT'L ECON. COUNCIL, EXEC. OFFICE OF THE PRESIDENT, THE FAST TRACK TO CIVILIAN EMPLOYMENT: STREAMLINING CREDENTIALING AND LICENSING FOR SERVICE MEMBERS, VETERANS, AND THEIR SPOUSES 5-7 (2013) [hereinafter FAST TRACK], available at [http://www.whitehouse.gov/sites/default/files/docs/military\\_credentiaing\\_and\\_licensing\\_report\\_2-24-2013\\_final.pdf](http://www.whitehouse.gov/sites/default/files/docs/military_credentiaing_and_licensing_report_2-24-2013_final.pdf) (discussing the plans in place as well as the ones in the future to help promote better transitions for veterans into various sectors of the workforce).

49. FAST TRACK, *supra* note 48, at 7 ("The President created the Department of Dense Military Credentialing and Licensing Task Force, charged with (1) identifying military specialties that readily transfer to high-demand jobs; (2) working with civilian credentialing and licensing associations to address gaps between military training programs and credentialing and licensing requirements; and (3) providing service members with greater

national associations, including the Physician Assistant Education Association (PAEA),<sup>50</sup> the American Academy of Physician Assistants,<sup>51</sup> and the Department of Veterans Affairs (VA).<sup>52</sup>

In addition to the federal government's efforts, the participation of the states is an essential component to ensure that veterans receive medical education and experience applicable in civilian care.<sup>53</sup> In the forefront of this pursuit, California has implemented programs and legislation that allow medical veterans to rely on their medical knowledge and experience and take a preliminary qualification course in order to become eligible for licensure.<sup>54</sup> This qualification course offers veterans an opportunity to

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access to necessary certification and licensing exams.”).

50. See Jeanette Smith, *PAEA Applauds White House Initiative to Help Veterans Become Physician Assistants*, PHYSICIAN ASSISTANT EDUC. ASS'N. (October 25, 2011), <http://www.paeaonline.org/index.php?ht=d/sp/i/130963/pid/130963> (statement of PAEA President Kevin Lohenry) (“The Obama Administration is right to support the professional development of our returning veterans and help them enter the Physician Assistant field. . . . [It] has capitalized on a rare win-win-win policy that gives back to veterans, creates job opportunities and helps address one of the most critical health care challenges we face.”).

51. See *White House Emphasizes PA Profession for Veterans*, AM. ACAD. PHYSICIAN ASSISTANTS (Oct. 26, 2011), [http://www.aapa.org/news\\_and\\_publications/news/item.aspx?id=3079](http://www.aapa.org/news_and_publications/news/item.aspx?id=3079) (acknowledging the Obama Administration's effort to help more veterans transition into the field of physician assistants, and applauds the Administration for “offering those who have served on the battlefield a pathway to PA educational programs”).

52. See Wakefield, *supra* note 43 (supporting and explaining how the Obama Administration plans to increase the medical education at certain military institutions as well as fun nursing schools that choose to offer “pro-Veteran learning environments, recruit and support Veterans interested in pursuing nursing careers, and facilitate academic credit for enlisted health care training”).

53. *E.g.* FAST TRACK, *supra* note 48, at 12. Considering states are the entities that set forth the legal scopes of practice for medical professions, it only makes sense that their cooperation is essential to closing the gap between the requirements of civilian care and that which is provided by the Hospital Corps. *Id.* (explaining the Obama Administration's plan to accelerate state's licensing and opportunities for military medical personnel, including pushing states to work together with academic institutions to equivocate military and academic education, and promoting states to analyze the “gaps between military training and experience and state licensing requirements” in order to “develop bridge programs to address these gaps”).

54. CAL. CODE REGS. tit. 16, § 1418 (2013) (stating that a military applicant that have satisfied the requirements of § 2736.5 of the California Business and Professional Code, and has completed a course that provided “the knowledge and skills necessary to function in accordance with the minimum standards for competency” stated in § 1443.5 is legally considered to have completed the prerequisites for licensure). In addition to California,



surpass the extensive re-education that they are required to complete in other states, and instead qualify using their own merits from their military experience.<sup>55</sup> By allowing veterans to skip the further institutional education requirements, California is also combating one of the prominent contributors to the nursing shortage: the limited admittance space in nursing schools.<sup>56</sup>

Besides providing alternate routes of licensure, California is also one of several states allowing corpsmen, medics, and military nurses to challenge the LVN license exam without first requiring additional education credits; this simple step offers a possible seamless transition for medical personnel veterans into civilian care.<sup>57</sup> California is also easing the process for veterans residing outside of the state by reforming its interstate licensing to

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several other states have begun to offer alternative qualification routes to licensure for veterans as well. *E.g.*, LOIS KAZMIER HALSTEAD ET AL., METC BASIC MEDICAL TECHNICIAN CORPSMAN PROGRAM TO LICENSED PRACTICAL NURSE COURSE PROPOSAL 1–3 (Dec. 20, 2012), *available at* <http://www2.illinois.gov/veterans/SiteCollectionDocuments/METC%20Corpsman%20-%20LPN%20Approved%20Gap%20Assessment.pdf> (proposing a course that would allow medical corpsmen to obtain a practical nurse certificate, and sit for the licensure exam); Goldstein, *supra* note 6, at 254, 256–58 (explaining how New Jersey has had programs in place since the 1970s to help alleviate the problems with transitioning corpsmen from the military to civilian health care professions).

55. *See, e.g.*, CAL. BUS. & PROF. CODE § 2736.5 (West 2013) (stating that, in California, an individual may qualify for certain nursing licenses upon proof of completion of their rating qualification course as well as records of medical corps experience in the Armed Forces).

56. *E.g.*, Clair Courchane, *With Nurse Shortage Looming, America Needs Shot in the Arm*, WASH. TIMES (June 6, 2011), <http://www.washingtontimes.com/news/2011/jun/6/with-nurse-shortage-looming-america-needs-shot-in-/?page=all> (claiming that the primary bar to solving the nursing shortage is not a lack of interest in the profession, but instead the general lack of nursing school space and faculty); *cf.* Nicole Ostrow, *Nursing Shortage is Over in U.S. Until Retirement Glut Hits*, BLOOMBERG (Mar. 21, 2012 11:00 PM), <http://www.bloomberg.com/news/2012-03-21/nursing-shortage-in-u-s-is-over-temporarily-researchers-find.html> (discussing the inevitable exodus of nurses in the coming years due to a large percentage of current nurses reaching the retirement age and how this will create an even more extensive nurse shortage).

57. *See supra* note 44 and accompanying text (discussing the options for veterans to challenge the LVN examination in California); *e.g.*, Emily Vizzo, *Course Helps Corpsmen, Medics Become LVNs*, SAN DIEGO UNION-TRIB., Mar. 21, 2008, [http://www.utsandiego.com/uniontrib/20080321/news\\_1mc21lvn.html](http://www.utsandiego.com/uniontrib/20080321/news_1mc21lvn.html) (explaining the opportunity for medical veterans to take a course offered by MiraCosta College in order to challenge the LVN examination and become licensed in California).

permit less stringent standards for interstate LVN license transfers.<sup>58</sup> These steps taken by California are both basic and beneficial, which is why they should not only be recognized by other states but also replicated and implemented in order to nationalize the modernization of the transition into civilian care for veteran medical personnel.

#### V. PROPOSAL

In order to provide legitimate solutions to two of the most significant problems facing the United States today—the extreme shortage of nurses and general practitioners and the flood of recent veterans that are unable to find civilian employment—there must be a more dramatic dedication by both state and federal governments to provide efficient transitions for medical veterans into civilian health care. One of the most probable and efficient solutions to these problems is to follow the progressive steps of the state of California and its reformation of the transition process for these veterans.

While the federal government made efforts to improve the transition for veteran corpsmen into civilian care, the final responsibility for the process falls onto the states to make changes to help both veterans and the population as a whole. Although the current legislation in California is promising,<sup>59</sup> there are still an overwhelming number of states that have remained silent on the issue.<sup>60</sup> The statutory implementations in California

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58. See CAL. BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS, APPLICATION FOR VOCATIONAL NURSE LICENSURE BY ENDORSEMENT 1 (2012), available at <http://www.bvnpt.ca.gov/pdf/endorsement.pdf> (allowing out-of-state LVNs to transfer their license to California without retaking the license exam).

59. See *supra* note 54 and accompanying text (discussing the legislation from California and New Jersey aiming to provide better transitions for veteran corpsmen).

60. E.g., COMPARISONS, *supra* note 29, at 10 (recognizing that California remains an “outlier[,]” while many states have not altered their accreditation programs to accommodate military medical education and experience). However, even if it is not to the extent of California, other states have made progress in the area. See *supra* note 54 and accompanying text (discussing the historical efforts by New Jersey to ease the transitions for

provide the most prominent progress in creating change, and thus should be a template for other states to do the same. Even the most minor aspects of California's changes have made significant progress for the veteran populations in those states, and the rest of the state population benefits from the boost of medical personnel in their local hospitals due to the newly enacted laws.<sup>61</sup>

In addition to the ability to adjust licensure requirements, states also possess the power to change the legal scope of practices for medical professions.<sup>62</sup> States must try to closely align the scopes of practice of the professions mentioned below with the new advanced scopes of corpsmen in order to allow a smoother transition for both sides.<sup>63</sup> On the other hand, the federal government must push the military to modernize their medical education and training programs in order to provide corpsmen the level of training that will help them succeed not only on the battlefield, but in the civilian world as well.<sup>64</sup> States may feel less pressure in altering their own scopes of practice for medical professionals if the various military branches can reform their own expectations and increase the scope of practice of military medical personnel to one more comparable to their civilian counterparts.

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medical veterans).

61. *E.g.*, NURSING SHORTAGE, AM. ASS'N COLLS. NURSING 4–6 (2012), available at <http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf> (stating many of the benefits of adequate nursing staffing for the surrounding communities).

62. *See* REBECCA LEBUHN & DAVID A. SWANKIN, REFORMING SCOPES OF PRACTICE 2–3 (2010), available at <https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf> (“It is increasingly recognized that scope of practice restrictions often prevent professionals other than physicians from practicing to the full extent of their training and skills. . . . [S]tates should be encouraged to experiment with new approaches to scope of practice as part of healthcare reform.”).

63. *Cf. id.* at 3–20 (explaining the benefits of altering the scopes of practice of certain professions in order to provide better access and care).

64. *See* Krause, *supra* note 28, at 74 (proposing the creation and implementation of a “standardized nurse transition program” throughout the navy including both clinical and non-clinical aspects, “cooperative training agreements with civilian facilities,” and establishment of more trauma and simulation centers).

Although it would be preferable for the states to act on their own in altering the scopes of practice for medical professions, if they decline to follow California's lead by altering their current laws to provide efficient transitions and opportunities to Hospital Corps veterans, federal intervention may eventually be necessary.<sup>65</sup> Congress must realize that the urgency of the situation may exceed deference to the states in enacting their own statutes to promote veteran transitions, and it must contemplate possible methods to accelerate the process such as providing subsidies or other benefits.<sup>66</sup>

## VI. CONCLUSION

Although the demands and change required to promote the transitions of military medical personnel to civilian practitioners appears daunting, the ultimate result is far worth the reformation and adjustment, as apparent from the positive results in California. If cooperation between the military and state legislatures can be established, the proposed changes can not only occur, but exceed expectations in solving both the problems of unemployed veterans and the nurse shortage. The PAEA's president Kevin Lohenry described the situation best as a rare "win-win-win" scenario,<sup>67</sup> and if the correct steps are taken by the parties who hold the power to change the

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65. See generally Randall R. Bovbjerg, Joshua M. Wiener, & Michael Houseman, *State and Federal Roles in Health Care*, in *FEDERALISM AND HEALTH POLICY* ch. 2 (John Holahn, Alan Well, & Joshua Wiener eds., Urban Institute Press 2003), available at <http://assets.wharton.upenn.edu/~housman/files/UrbanInstitute.pdf> (discussing the balance between state and federal authorities, including federal intervention, when approaching healthcare issues).

66. E.g., Health Resources & Services Administration, *Helping Veterans Become Physician Assistants*, U.S. DEP'T HEALTH & HUMAN SERVS., <http://bhpr.hrsa.gov/veterans/physicianassistants.html> (noting the \$45 million in federal grants that the Health Resources and Services Administration plan to provide for physician assistant education programs for veterans by 2016).

67. See Smith, *supra* note 50 (statement of PAEA President Kevin Lohenry) (quoting Mr. Lohenry in response to the Obama Administration's intentions to promote more medical veterans to pursue careers as physician assistants).

system, then there is no reason that the scenario should not end resulting as such.

Nurse Practitioners:  
Comparing Two States' Policies

*Colin Goodman\**

I. INTRODUCTION

Health care in the United States is at the forefront of debates in the United States with the passage of the Patient Protection and Affordable Care Act (PPACA), shortages of doctors, and a growing call for reform in access to health care.<sup>1</sup> One of the many suggested solutions to the shortage of doctors and the call for reform in access to health care is to expand the scope of practice of non-physician healthcare providers, such as nurse practitioners. Expansion of the scope of practice of non-physician healthcare providers is greatly debated.<sup>2</sup> States are responding differently to the proposition to increase the scope of practice of non-physician healthcare providers.<sup>3</sup> Currently, seventeen states and the District of Columbia allow nurse practitioners to practice independent of a physician.<sup>4</sup> Twelve states require physician supervision of nurse practitioners, while the

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1. See, e.g., *The Shame of American Health Care*, N.Y. TIMES (Nov. 17, 2013), <http://www.wausaudailyherald.com/article/20131127/WDH06/311270092/>.

2. See generally James L.J. Nuzzo, *Independent Prescribing Authority of Advanced Practice Nurses: A Threat to the Public Health?*, 53 FOOD & DRUG L.J. 35, 38-42 (1998) (discussing the debate in the 1990s about allowing nurse practitioners to prescribe drugs and the debate that took place in the early twentieth century between the highly trained physicians and lesser-trained pharmacists about who was better qualified to prescribe drugs).

3. See generally Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH L. 21, 23 (2008) (discussing different states' policies and practices pertaining to nurse practitioners).

4. Robin Wulffson, *California Nurse Practitioners Fighting to Independently Treat Patients*, L.A. HEALTH EXAMINER (Aug. 15, 2013), <http://www.examiner.com/article/california-nurse-practitioners-fighting-to-independently-treat-patients>.

other twenty-one states require a collaborative agreement with a physician.<sup>5</sup> Oregon and California are two states that demonstrate the opposite ends of states' reactions to the expansion of the scope of practice for nurse practitioners.<sup>6</sup> Neither Oregon nor California has the perfect solution. However, by giving nurse practitioners a greater scope of practice, Oregon better addresses the shortage of primary care physicians and the lack of access to health care. Other states should follow Oregon's model of allowing nurse practitioners to practice independently while further regulating the profession.

This article is organized into five parts. Part II will give background of the nurse practitioner profession. Part III will analyze California's policies regarding the scope of practice of nurse practitioners. Part IV will analyze the policies in Oregon, which allow nurse practitioners to practice independently of physicians. Next, Part V presents the arguments for and against increasing nurse practitioners' scope of practice. The final section, Part VI, argues that Oregon provides a concrete solution for the shortage of primary care physicians that other states should follow, although there still is room for improvement.

## II. NURSE PRACTITIONERS

In response to a physician shortage, the University of Colorado School of Nursing created the first nurse practitioner program in 1965.<sup>7</sup> A nurse practitioner is a registered nurse (RN) who has completed some advanced degree in the field of nursing.<sup>8</sup> Usually this degree is a master's degree.<sup>9</sup>

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5. *Id.*

6. See Linda J. Pearson, *The Pearson Report: A National Overview of Nurse Practitioner Legislation and Healthcare Issues*, AM. J. FOR NURSE PRACS., Feb. 2009, at 21, 67, available at [http://www.npfreebies.com/ajnp\\_pearson09.pdf](http://www.npfreebies.com/ajnp_pearson09.pdf).

7. *Id.*

8. *Id.*

9. *Id.*

After completing an advanced degree or program, a nurse practitioner is qualified to provide primary care to patients.<sup>10</sup> Today, nurse practitioners provide primary care to many patients in the United States in an ever-increasing number of settings.<sup>11</sup>

There still is a large shortage of primary care physicians in the United States, and the nurse practitioner profession continues to fill the void.<sup>12</sup> In 2007, almost 1,600 primary care physician residency spots were unfilled out of a total of about 2,700 spots.<sup>13</sup> In the same year, 3,700 primary care nurse practitioners graduated from postgraduate nurse practitioner programs.<sup>14</sup> By 2025, the shortage of primary care physicians may grow to 65,800.<sup>15</sup> This number is staggering, especially in a time when the federal and state governments are focusing on providing basic health care to every American through the implementation of the PPACA.<sup>16</sup> Meanwhile, nurse practitioner numbers have continued to grow; in 2009, over 150,000 nurse practitioners were practicing in the United States.<sup>17</sup>

All nurse practitioners must be RNs.<sup>18</sup> Beyond this initial requirement, each state's policies and regulations pertaining to nurse practitioners differ

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10. *See id.*

11. Ritter & Hansen-Turton, *supra* note 3, at 21. Nurse practitioners work in traditional settings such as physician groups and hospitals as well as less-traditional settings such as nurse-managed health centers and retail health clinics. *Id.*; Lauren E. Battaglia, *Supervision and Collaboration Requirements: The Vulnerability of Nursepractitioners and Its Implications for Retail Health*, 87 WASH. U. L. REV. 1127, 1128 (2010).

12. *See id.*

13. *See id.*

14. *Id.*

15. Wulffson, *supra* note 4.

16. *See, e.g., A Better Bargain for the Middle Class*, THE WHITE HOUSE, <http://www.whitehouse.gov/a-better-bargain#health> (last visited Nov. 3, 2013).

17. Michael B. Zand, *Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioner Autonomy Can Safely and Economically Meet the Growing Demand for Basic Health Care*, 24 J.L. & HEALTH 261, 263 (2011); *see* Ritter & Hansen-Turton, *supra* note 3, at 21.

18. Zand, *supra* note 17, at 264.



greatly from those of other states.<sup>19</sup> Forty-two states require nurse practitioners to hold a master's degree while the remaining eight states require a specific course of study.<sup>20</sup> States also differ in regulating the practice of nurse practitioners. Most states require some level of physician involvement in the practice of nurse practitioners.<sup>21</sup> At times, the amount of required physician involvement can be ambiguous in states' regulations.<sup>22</sup> Fourteen states and the District of Columbia do not require physician involvement.<sup>23</sup> California does not allow nurse practitioners to practice independently and requires collaboration with physicians.<sup>24</sup> On the other hand, Oregon is one of the least restrictive states for nurse practitioners.<sup>25</sup>

### III. CALIFORNIA

The scope of practice for nurse practitioners in California is very limited in that it is the same as the defined scope of practice for RNs.<sup>26</sup> California requires that an applicant seeking certification as a nurse practitioner have an active, valid RN license; have a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing; and finish a nurse practitioner program approved by the California Board of Registered Nursing (the California Board).<sup>27</sup> The California Board requires that the program include all of the theoretical and clinical instruction that

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19. See generally Pearson, *supra* note 6 (charting the different laws and regulations of each state).

20. See *id.*

21. See *id.* at 273.

22. *Id.* (noting that some states have explicit requirements of physician involvement, such as explicitly defining cooperation between nurse practitioners and physicians, while other states do not define their requirements).

23. See *id.* at 277.

24. See Pearson, *supra* note 6, at 21.

25. See generally *id.* at 67 (providing a break down of states' laws and regulations with respect to different categories of nurse practitioner responsibilities).

26. CAL. CODE REGS. tit. 16, § 1485 (Westlaw through 8/30/13 Reg. 2013, No. 35).

27. CAL. BUS. & PROF. CODE § 2835.5 (West, Westlaw through Ch. 309 of 2013 Reg. Sess. & all 2013-2014 1st Ex. Sess. laws).

the nurse practitioner will need to provide primary health care.<sup>28</sup> The program must consist of thirty semester units, of which three credits per week must be clinical practice.<sup>29</sup>

California, like all fifty states, allows nurse practitioners to prescribe medicine, though in California the prescribing authority of a nurse practitioner must be under an agreement with a physician.<sup>30</sup> California's Business and Professional Code allows nurse practitioners to order durable medical equipment, to certify disability in collaboration with a physician, and to approve, sign, modify or add to a plan of treatment for those receiving home health services, but only after consultation with a physician.<sup>31</sup>

On February 21, 2013, Senator Hernandez of the California State Senate introduced a bill that would allow nurse practitioners to practice independently of physicians.<sup>32</sup> The bill stated that the California Senate found that nurse practitioners are integral to the state's healthcare system.<sup>33</sup> It further stated that allowing nurse practitioners to practice independently would become necessary with the addition of an estimated five million people who would obtain healthcare coverage through the PPACA.<sup>34</sup> Currently, the bill is sitting in committee and will not become law.<sup>35</sup> The California Medical Association, which represents physicians in the state,

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28. CAL. CODE REGS. tit. 16, § 1484 (Westlaw through 9/13/13 Reg. 2013, No. 37).

29. *Id.*

30. Ritter & Hansen-Turton, *supra* note 3, at 24; *see* Pearson, *supra* note 6, at 21. Nurse practitioners are only allowed to prescribe drugs or devices specifically agreed on by the nurse practitioner and physician. Pearson, *supra* note 6, at 21.

31. *See* CAL. BUS. & PROF. CODE. § 2835.7 (West 2013).

32. S.B. 491, Cal. Leg. 2013-2014, Reg. Sess. (2013).

33. *Id.*

34. *Id.*

35. *See id.*; Stephanie O'Neill, *Battle to Reform Nurse Practitioner Rules Will Continue, Vows Author of SB 491*, S. CAL. PUB. RADIO (Sept. 6, 2013, 6:00 AM), <http://scpr.org/news/2013/09/06/39086/battle-to-reform-nurse-practitioner-rules-will-con/>.

spent over one million dollars in opposition of the bill.<sup>36</sup>

The bill introduced by Senator Hernandez proposed further regulation of the nurse practitioner profession as well as an expansion of its scope of practice.<sup>37</sup> The bill proposed an added requirement that an applicant for nurse practitioner certification must hold a national certification as a nurse practitioner from a national certifying body recognized by the California Board.<sup>38</sup> In addition to the activities already allowed by California law, the bill allowed nurse practitioners to manage physical and psychosocial health status, examine and diagnose patients, prescribe drugs, give referrals, delegate tasks to a medical assistant, and perform other tasks in accordance with their training.<sup>39</sup> The bill also tried to amend the section of the law allowing nurse practitioners to prescribe drugs;<sup>40</sup> the new provisions sought to require nurse practitioners to take a prescription drug course, which would allow them to prescribe Schedule II drugs.<sup>41</sup>

#### IV. OREGON

In Oregon, the scope of practice of nurse practitioners is much less restrictive than in California.<sup>42</sup> This less restrictive scope of practice helps alleviate some problems that arise from the shortage of primary care physicians. Oregon defines a nurse practitioner as a RN who is qualified to practice nursing in a more expanded role and has been deemed qualified as such by the Oregon State Board of Nursing (the Oregon Board).<sup>43</sup> Oregon allows a nurse practitioner to complete and sign death certificates and to

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36. Wulffson, *supra* note 4.

37. *See* Cal. S.B. 491.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *Compare* Pearson, *supra* note 6, at 21 *with id.* at 67.

43. OR. REV. STAT. § 678.010 (2013).

prescribe drugs.<sup>44</sup> The laws of Oregon dictate that the Oregon Board decides nurse practitioners' scope of practice.<sup>45</sup> The Oregon Board is comprised of five registered nurses, one licensed practical nurse, one certified nurse assistant, and two members of the public who do not fit the description of the other required positions on the board.<sup>46</sup>

Oregon has more qualifications than California before an individual is able to hold himself out as a nurse practitioner. With respect to a nurse practitioner's qualifications, the applicant must hold a current RN license in the State of Oregon.<sup>47</sup> The applicant must also obtain either a Master's Degree in Nursing or a Doctorate in Nursing from a Commission on Collegiate Nursing Education or from a National League for Nursing Accreditation Commission accredited graduate nursing program.<sup>48</sup> This requirement is similar to California's requirement of an advanced degree. However, Oregon stipulates exactly what degrees would fulfill the requirement.<sup>49</sup> Oregon specifically noted what education and experiences the Oregon Board thinks that a nurse practitioner should have in order to practice primary care by providing that a nurse practitioner must also complete a one-year program involving both theoretical and clinical experience.<sup>50</sup> After certification, a nurse practitioner must renew his or her license every two years after completing 100 hours of continuing education.<sup>51</sup>

Oregon nurse practitioners are given many responsibilities, more than

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44. *Id.* § 678.375.

45. *See id.* §§ 678.375, 380.

46. *Id.* § 678.140.

47. OR. ADMIN. R. 851-050-0002 (2013).

48. *Id.*

49. *See Id.*

50. *See id.* 851-050-0001.

51. *Id.* 851-050-0138; *RN/LPN Licensure Information*, OR. STATE BD. OF NURSING, [http://www.oregon.gov/osbn/Pages/rn-lpnlicensure.aspx#RN/LPN\\_Renewal\\_Information](http://www.oregon.gov/osbn/Pages/rn-lpnlicensure.aspx#RN/LPN_Renewal_Information) (last visited Dec. 13, 2013).

many states.<sup>52</sup> According to the Oregon Board, a nurse practitioner must manage a client's health problems.<sup>53</sup> The nurse practitioner is held accountable for her actions and for the patient's outcome.<sup>54</sup> In order to do this, a nurse practitioner may assess, diagnose, develop a plan for, intervene for, or evaluate a patient.<sup>55</sup> A nurse practitioner is also allowed to prescribe drugs that are in accordance with the practitioner's training and scope of practice.<sup>56</sup> Senator Hernandez's bill in California proposed a very similar scope of practice for nurse practitioners.<sup>57</sup> Without the passage of such a bill in California, nurse practitioners in that state are essentially RNs with a few extra responsibilities while Oregon nurse practitioners actually have many responsibilities. California and other states with a restrictive scope of practice for nurse practitioners should propose legislation to increase their nurse practitioners' scope of practice to mirror that of Oregon's nurse practitioners.

#### V. SCOPE OF PRACTICE ARGUMENTS

The topic of the expansion of the scope of practice of nurse practitioners is hotly debated.<sup>58</sup> The most vocal opponents are physicians,<sup>59</sup> who argue that expanding the scope of practice is bad for public health because of the dangers posed by allowing nurse practitioners to practice independently when they have significantly less education and experience in the medical

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52. See generally Pearson, *supra* note 6 (charting the different laws and regulations with respect to nurse practitioners of each state).

53. OR. ADMIN. R. 851-050-0005 (2013).

54. *Id.*

55. *Id.*

56. *Id.*

57. Compare *id.* with S.B. 491, Cal. Leg. 2013-2014, Reg. Sess. (2013).

58. See, e.g., *supra* note 4.

59. See generally Nuzzo, *supra* note 2; Zand *supra* note 17; O'Neill *supra* note 35; Wulffson *supra* note 4 (giving physician's arguments and specific instances of their opposition).

field.<sup>60</sup> Physicians must obtain an undergraduate degree while completing required courses, obtain a medical degree from a four-year institution, pass the boards, and have a minimum of three years of residency and further training in medicine.<sup>61</sup> A nurse practitioner must complete either an associate or a bachelor's degree, and then complete a Master's degree in nursing, which can be either two or three years.<sup>62</sup> The number of years of education for a physician is almost always greater than the number of years for a nurse practitioner.

Some physicians liken the push for independent prescribing authority for nurse practitioners to the debate between physicians and pharmacists in the early 1900s.<sup>63</sup> Drugs were unregulated, and when the government tried to regulate them, the laws were not enforced.<sup>64</sup> Pharmacists were prescribing drugs to people after a limited consultation with a physician and, in some cases, were diagnosing illnesses and giving drugs to patients with no physician involvement.<sup>65</sup> Drugs were poorly administered, and there were health consequences.<sup>66</sup> Physicians argue that only through better regulation and more restrictions on the prescription authority of pharmacists was the health crisis caused by independently prescribing pharmacists averted.<sup>67</sup> Physicians, in the same way, believe that nurse practitioners are not trained extensively and that they lack the knowledge to properly prescribe drugs.<sup>68</sup>

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60. See, e.g., Nuzzo, *supra* note 2.

61. See *id.* at 45.

62. AM. ASS'N. OF COLLS. OF NURSING, YOUR GUIDE TO GRADUATE NURSING PROGRAMS 3-4 (2011), available at [http://www.aacn.nche.edu/news/articles/attachment/2011/10/07/grad-brochure.gradstudentsbrochure\\_omyqp.pdf](http://www.aacn.nche.edu/news/articles/attachment/2011/10/07/grad-brochure.gradstudentsbrochure_omyqp.pdf).

63. See generally Nuzzo, *supra* note 2 (discussing the debate in the early 1900s about prescribing authority granted to pharmacists and comparing that debate to the debate about prescribing authority of nurse practitioners).

64. See *id.* at 35-36, 39.

65. See *id.* at 39.

66. See *id.*

67. See *id.* at 46.

68. *Id.* at 45.

On the other side, advocates for the expansion of the scope of practice of nurse practitioners argue that healthcare costs will decline and more people will have access to health care.<sup>69</sup> As mentioned above, there is a serious shortage of primary care physicians in the United States.<sup>70</sup> Nurse practitioners may be a good option for alleviating some of that shortage.<sup>71</sup> Advocates for the expansion of scope of practice also point to studies that suggest quality of care does not suffer when comparing the treatment of a physician and an independently practicing nurse practitioner.<sup>72</sup> An early study conducted by the Office of Technology Assessment of the United States Congress in 1986 reported that the quality of care was just as good with nurse practitioners as it was with physicians.<sup>73</sup> This study emphasized the patient's experience and did not focus on things such as correctness of diagnosis and morbidity rates.<sup>74</sup> A more recent study, completed in 2000 by the Journal of American Medical Association, showed that nurse practitioners offer the same or better quality of care than physicians.<sup>75</sup> The result was that little difference, if any at all, was found between physician and nurse practitioner primary care.<sup>76</sup> Advocates for the expansion of nurse practitioner scope of practice also suggest that nurse practitioners are more patient-focused and better prepared for the current trend in patient-centered care.<sup>77</sup>

The PPACA is expected to create a larger clientele of patients in the

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69. See Zand, *supra* note 17, at 261.

70. See Ritter & Hansen-Turton, *supra* note 3, at 21; Zand, *supra* note 17, at 265-66.

71. See Zand, *supra* note 17, at 261.

72. See Ritter & Hansen-Turton, *supra* note 3, at 22.

73. *Id.*

74. Nuzzo, *supra* note 2, at 43.

75. See Ritter & Hansen-Turton, *supra* note 3, at 22.

76. *Id.* (quoting Mary Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians*, 283 JAMA 59, 68 (2000)).

77. See Zand, *supra* note 17, at 262 (suggesting that nurse practitioners are better at examining patient's history and family and providing patient-focused care as opposed to physicians' disease-focused practice).

healthcare industry.<sup>78</sup> This expectation is supported by the growth in the number of patients in Massachusetts after the passage of a similar healthcare act in the state.<sup>79</sup> Primary care physician shortage is already a serious problem that affects access to healthcare in the United States.<sup>80</sup> Nurse practitioners and their advocates argue that they can help solve the problem.<sup>81</sup>

It is important to note that financial self-interest plays a large role in the debate over nurse practitioner scope of practice.<sup>82</sup> This self-interest is evidenced by the amount of money spent by the California Medical Association in support and on behalf of physicians in order to defeat the California bill which would increase nurse practitioner scope of practice.<sup>83</sup> Both sides admit that financial self-interest is a consideration;<sup>84</sup> however, they maintain that their offered propositions would benefit all healthcare consumers.<sup>85</sup>

## VI. ARGUMENT

### *A. Arguments for and Against the Expansion of Nurse Practitioner Scope of Practice*

Both sides of the scope of practice debate present valid arguments. However, just because something is the status quo does not mean that it is

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78. See Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1235 (2010).

79. See *id.*

80. See *id.* at 1236 (providing statistics showing twenty-nine percent of people with Medicare had trouble finding a doctor who would take the insurance, seventy-five percent of Americans have trouble getting health care nights, weekends, and holidays, and thirty percent of Americans cannot get into see a doctor on the same day as making the appointment).

81. See *id.* at 1245.

82. See Nuzzo, *supra* note 2, at 46.

83. See Wulffson, *supra* note 4.

84. See Nuzzo, *supra* note 2, at 46.

85. See *id.*



the best method.<sup>86</sup> The proponents for limiting nurse practitioner scope of practice cannot argue with the fact that there is a serious shortage of primary care healthcare providers.<sup>87</sup> Therefore, the scope of practice must be expanded for nurse practitioners in all states similar to the way the state of Oregon regulated this expansion, and ideally the scope of practice for nurse practitioners across the nation would be expanded even further than in Oregon to meet the needs of Americans.

The PPACA seeks to make health care more accessible to all Americans.<sup>88</sup> The PPACA's undertaking is noble, but it will be hard to accomplish without an increase in the scope of practice for nurse practitioners. States take different approaches to expanding the scope of practice for nurse practitioners.<sup>89</sup> As discussed above, Oregon and California currently have very opposite approaches.<sup>90</sup> Neither is perfect, but Oregon better meets the demands caused by a primary care physician shortage by allowing nurse practitioners to practice independently and, therefore, has the better policy.

California's bill that would have expanded nurse practitioners' scope of practice failed in part due to the intense opposition by the California Medical Association.<sup>91</sup> Without some other development, the shortage in California will not be remedied by staying on its current course. Only sixteen of fifty-eight counties in California have enough providers for their

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86. See generally Zand, *supra* note 17, at 268-69 (explaining the physician monopoly and evolution of that monopoly on medical care).

87. See generally Wulffson, *supra* note 4 (outlining the primary care physician shortage in California as well as the United States as a whole).

88. *The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs*, LEGISLATIVE ANALYST'S OFFICE (May 13, 2010), [http://www.lao.ca.gov/reports/2010/hlth/fed\\_healthcare/fed\\_healthcare\\_051310.aspx](http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.aspx).

89. See generally Pearson, *supra* note 6 (charting the different laws and regulations of each state).

90. See discussion *supra* Parts II-III.

91. Wulffson, *supra* note 4.

residents.<sup>92</sup> This lack of providers can be alleviated by nurse practitioners if their scope of practice is increased to allow them more responsibilities such as the ability to practice and prescribe certain drugs independent from a physician. Restricting a nurse practitioner to practice under a doctor prevents that nurse practitioner from practicing in areas underserved by physicians because there are no or very few physicians under which to practice. Eliminating the restriction would allow those nurse practitioners to go out into these areas and help meet the primary care needs of the people living there. It would also allow nurse practitioners to more efficiently treat patients because they would not be required to consult a physician before every treatment, diagnosis, or prescription. Oregon better regulates its nurse practitioners compared to California because Oregon provides its residents greater access to care due to the expanded role of nurse practitioners. Although the primary care physician shortage continues to affect Oregon, the state can rely on nurse practitioners to carry some of the burden.<sup>93</sup>

Oregon's success refutes some of the arguments against an expansion of the scope of practice of nurse practitioners. First, Oregon's success refutes the argument that nurse practitioners do not have enough education and are not prepared to practice independently. This proposition is not supported because studies show that quality of care does not suffer when comparing the treatment and care of a nurse practitioner and of a primary care physician.<sup>94</sup> Oregon regulates what educational programs will be accepted

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92. *Id.*

93. See Elizabeth Hayes, *Doctor Shortage is on the Horizon. Who'll Pick Up the Slack?*, PORTLAND BUS. J. (Aug. 5, 2013), <http://www.bizjournals.com/portland/blog/health-care-inc/2013/08/doctor-shortage-is-on-the-horizon.html?page=all> (quoting Janet Meyer, CEO of Health Share of Oregon, as saying, "We do rely on nurse practitioners for a big part of our capacity. I don't know how we'd maintain the system if we didn't have them.").

94. See Ritter & Hansen-Turton, *supra* note 3, at 22.

for those wanting to be licensed as nurse practitioners in the state.<sup>95</sup> One can assume that Oregon believes these programs to be the focused education needed for proper care.<sup>96</sup> The greater access to care that Oregon residents receive can be recreated in other states that decide to implement similar scope of practices for their nurse practitioners.

*B. Further Steps to Expand Scope of Practice*

The policies and regulations in Oregon do not address all concerns. Physicians complete extensive training to be licensed to practice medicine.<sup>97</sup> One can imagine that this commitment is a serious investment in time, money, and hard work. If a nurse practitioner with less training is allowed to do some of a physician's tasks, provisions should be in place to ensure that the nurse practitioner is able to provide adequate primary care. In this regard, Oregon's policies concerning nurse practitioners could be strengthened considerably and still provide for an alternative to physicians. For instance, Oregon could stipulate that nurse practitioners be allowed to practice only after completing a set amount of time under the supervision of a physician, in a program similar to a physician's residency requirement. This additional regulation, if adopted by other states, would benefit those states as well by helping to ensure that nurse practitioners are ready to take on additional responsibilities.

The Oregon legislature gave the Oregon State Board of Nursing wide discretion in deciding the scope of practice of nurse practitioners.<sup>98</sup> Since

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95. OR. ADMIN. R. 851-050-0002 (2013).

96. For instance, the Oregon State Board of Nursing stipulates exactly what advanced degrees will be accepted. *See id.* 851-050-0002. It also has many requirements about the programs that will be deemed acceptable for nurse practitioners. *See id.* 851-050-0001.

97. *See* Nuzzo, *supra* note 2, at 45.

98. *See generally* OR. REV. STAT. §§ 678.375, 380 (2013) (providing that the Oregon State Board of Nursing can stipulate the required education for nurse practitioners, determine the scope of practice, and set procedures for certification).

the Oregon Board is appointed and not elected, one can imagine that this decision would circumvent some of the political pressures from physician and nursing groups that affected the California legislature in its decision to table the expansion of nurse practitioners' scope of practice. However, this decision also allows nurses to control their own scope of practice. As mentioned above, the Oregon Board is completely comprised of people involved in the nursing profession with the addition of two community members.<sup>99</sup> This composition could possibly lead to decisions that benefit nurses and nurse practitioners, but may jeopardize patient outcomes. Oregon should provide for a more impartial decision maker in this process, possibly by including a physician or a state official involved in health care to the Oregon Board.

Other possible disadvantages to an expanded scope of practice for nurse practitioners could be addressed in further legislation and regulation.<sup>100</sup> For example, if nurse practitioners practice independently there is a potential misunderstanding by the public that nurse practitioners are doctors.<sup>101</sup> Policies and regulations dictating how nurse practitioners should identify themselves should be enforced.<sup>102</sup>

The failed bill in California seemed to address some of the problems that could result from allowing nurse practitioners to practice independently. It

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99. OR. REV. STAT. §§ 678.375, 380 (2013).

100. Other issues such as insurance and malpractice are outside the scope of this article but are important issues that need to be addressed as independently practicing nurse practitioners become more prevalent in the United States. *See generally id.* at 279-83 (discussing insurance and malpractice and the issues they present to nurse practitioners).

101. *See Zand, supra* note 17, at 279.

102. *See id.* Currently, nurse practitioners that have a doctorate degree in nursing may legally identify themselves with the prefix of "Dr." in some states. *Id.* Previously, Oregon did not allow nurse practitioners with doctorate degrees to identify "Dr."; in 2009, Oregon reversed and allowed this identification. *Id.* at 279 n.158. Allowing nurse practitioners to identify as "Dr." could lead to confusion about whether or not the nurse practitioner is a medical doctor. *Id.* at 279. Currently, six states do not allow them to identify as doctors, while many states do not regulate the title and ability to use "Dr." as prefix. *Id.*

provided that a nurse practitioner could practice independently only after a set number of hours under physician supervision.<sup>103</sup> The bill also required certification by a national certifying body.<sup>104</sup> Although the California bill did not go as far as Oregon in stipulating exact degrees, the requirement of national certification seems to fulfill this deficiency by naming a trusted source that the state of California recognizes as a certification that would enable a person to practice as a nurse practitioner within the state.<sup>105</sup>

## VII. CONCLUSION

Oregon tries to solve the problem of primary care provider shortage by allowing nurse practitioners to practice independently. Its policy is more effective and efficient than California's, which places restrictions on nurse practitioners that do not allow them to practice independently.<sup>106</sup> However, Oregon's regulations concerning nurse practitioners fail to completely address the many issues that arise from allowing nurse practitioners to practice independently. Legislation that allows independent practice, but provides more guidelines and stricter qualification processes should be instituted in Oregon as well as in other states. California and other states should follow Oregon's lead and work to enact laws that will expand the scope of practice of nurse practitioners. Quality of care is not decreased in

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103. S.B. 491, Cal. Leg. 2013-2014, Reg. Sess. (as amended August 14, 2013) ("Notwithstanding any other provision of this chapter, a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body may practice under this section without physician supervision if the nurse practitioner has practiced under the supervision of a physician for at least 4160 hours . . .").

104. *Id.*

105. Compare S.B. 491, Cal. Leg. 2013-2014, Reg. Sess. (2013) (requiring that a person wishing to practice as a nurse practitioner in the state "[p]ossess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing"), with OR. ADMIN. R. 851-050-0002 (2013) (requiring a Master's Degree in Nursing or a Doctorate in Nursing from a Commission on Collegiate Nursing Education or from a National League for Nursing Accreditation Commission accredited graduate nursing program).

106. See Pearson, *supra* note 6, at 21.

states that allow independent practice.<sup>107</sup> It follows that nurse practitioners should be allowed to do that which they are trained to do: help the public with its primary care shortage by practicing independently.

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107. See Ritter & Hansen-Turton, *supra* note 3, at 22.

New Mexico: An Expansion of  
Scope of Practice Model

*Andrea Reino\**

I. INTRODUCTION

Healthcare reform exacerbates primary care shortage problems in the United States, continuing the tug-of-war between physicians and nurse practitioners (NPs)<sup>1</sup> over who will provide primary care services.<sup>2</sup> This tug-of-war is especially problematic with the thirty-million expected newly insured Americans come 2014.<sup>3</sup> The existing shortage is highlighted by the sixty-five million Americans already living in regions without adequate primary care.<sup>4</sup> In order to shrink the gap, between the care needed and the

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1. A nurse practitioner is a registered nurse with at least a master's degree in nursing and advanced education in primary care of particular groups of clients in; nurse practitioners are capable of independent practice in a variety of settings. State laws regulate their scope of practice and degree of autonomy. STEDMAN'S MEDICAL DICTIONARY (27<sup>th</sup> ed. 2000).

2. Shannon Pettipeice, *Nurse Practitioners, Doctors in Tug-of-War Over Patients*, BLOOMBERGBUSINESSWEEK (Mar. 7, 2013), <http://www.businessweek.com/articles/2013-03-07/nurse-practitioners-doctors-in-tug-of-war-over-patients>.

3. Shannon Pettipeice, *Nurses Spar With Doctors as 30 Million Insured Seek Care*, BLOOMBERG (Mar. 4, 2013), <http://www.bloomberg.com/news/2013-03-04/nurses-spar-with-doctors-as-30-million-insured-seek-care.html>; Christine Vestal, *Nurse Practitioners Slowly Gain Autonomy*, KAISER HEALTH NEWS (July 19, 2013), <http://www.kaiserhealthnews.org/stories/2013/july/19/stateline-nurse-practitioners-scope-of-practice.aspx>.

4. *States in Action Archive: State and Federal Efforts to Enhance Access to Basic Health Care*, THE COMMONWEALTH FUND (March/April 2010), <http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Mar/March-April-2010/Feature/Feature.aspx>; Doctors and clinicians have continued to migrate away from primary care to specialty fields that offer higher pay and better hours. Ann Sanner, *Newly Insured to Deepen Primary Care Doctor Gap*, THE ADVOCATE (June 29, 2013), <http://theadvocate.com/news/business/6323359-123/newly-insured-to-deepen-primary>. The doctors entering the field aren't expected to keep pace with the demand – about 25,000 primary care physicians work in America now. *Id.* The Association of Medical Colleges projects that the shortage will reach 30,000 in two years, and 66,000 in 10 years. *Id.*

care available, there must be an increase in primary care providers.<sup>5</sup> One proposed solution by state legislatures is to increase the number of primary care providers by expanding scope of practice laws for mid-level practitioners.<sup>6</sup> Scope of practice expansion for mid-level practitioners will have a greater immediate impact on the supply of primary care providers than practice redesign or a restructuring of medical education.<sup>7</sup>

Scope of practice laws are state specific.<sup>8</sup> The dichotomous relation between laws in New Mexico and Texas exemplifies the possible range of scope of practice laws. While Texas requires collaborative agreement and tight supervision, New Mexico allows NPs to be independent providers.<sup>9</sup> Loosening restrictions on scope of practice laws would allow for greater access to primary care.<sup>10</sup> Expanding scope of practice is supported by availability, lower cost, and the quality of services that NPs provide.<sup>11</sup> In addition, allowing NPs to function independently will reduce physician liability concerns.<sup>12</sup>

This article asserts that states should follow New Mexico's model by expanding NP scope of practice laws and removing physician supervision. In Part I, this argument will be developed by examining the dichotomous

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5. For example, by changing the structure or funding of Medical education, making primary care more appealing and financially rewarding, or encouraging a team based medicine approach. Sarah Klein, *Quality Matters: Strengthening the Primary Care Workforce to Meet Population Needs*, THE COMMONWEALTH FUND (May 2011), <http://www.commonwealthfund.org/Newsletters/Quality-Matters/2011/April-May-2011/In-Focus.aspx>.

6. *Id.*, See Vestal, *supra* note 3.

7. Practice redesign would be a change in medical care delivery through a team-based approach. The restructuring of medical education would involve changes to the education and funding structure of medical schools in an effort to incentivize student to go into primary care by making it more financially rewarding. See Klein, *supra* note 5.

8. *The future of Nursing: Focus on Scope of Practice*, INST. OF MED. (October 2010) <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf>.

9. See Pettypiece, *supra* note 3.

10. See *infra* Part II.

11. See *infra* Parts II-III.

12. See *infra* Part IV.



positions between New Mexico and Texas scope of practice laws and their impact on access to care. Part II will present arguments in support of scope of practice expansion for NPs by examining the availability and cost of employing NPs to the healthcare system. Then, Part III will evaluate the necessity of scope of practice expansion per New Mexico's model by countering opponents against NP quality of care arguments. Finally, Part IV will discuss how physician liability concerns are effectively handled by the New Mexico model functions and support for expanding scope of practice laws.

## II. NURSE PRACTITIONER SCOPE OF PRACTICE EXPANSION: AVAILABILITY & COST

The nursing profession makes up the largest percentage of the United States' healthcare workforce at over three million.<sup>13</sup> The number of NPs is rapidly growing while the number of physicians entering general internal medicine or primary care is decreasing.<sup>14</sup> Only about two percent of medical school students are preparing for primary care.<sup>15</sup> In fact, between the years 1995-2009, the number of NPs per primary care physician doubled.<sup>16</sup> The supply of NPs, because of the shorter training time in comparison to physicians, can be used to increase workforce supply in less time than medical schools can turn out physicians.<sup>17</sup> This discrepancy in the supply of NPs and physicians will continue given that the new federal healthcare law provides more funding for nursing education and nurse-

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13. *The Future of Nursing: Leading Change, Advancing Health*, INST. OF MED. (October 2010) <http://www.iom.edu/reports/2010/the-future-of-nursing-leading-change-advancing-health.aspx>.

14. *The Future of Nursing: Infographic*, INST. OF MED. (October 2010). <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Infographic.aspx>.

15. *Id.*

16. *Id.*

17. *Id.*

managed clinics,<sup>18</sup> allowing for more positions in nursing schools and job opportunities.<sup>19</sup>

In addition to the higher numbers of NPs available to the primary care field, NPs have a lower labor cost than physicians,<sup>20</sup> and they are able to provide basic clinical services at lower costs.<sup>21</sup> This discrepancy may be due to the lower cost of educating NPs over physicians, which costs four to five times less and can be completed in a shorter time frame.<sup>22</sup> Over all, greater utilization of NPs results in greater cost savings for the healthcare system.<sup>23</sup> These lower costs have been demonstrated by retail health clinics (RCs)<sup>24</sup>, which are staffed primarily by NPs and follow state scope of practice and prescription authority laws.<sup>25</sup> RC treatment provided by NPs

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18. Tine Hansen-Turton et al., *Nurse practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1243 (2010).

19. See Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 HEALTH L. 21, 26 (2008).

20. From surveys taken in 2012 an Average Full time NP earned \$93,032 while a primary care/ internal medicine physician earned roughly \$185,000. *2012 NP and PA Salary Survey Results*, ADVANCE HEALTHCARE NETWORK (July 14<sup>th</sup>, 2013) <http://nurse-practitioners-and-physician-assistants.advancweb.com/Web-Extras/Online-Extras/2012-NP-PA-Salary-Survey-Results.aspx>; *Physician Compensation Report 2013: Physician Compensation in 2012*, MEDSCAPE, <http://www.medscape.com/features/slideshow/compensation/2013/public> (last visited December 13<sup>th</sup>, 2013).

21. Lauren E. Battaglia, *Supervision and Collaboration Requirements: The Vulnerability of Nurse Practitioners and its Implications for Retail Health*, 87 WASH. U. L. REV. 1127, 1142-44 (2010).

22. *Nurse Practitioners: The Growing Solution in Health Care Delivery*, AM. ASS'N OF COLL. OF NURSING <http://www.aacn.nche.edu/media-relations/fact-sheets/nurse-practitioners> (last visited December 13<sup>th</sup>, 2013).

23. Battaglia, *supra* note 21 at 1142.

24. New Mexico may have less need than more restricted scope of practice states because NPs can run independent clinics, ambulatory and urgent care centers. *New Mexico Urgent Care and Walk-in Clinics*, URGENT CARE LOCATIONS, <http://www.urgentcarelocations.com/nm/new-mexico-urgent-care> (last visited December 13, 2013). There are about 85 retail clinics in Texas. *Retail Health Clinics: State Legislation and Laws*, NAT'L CONF. OF STATE LEG. (last updated September 2012) <http://www.ncsl.org/research/health/retail-health-clinics-state-legislation-and-laws.aspx>. Generally the states with independent NPs and broader scope of practice laws have fewer to no retail clinics. *Id.*

25. Roxanne Nelson, *Reports: Retail Health Clinics on the Rise*, 107 AM. J. OF NURSING 25, 25 (July 2007) [http://www.nursingcenter.com/lnc/JournalArticle?Article\\_ID=727885&Journal\\_ID=54030&Issue\\_ID=727854](http://www.nursingcenter.com/lnc/JournalArticle?Article_ID=727885&Journal_ID=54030&Issue_ID=727854).

cost less than treatment provided in physician offices and demonstrates no obvious adverse effects on quality of care.<sup>26</sup> The cost of RC services is low and usually ranges from \$30-\$60 without insurance coverage.<sup>27</sup>

A recent estimate projects that underutilization of nurse practitioners costs the nation nearly nine billion dollars annually due to practice restrictions in state laws.<sup>28</sup> Increasing the current NP work force can be done more quickly and cheaply than other professions.<sup>29</sup> Services in NP-run clinics are cheaper for patients and are comparable to physician care.<sup>30</sup> These facts demonstrate that expanding scope of practice laws for NPs is a fiscally responsible decision, given that greater utilization of NPs overall would mean more cost savings for the healthcare system as a whole.<sup>31</sup>

### III. NURSE PRACTITIONER SCOPE OF PRACTICE EXPANSION: QUALITY OF CARE

Over the past forty years, the healthcare system has expanded and the education and roles being carried out by NPs have evolved.<sup>32</sup> NPs work throughout the entire healthcare spectrum, from health promotion and disease prevention to early detection.<sup>33</sup> Generally, NPs enter the healthcare system trained to do more than many states allow them to.<sup>34</sup> Depending on state specific restrictions, NPs may be prohibited from admitting patients to hospitals, assessing patient condition, or ordering tests, which could restrict

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26. *Id.*

27. *Id.*

28. AM. ASS'N OF COLL. OF NURSING, *supra* note 22

29. *Id.*; Battaglia, *supra* note 21 at 1142; INST. OF MED., *supra* note 14.

30. See Nelson, *supra* note 25; Battaglia, *supra* note 21 at 1160.

31. AM. ASS'N OF COLL. OF NURSING, *supra* note 22

32. Ritter, *supra* note 19 at 22.

33. INST. OF MED., *supra* note 8.

34. Most states recognize national certification requirements, however scope of practice law may be restricted based more on political decision with in the states where NPs work rather than being restricted based on ability or training. *Id.*

a patient's access to care.<sup>35</sup> NPs, when allowed by scope of practice laws, are capable of providing many services that people associate with physicians, such as assessing conditions, evaluating tests, and a full range of other services.<sup>36</sup>

Evidence shows that NPs provide quality care to patients, including preventing medical errors, reducing infections, and helping with home transitions.<sup>37</sup> A number of studies demonstrate that quality of care would be upheld by adding NPs to the primary care market. In 1986, the Office of Technology Assessment of the United States Congress (OTA) reported that studies comparing NPs and physicians found that the quality of care demonstrated by NPs, when performing the same tasks within their training and expertise, was just as good as or better than their physician counterparts.<sup>38</sup> The OTA report also remarked that NPs were better than physicians in assisting ambulatory care patients with chronic problems, and communicating with, counseling, and interviewing patients.<sup>39</sup> NPs incorporate a range of disciplines, including social work, nutrition and physical therapy, in both training and practice.<sup>40</sup> NPs advise their patients holistically, emphasizing patient treatment in the context of the patient's total well-being and encouraging patient education.<sup>41</sup> This care is the nursing model of care.<sup>42</sup> In 2000, the Journal of the American Medical Association found that in ambulatory care settings where NPs had the same responsibilities and patient population as a physician, patient outcomes

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35. *Id.*

36. *Id.*

37. *Id.*

38. Ritter, *supra* note 19 at 22.

39. *Id.*

40. INST. OF MED., *supra* note 14.

41. Hansen-Turton, *supra* note 18 at 1243.

42. *Id.*; INST. OF MED., *supra* note 14.

between NPs' and physicians' care were comparable.<sup>43</sup> A 2004 study confirmed these conclusions.<sup>44</sup> A 2002 study found that patients that received care from NPs at nurse-managed health centers were given cost effective generic medications at higher rates and had lower rates of hospitalization, than patients of like providers.<sup>45</sup>

This evidence contradicts physician and AMA arguments that scope of practice laws should not be expanded because of quality of care and safety concerns. Study findings that quality of care is comparable between NPs and physicians carrying out the same tasks, supports expanding scope of practice laws. Arguments by a variety of stakeholders, from state legislators to the Centers for Medicare and Medicaid Services, support expansion of scope of practice laws and argue that NPs should be allowed to practice to the full extent of their education and training.<sup>46</sup> The growing shortage in primary care is negatively impacting the access Americans have to affordable health care.<sup>47</sup> The only way NPs can reduce the primary care shortage is if they are allowed to perform to the full extent of their training under the state scope of practice law.<sup>48</sup>

In Texas, where the scope of practice laws are restrictive, NPs that are capable of independently providing primary care are barred from doing so.<sup>49</sup> NPs in Texas are required to have a physician under contract to sign off on ten percent of medical charts and spend at least one in ten days in the

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43. Hansen-Turton, *supra* note 18 at 1243; INST. OF MED., *supra* note 14.

44. *Id.*

45. *Id.*

46. *The Future of Nursing: Leading Change, Advancing Health*, INST. OF MED. (October 2010) <http://www.iom.edu/reports/2010/the-future-of-nursing-leading-change-advancing-health.aspx>.

47. See THE COMMONWEALTH FUND, *supra* note 4; Sanner, *supra* note 4.

48. See Pettypiece, *supra* note 3.

49. *Id.*

clinic.<sup>50</sup> These requirements result in medical clinics sitting empty for lack of a supervising physician and a waitlist of patients.<sup>51</sup> If these clinics are not able to cover a physician's asking price to sign such a contract or collaborative agreement, the clinic will remain closed.<sup>52</sup> The law makes it harder to access care in the communities where these clinics are needed.<sup>53</sup>

Unlike Texas, New Mexico does not require physician supervision, and qualified independent NPs have full authority to diagnose, order tests, and prescribe medications to their patients.<sup>54</sup> This allows clinics to stay open and provide needed and affordable healthcare to patients.<sup>55</sup> Based on quality of care and the shortage of primary care, states should follow in New Mexico's expanded scope of practice footsteps and loosen the restriction on NPs to allow them to more independently offer primary care services.

#### IV. NURSE PRACTITIONER SCOPE OF PRACTICE EXPANSION: MEDICAL LIABILITY

Physicians are concerned that expanding scope of practice for NPs would negatively impact their own liability.<sup>56</sup> This concern is likely a result of the cyclical return of medical malpractice crises<sup>57</sup> and the fear of getting

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50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. See Christine Vestal, *In Many Communities Nurse Practitioners Fill an Important Void*, KAISER HEALTH NEWS (Dec 06, 2012), <http://www.kaiserhealthnews.org/stories/2012/december/06/nurse-practitioners-rural-health-care.aspx>. (illustrating how Virginia's new law requiring NPs to be part of doctor- led patient care teams, which have a volunteer supervising physician asking his lawyer to review what his own liability as a volunteer team leader would be under the new law when collaborating with two NPs and their outreach in to communities that lack access to healthcare).

57. Medical malpractice cases are negligence actions where the plaintiff, i.e. the patient, alleges an injury that resulted from a breach of accepted medical standards of care. David N. Hoffman, *The Medical Malpractice Insurance Crisis, Again*, 35 HASTINGS CTR. REP. 15

sued.<sup>58</sup> It may also be one reason physicians are arguing against expansion of NP scope of practice.<sup>59</sup> Physicians would face less liability risk if scope of practice laws for NPs were expanded to mirror New Mexico's model allowing independent practice.<sup>60</sup> Physicians actually face greater liability risk, with team based models or collaborative agreements,<sup>61</sup> where physicians are the head of a collaborative team of medical providers that include NPs.<sup>62</sup> As part of a team, NPs would be under the physician's employment or supervision.<sup>63</sup> In New Mexico, NPs can function independently and run clinics or NPs can continue to be supervised by physicians.<sup>64</sup> In cases where a NP is supervised or employed by a physician and does not function independently, a physician could still be held liable for the NPs actions under New Mexico law through vicarious liability laws like respondeat superior.<sup>65</sup>

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(2005), <http://www.medscape.com/viewarticle/503853>.

58. Marcia Frellick, *Liability fears Drive Doctors to Defensive Medicine*, *amednews.com* (Aug. 21, 2013), <http://www.amednews.com/article/20130821/profession/130829998/8/>.

59. *Id.*

60. See Battaglia, *supra* note 21 at 1142-43.

61. "The majority of states require a nurse practitioner to have a collaborative agreement with a local physician in order to provide professional care. Although there is not one definition or understanding of a collaborative practice, Medicare law defined collaboration as a process in which a nurse practitioner . . . works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with [physician] medical direction and appropriate supervision . . . as defined by the law of the State in which the services are performed." Hansen-Turton, *supra* note 18 at 1245.

62. Alicia Gallegos, *Physician Liability: Your Team, Your Legal Risk*, *AM. MED. NEWS*, (July 29, 2013), <http://www.amednews.com/article/20130729/profession/130729942/4/>.

63. *Id.*

64. N.M. Stat. Ann., *supra* note 65.

65. Liability can be shifted onto a physician by vicarious liability. Vicarious liability is a legal doctrine whereby liability for an injury is assigned to a party that did not cause the injury, but that has a particular legal relationship with the party that did. Gallegos, *supra* note 6. The basic agency theory of respondeat superior shifts liability from employee to employer or from servant to master for negligent acts which arise in the scope of the employee's service, such as NPs under the supervision of a physician in a physician's practice. This theory shifts liability to the physician if the physician has the right to direct or control the NPs practice. Mary Beck, *Improving America's Healthcare: Authorizing Independent*

A malpractice scenario where NPs are not functioning independently requires the investigation of their supervising physician.<sup>66</sup> A NPs employment contract or physician supervision requirement extends the physician's constructive knowledge and liability based on a NPs actions.<sup>67</sup> The physician has responsibility over the NP as an extension of his practice, and the physician would be more likely to be held liable in both New Mexico and Texas models.<sup>68</sup>

Scope of practice expansion creates a shift where independent NPs will be providing care without a supervising physician, like NP-run clinics in New Mexico.<sup>69</sup> The physician would not have the requisite level of control over the independent NP needed to establish vicarious liability.<sup>70</sup> Texas, with increased supervision, puts physicians in more control of NPs through the use of collaborative agreements, which opens physicians to greater liability for NP actions.<sup>71</sup> The scope of practice and liability law in New Mexico addresses both physician delegation and supervision as well as a NPs independent practice.<sup>72</sup> New Mexico still uses respondeat superior in cases where the principal actor, the NP, functions completely under the scope of a physician's agency.<sup>73</sup> Where an independent NP provides

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*Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. Rev. 951, 963 (1995). Supervising physician and physician's leading a collaborative team, already have a level of control over what a NP following their direction does. See Battaglia, *supra* note 21 at 1142-43.

N.M. Stat. Ann., UJI 13-402 (West, WestlawNext 7/15/2013).

66. Linda M. Atkinson, *Who's Really in Charge?*, 43 TRIAL 30, 37 (2007).

67. *Id.* at 38

68. See Battaglia, *supra* note 21 at 1142-1143

69. See *Id.*

70. *Id.*; Susan E. Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 Health Matrix 325, 349 (1992).

71. *Id.*

72. New Mexico's model includes exceptions for nursing in its state's Medical Practice Act (the Act) stating that it will not affect or apply to nursing licensing laws. N.M. Stat. Ann. § 61-6-17 (West, WestlawNext through Ch. 228 (end) of the First Regular Session of the 51st Legislature 2013); UJI 13-402 (Westlaw); UJI 13-1114 (Westlaw).

73. UJI 13-402 (Westlaw)



primary care, the NP is solely responsible for the treatment of a patient.<sup>74</sup> A physician that is not involved in the treatment of a patient cannot not be trapped by vicarious liability laws.<sup>75</sup> New Mexico law mitigates physician liability in relation to NPs.<sup>76</sup>

Texas allows physicians greater supervision and control over NPs and the delegation of certain medical acts.<sup>77</sup> The wording of the delegation segment of Texas law is vague and leaves a physician's liability open to interpretation.<sup>78</sup> The law outlines that physicians can delegate to a person acting under the physician's supervision any medical act they find reasonable to delegate.<sup>79</sup> Texas law also outlines that a delegating physician will remain responsible for the medical acts they delegate.<sup>80</sup> Texas gives total discretion to delegate the performance of medical acts to the delegating physician.<sup>81</sup>

Physicians, from the structuring of the laws in Texas, are open to more liability based on the actions of the NPs they supervise, and physician liability is directly related to how NP scope of practice is limited.<sup>82</sup> The New Mexico model allows for a separation of physician liability from NP liability when a physician is only tangentially related and not in charge of

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74. UJI 13-1114 (Westlaw)

75. *Id.*

76. *See Id.*; Baker, *supra* note 70 at 349.

77. V.T.C.A., Occupations Code § 157.001 (West, WestlawNext through the end of the 2013 Third Called Session of the 83rd Legislature).

78. *See Id.*

79. *Id.*

80. *Id.*

81. This interpretation is supported by Texas' use of several liability, where parties are proportionally liable for breaches in care to a patient based on percent of fault, unless the percentage of responsibility attributed to the defendant with respect to a cause of action is greater than 50 percent. *Medical Liability/ Medical Malpractice Laws*, NAT'L CONF. OF STATE LEG. (last updated August 15, 2011) <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx#TX>.

82. *See V.T.C.A., Occupations Code, supra* note 79.

patient care, thereby lowering physician liability concerns.<sup>83</sup> This separation affords physicians less liability concerns when NPs practice independently.<sup>84</sup>

#### V. CONCLUSION

In an effort to deal with the primary care shortage, which is an ever-increasing problem in today's healthcare system, expanding scope of practice is a viable option.<sup>85</sup> Expanding scope of practice for NPs would allow the large, increasing and underutilized NP population to practice to the full scope of their abilities and provide care affordably to patients and to areas which currently struggle or do not have access to primary care.<sup>86</sup> New Mexico's scope of practice laws allowing for independent NPs that can open and run clinics are an avenue that more states should follow.<sup>87</sup> The AMA and other physician organizations have enumerated concerns against scope of practice expansion relating to issues of quality of services and liability.<sup>88</sup> There is no evidence to say that a NP allowed to give primary care to the full scope of their training, practice and experience is a reduction in the quality of services a patient would receive.<sup>89</sup> In fact a number of studies and evidence show in measures like readmission rates, affordability of prescriptions and patient satisfaction, NPs provide care comparable if not better than some of their physician counterparts.<sup>90</sup> Physician groups may be rebelling against scope of practice expansion partly because of their own

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83. See Battaglia, *supra* note 21 at 1142-43; N.M. Stat. Ann., *supra* note 72.

84. See Battaglia, *supra* note 21 at 1142-43; N.M. Stat. Ann., *supra* note 72.

85. See *supra* Part I Introduction.

86. See *supra* Part II - III.

87. See *supra* Part I Introduction.

88. See *supra* Part II.

89. See *supra* Part III.

90. See *supra* Part III.

liability concerns.<sup>91</sup> The New Mexico scope of practice laws allow the independent functioning of NPs under their nursing licenses and reduces physician liability concerns.<sup>92</sup> Physicians appear to be more protected in New Mexico from liability than they are in Texas.<sup>93</sup> Physicians may have their concerns about expanding scope of practice for NPs, but those concerns are not supported when it comes to the availability, cost, quality of primary care services NPs provide and concerns about physician vicarious liability.<sup>94</sup>

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91. *See supra* Part IV.

92. *See supra* Part IIV.

93. *See supra* Part IIV.

94. *See supra* Parts II-IV.

## Maine: Setting the Example for the Role of Nurse Practitioners

*Adrienne Saltz\**

### I. INTRODUCTION

Changes to a healthcare profession's scope of practice are often perceived as turf wars between two or more professions about who controls what activities within the practice of medicine.<sup>1</sup> These changes, although controversial, can serve as a solution to one of the United States' most serious of healthcare system crises, its scarcity of primary care physicians.<sup>2</sup> Upon implementation of the Patient Protection and Affordable Care Act (PPACA), there will be numerous new healthcare consumers, and this increase in consumers will create even greater demand for the primary care sector.<sup>3</sup> In the face of such a crisis, the answer does not lie in convincing medical school students to choose primary care,<sup>4</sup> but in shifting the focus to

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1. NAT'L COUNCIL OF STATE BDS. OF NURSING, CHANGES IN HEALTHCARE PROFESSIONS' SCOPE OF PRACTICE: LEGISLATIVE CONSIDERATIONS 7 (2006), available at [https://www.ncsbn.org/ScopeofPractice\\_09.pdf](https://www.ncsbn.org/ScopeofPractice_09.pdf).

2. See CLAYTON M. CHRISTENSEN ET AL., THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE 128 (2009).

3. NAT'L GOVERNORS ASS'N, THE ROLE OF NURSE PRACTITIONERS IN MEETING INCREASING DEMAND FOR PRIMARY CARE 2 (2012), available at <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>. Following the passage of the PPACA, by the year 2019, it is predicted that the demand for primary care in the United States will increase by fifteen to twenty-five million visits per year, requiring between four thousand and seven thousand more physicians to meet this new demand. *Id.* Moreover, any future increased demand for primary care will be added to the already existing shortage of primary care physicians. *Id.* Today, an estimated thirty-five million people living within the health professional shortage areas nationwide do not currently receive adequate primary care services. *Id.* at 2-3.

4. See Glen Cheng, *The National Residency Exchange: A Proposal to Restore Primary*

an entirely different group, nurse practitioners.<sup>5</sup>

As several medical treatments move away from intuitive medicine<sup>6</sup> and into the realm of precision medicine,<sup>7</sup> nurse practitioners have become increasingly capable of providing a wider range of treatments and procedures.<sup>8</sup> Therefore, an important step in solving the primary care crisis is the expansion of nurse practitioners' scope of practice,<sup>9</sup> discarding the restrictive state-imposed physician supervision and collaboration requirements, to reflect the shift in medicine.<sup>10</sup> Nurse practitioners can be successful in alleviating pressures placed on primary care physicians because such a change in their scope of practice will increase the number of primary care providers and potentially free up physicians to care for more patients.<sup>11</sup> This type of scope of practice expansion is exemplified in Maine's regulations and statutes regarding nurse practitioners.<sup>12</sup> In Maine, after completing specific

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*Care in an Age of Microspecialization*, 38 AM. J.L. & MED. 158, 168-69 (2012) ("Particularly over the past decade, there has been an alarming drop in the number of students matching into primary care.").

5. See Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 192-93 (1992) ("An often overlooked approach to meeting the primary care requirements of the American health care system is the increased utilization of advanced practice nurses"). Nurse practitioners are registered nurses who have completed additional graduate-level education and trained to provide a broad range of primary care services. Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, in RESEARCH BRIEF NO. 13, 1 (National Institute for Health Care Reform ed., 2013), available at <http://www.nihcr.org/PCP-Workforce-NPs>.

6. Intuitive medicine is the provision of care for conditions that can be diagnosed only by their symptoms and only treated with therapies whose efficacy is uncertain. CHRISTENSEN, *supra* note 2, at 44. By its very nature, intuitive medicine depends upon the skill and judgment of the physician. *Id.*

7. Precision medicine is the provision of care for diseases that can be precisely diagnosed, whose causes are understood, and which consequently can be treated with rules-based therapies that are predictably effective. *Id.* at 44.

8. See *id.* at 64-65.

9. Scope of practice includes a nurse practitioner's practice authority, prescriptive authority, reimbursement, and costs. NAT'L GOVERNORS ASS'N, *supra* note 3, at 9.

10. See NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 1, at 3.

11. See NAT'L GOVERNORS ASS'N, *supra* note 3, at 1.

12. See *NP Scope of Practice Laws: Interactive Nurse Practitioner (NP) Scope of Prac-*

state requirements,<sup>13</sup> nurse practitioners can independently diagnose, treat, and prescribe medication<sup>14</sup> to patients without physician involvement.<sup>15</sup> Due to the national shortage of primary care physicians, other states should follow Maine's example, expanding the scope of practice for nurse practitioners while balancing the concerns for patient safety and quality of care.<sup>16</sup>

## II. THE SHORTAGE OF PRIMARY CARE PHYSICIANS

In 2010, the total percentage of active physicians in the United States specializing in primary care, which includes general practice, internal medicine, obstetrics, and pediatrics, was approximately forty percent.<sup>17</sup> Of these primary care specialists, only around thirty percent were in general practice or family medicine.<sup>18</sup> Today, the majority of medical school graduates still continue to bypass careers in primary care for careers in specialty and sub-specialty areas because careers in specialty and sub-specialty areas pay more for fewer work hours.<sup>19</sup> The steep tuition of attending medical school

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*tice Law Guide*, BARTON ASSOCIATES, <http://www.bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/> (last visited Nov. 3, 2013).

13. A certified nurse practitioner must complete a minimum of two hundred hours of practice in an expanded specialty role within the preceding two years and forty-five contact hours (or three credits) of pharmacology. 02-380-008 ME. CODE. R. § 6(2) (LexisNexis 2013). The required pharmacology may be obtained in a formal academic setting as a discrete offering or as non-credit continuing education offering. 02-380-008 ME. CODE. R. § 6(3) (LexisNexis 2013).

14. 02-380-008 ME. CODE. R. § 7 (LexisNexis 2013).

15. BARTON ASSOCS., *supra* note 12.

16. *See id.* Maine is able to balance concerns for patient safety and quality of care with its continuing education requirements. *See* 02-380-008 ME. CODE. R. § 8 (LexisNexis 2013).

17. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS. No. 2013-1232, HEALTH, UNITED STATES, 2012: WITH SPECIAL FEATURE ON EMERGENCY CARE, 309-10 (2013), *available at* <http://www.cdc.gov/nchs/data/hsr/hsr12.pdf>. In 2010, the total number of active physicians in the United States was 794,862 with 308,687 specializing in general primary care. *Id.*

18. *See id.* at 310. Of these general primary care specialists, only 94,746 were in general practice or family medicine with the greatest number of general primary care specialists in internal medicine. *Id.*

19. Jennifer Lorio, Note, *Physician Reimbursement, Impending Shortages, and Healthcare Reform*, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 11, 13 (2011), *available at* <http://www.luc.edu/media/lucedu/law/centers/healthlaw/pdfs/advancedirective/pdfs/issue7/lorio>

also contributes to medical students' gravitation toward specialties as lucrative salaries<sup>20</sup> help offset their seemingly insurmountable debt.<sup>21</sup> The extreme disparity found in medical students electing specialties over primary care<sup>22</sup> renders it unlikely that leading medical schools will be able to act quickly and decisively enough to correct the primary care problem on their own.<sup>23</sup> Medical schools only begrudgingly yield to change and are good at reinforcing the status quo.<sup>24</sup>

Medical students' financial concerns in choosing a career in primary care are further exacerbated by the current fee-for-service reimbursement schemes utilized by Medicare, Medicaid, and most private insurers.<sup>25</sup> These reimbursement schemes provide few financial incentives for preventive ser-

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rio.pdf. The American College of Physicians identified three major challenges facing medical students who want to choose primary care: "high levels of educational debt; lifestyle concerns due to administrative hassles and practice design; and payment issues, including the disparity in salaries between primary care providers and specialists, and payment policies that do not appropriately recognize the care that primary care providers provide." Cheng, *supra* note 4, at 168-69 (quoting M. RENEE ZEREHI, AM. C. PHYSICIANS, SOLUTIONS TO THE CHALLENGES FACING PRIMARY CARE MEDICINE: COMPREHENSIVE STRATEGIES FROM THE AMERICAN COLLEGE OF PHYSICIANS (2009), available at [http://www.acponline.org/advocacy/where\\_we\\_stand/policy/solutions.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/solutions.pdf)).

20. Specialists in non-primary care areas earn typically \$150,000 more than their primary care counterparts with some specialists earning \$330,000 more than them on average. See Jacquelyn Smith, *The Best- And Worst- Paying Jobs For Doctors*, FORBES (July 20, 2012), <http://www.forbes.com/sites/jacquelynsmith/2012/07/20/the-best-and-worst-paying-jobs-for-doctors-2/>.

21. Lorio, *supra* note 19, at 13. According to the American Medical Association, the average educational debt of a medical student in 2012 was \$166,750. Medical Student Debt, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/medical-student-debt/background.page?> (last visited Nov. 3, 2013).

22. The shortage of primary care physicians is so severe that in 2005 foreign medical school graduates filled approximately forty percent of over twenty thousand residency positions in internal medicine. CHRISTENSEN, *supra* note 2, at 128 (citing Sarah E. Botherton and Sylvia I. Etzel, *Graduate Medical Education, 2005-2006*, 296 JAMA 1154 (2006)). This employment of foreign medical graduates was necessary because most graduates from American medical schools opted for training as specialists in other areas of medicine. *Id.*

23. See *id.* at 358.

24. See *id.*

25. Cheng, *supra* note 4, at 171.

vices essential to a primary care physician's practice.<sup>26</sup> Although the PPACA attempts to rectify reimbursement issues and promote careers in primary care,<sup>27</sup> this act of encouragement will likely not be enough to relieve the immense demands placed on the primary care sector.<sup>28</sup> Therefore, the answer to solving the primary care crisis will not be found in convincing medical students to choose primary care, but rather in expanding the responsibilities of an already established group of primary care providers,<sup>29</sup> the nurse practitioners.<sup>30</sup> Unlike medical students, nurse practitioners already gravitate toward primary care.<sup>31</sup> By increasing nurse practitioners' scope of practice, and thus their autonomy, careers as a nurse practitioner will become a more attractive option for nursing students.<sup>32</sup> Appealing to nursing students can ensure that the number of nurse practitioners in the future continues to increase,<sup>33</sup> helping to support the impending demands on the primary care market.<sup>34</sup>

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26. *Id.*

27. The PPACA contains several important provisions designed to help revitalize primary care, including increased payments to primary care providers, incentives to explore different modes of primary care delivery such as the patient-centered medical home, redistribution of residency positions to and increased funding for primary care residency programs, greater opportunities for primary care providers to qualify for federal loans and loan forgiveness, and expanded coverage of preventive care services. *Id.* at 174.

28. See Kristine Marietti Byrnes, *Is There A Primary Care Doctor in the House? The Legislation Needed to Address A National Shortage*, 25 RUTGERS L.J. 799, 803-04 (1994).

29. In 2010, over fifty percent of nurse practitioners specialized in primary care, totally 56,000 nurse practitioners. See U.S. DEP'T OF HEALTH AND HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, PUB. NO. 12-P001-1-EF, PRIMARY CARE WORKFORCE FACTS AND STATS: OVERVIEW (2012), available at <http://www.ahrq.gov/research/findings/factsheets/primary/pcworkforce/pcworkforce.pdf>.

30. Aiken, *supra* note 5, at 193; see CHRISTENSEN, *supra* note 2, at 356-57.

31. Aiken, *supra* note 5, at 189, 193. Nurse practitioners are all trained as primary care providers as the philosophy of nursing education is based on a holistic approach to health and disease prevention. *Id.* at 195-96. This is in contrast to physicians who are largely trained in academic centers that emphasize specialization and technology. *Id.* at 196.

32. See *id.* at 193, 209.

33. "Nationally, the number of [nurse practitioners] is projected to nearly double by 2025 . . . particularly in primary care." NAT'L GOVERNORS ASS'N, *supra* note 3, at 7.

34. See Cheng, *supra* note 4, at 168.



### III. A SHIFT IN MEDICINE AND ITS IMPLICATIONS FOR THE ROLE OF NURSE PRACTITIONERS

As diseases move along the spectrum from intuitive to precision medicine, fewer people with highly specialized expertise are needed to solve the challenges that these diseases present.<sup>35</sup> Due to this shift in medicine, individuals with less medical training, such as nurse practitioners, are becoming more capable of delivering care once restricted to physicians.<sup>36</sup> Long relegated to a subservient role in healthcare delivery, nurse practitioners are now assuming increased levels of responsibility in patient care,<sup>37</sup> completing many tasks that once required a physician.<sup>38</sup> Due to this shift in medicine, nurse practitioners can fill the gap in the primary care workforce as the emerging primary care providers.<sup>39</sup>

Nurse practitioners are also an attractive solution to the primary care workforce shortage because they command lower salaries<sup>40</sup> and can be

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35. CHRISTENSEN, *supra* note 2, at 64. When diseases move along the spectrum, problem solving becomes focused on root cause mechanisms, replacing activities that were once grounded in conjecture and correlation, making it simpler to teach to nurse practitioners who have less experience and training than primary care physicians. *See id.* at 38-39.

36. *Id.* at 64-65.

37. *Id.* at 357.

38. *See* Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 424 (1992). These tasks include assessing and diagnosing; conducting physical examinations; ordering laboratory and other diagnostic tests; developing and implementing treatment plans for some acute and chronic illnesses; prescribing some medications; monitoring patient status; educating and counseling patients; and consulting and collaborating with, and referring to, other providers. *Id.* In short, nurse practitioners' training and competencies include the diagnosis and management of common acute illnesses, disease prevention, and management of stable, chronic illnesses. *Id.*

39. *See* Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1235 (2010).

40. Yee et al., *supra* note 5, at 2. In 2012, the national average nurse practitioner salary working full time was \$93,032. *2012 NP & PA Salary Survey Results*, ADVANCE HEALTHCARE NETWORK, <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Web-Extras/Online-Extras/2012-NP-PA-Salary-Survey-Results.aspx> (last visited Nov. 3, 2013). In comparison, as reported in 2012, primary care physicians had a base pay offer of \$189,000. *See* Smith, *supra* note 20.

trained at a lower cost than physicians.<sup>41</sup> Improved accessibility of quality healthcare will not come from replicating the expertise and costs of today's primary care physicians, but instead come from utilizing today's nurse practitioners.<sup>42</sup> As the number of diseases progress from the realm of intuitive medicine into the realm of precision medicine,<sup>43</sup> nurse practitioners will become the least costly of viable solutions to the primary care problem.<sup>44</sup>

#### IV. THE OBSTRUCTION OF STATE-IMPOSED REGULATIONS AND STATUTES

Before nurse practitioners can emerge as the new source of primary care providers, several barriers preventing nurse practitioners from expanding their scope of practice in the primary care field need to be addressed.<sup>45</sup>

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41. Aiken, *supra* note 5, at 197. Nurse practitioners can be trained at a fraction of the cost of primary care physicians. *Id.* Even in the most expensive private university nursing programs, nurse practitioners can be trained for approximately \$21,000 if the student already has a bachelor's degree in nursing or \$42,000 if the student lacks a bachelor's degree in nursing. *Id.*

42. See CHRISTENSEN, *supra* note 2, at 65.

43. *Id.* at 357. An example of such medical progression is rules-based work whereby work that was once intuitive and complex becomes routine, and specific rules are eventually developed to handle the steps in the process. *Id.* at 38-39. One rules-based work program is the Rules-Based Modeling (RBM), a computer simulation modeling technique relying on simple rules, representing pieces of information that can integrate existing knowledge and opinions with empirical data. JEAN-CHRISTOPHE CHIEM, JEAN MACQ & NIKO SPEYBROECK, RULE-BASED MODELING OF CHRONIC DISEASE EPIDEMIOLOGY: ELDERLY DEPRESSION AS AN ILLUSTRATION (Tricia A. Thornton-Wells ed., 2012), available at <http://www.plosone.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0041452&representation=PDF>. These rules are translated into computer code, and the resulting program is then used to generate simulated data. *Id.* The rules are then assessed by comparing the simulated data with observed trends. *Id.* These rules can be, for example, "if-then" rules and do not need to be mathematical formulas. *Id.* One of the most powerful features of RBM is its capacity to model complex human phenomena in a simple and flexible way. *Id.*

44. CHRISTENSEN, *supra* note 2, at 357.

45. See Lauren E. Battaglia, *Supervision and Collaboration Requirements: The Vulnerability of Nurse Practitioners and Its Implications for Retail Health*, 87 WASH. U.L. REV. 1127, 1129 (2010); see Hansen-Turton et al., *supra* note 39, at 1243. Despite technology progressing to the point that procedures can be performed by nurse practitioners instead of physicians, the rule of reimbursing only for services provided by certified caregivers makes it very difficult and less profitable to handoff care to lower-cost providers. U.S. CONG., OFF. OF TECH. ASSESSMENT, PB87-177465, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 37, 19 (1986); CHRISTENSEN, *supra* note 2, at 385. Specifically, when Medicare and private insurance companies follow a policy of

Such barriers include education requirements, accreditation requirements, and licensing requirements.<sup>46</sup> The most substantial of these barriers is the host of state-imposed regulations and statutes, limiting a nurse practitioner's scope of practice.<sup>47</sup> Of these types of regulations are physician supervision and collaboration requirements.<sup>48</sup> In addition to state-imposed regulations, a nurse practitioner's scope of practice is defined in each state's statutes in the form of a medical practice act.<sup>49</sup> Scope of practice statutes do not directly identify tasks that nurse practitioners can perform; however, they do authorize a broad range of practices and address whether or not the task requires physician supervision.<sup>50</sup> The degree of autonomy these statutes grant nurse practitioners in diagnosing, treating, and prescribing medications for patients without physician supervision and collaboration varies

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paying only for services provided by licensed professionals, they block nurse practitioners from doing certain procedures. CHRISTENSEN, *supra* note 2, at 385. Unfortunately, changes in reimbursement typically lag many years behind changes in technology. *Id.*

46. Battaglia, *supra* note 45, at 1129. Most states require nurse practitioners to meet education and training requirements, pass national certification examinations, and be approved under the state licensure process. *Id.* at 1149; *see, e.g.*, CAL. BUS. & PROF. CODE ANN. § 2835.5(d)(2)-(3) (West 2005) (requiring that nurse practitioners hold a master's degree in nursing or other clinical field related to nursing and must complete an approved nurse practitioners' program); OHIO REV. CODE ANN. § 4723.42(B)(2) (West 2013) (condition of license renewal that nurse practitioners provide documentation of continued certification in the nursing specialty with a national certifying organization). For example, twenty-seven states require that nurse practitioners have a master's degree, and thirty-five states mandate that nurse practitioners pass a national certification exam. *See* Hansen-Turton et al., *supra* note 39, at 1243. Even if states do not expressly state specific education requirements, national accreditation organizations such as the American Nurses Credentialing Center generally require individuals to hold a master's, post-master's, or doctorate from an approved nurse practitioner program in order to be eligible to sit for the national accreditation exam. Battaglia, *supra* note 45, at 1135.

47. Hansen-Turton et al., *supra* note 39, at 1241.

48. Battaglia, *supra* note 45, at 1129-30. In states with supervision and collaboration requirements, a nurse practitioner's authority to practice is conditioned upon some level of physician involvement. *Id.* at 1130. This usually entails a physician review of a proportion of the nurse practitioner's charts, physician on-site time requirements, or mandatory collaboration between the nurse practitioner and a physician in developing detailed care protocols. *Id.*

49. NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 1, at 7; *see* NAT'L GOVERNORS ASS'N, *supra* note 3, at 3, 8.

50. Yee et al., *supra* note 5, at 2.

widely from state to state.<sup>51</sup>

For example, nurse practitioners in California must be supervised by a physician, and in some cases, physicians are required to sign nurse practitioner charts<sup>52</sup> to qualify for reimbursement.<sup>53</sup> When prescribing medications, nurse practitioners in California must have a collaborative agreement with a physician, or alternatively, the supervision or delegation of a physician.<sup>54</sup> In New York and Illinois, nurse practitioners are required to establish a collaborative agreement with a physician in order to practice;<sup>55</sup> and like California, nurse practitioners are required to have a collaborative agreement with a physician, or alternatively, the supervision or delegation of a physician in order to prescribe medications.<sup>56</sup> These states' scope of

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51. Scope of Practice Legislative Database, NAT'L CONF. OF STATE LEGISLATURES (Nov. 3, 2013), [http://www.ncsl.org/issues-research/health/scope\\_of\\_practice-legislation-tracking-database.aspx](http://www.ncsl.org/issues-research/health/scope_of_practice-legislation-tracking-database.aspx); NAT'L GOVERNORS ASS'N, *supra* note 3, at 4.

52. Four states currently impose chart review requirements. *See, e.g.*, ALA. ADMIN. CODE r. 610-X-5-.08(9)(g) (2007) (physicians must review no less than ten percent of medical records plus all adverse outcomes); GA. COMP. R. & REGS. 360-32-.02(7)(b)-(c) (2007) (physicians must review and sign one-hundred percent of records with adverse outcomes within thirty days and ten percent of all other records at least annually); MONT. ADMIN. R. 24.159.1466(2)(b) (2006) (requiring nurse practitioners to have a quality assurance method involving review of fifteen charts or five percent of all their charts reviewed quarterly); TENN. COMP. R. & REGS. 0880-6-.02(8) (2007) (physicians must review at least twenty percent of charts every thirty days).

53. BARTON ASSOCS., *supra* note 12. The states as organized by geographic region that require nurse practitioners to be supervised by a physician, and in some cases, require physicians to sign nurse practitioner charts to qualify for reimbursement are: (Northeast) Delaware; (Southeast) South Carolina, North Carolina, Georgia, Florida, and Texas; (Southwest) California; (Midwest) Kansas. *Id.*

54. *Id.*

55. *Id.* The states as organized by geographic region that require a nurse practitioner to establish a collaborative agreement with a physician in order to practice are: (Northeast) Pennsylvania, New York, and Connecticut; (Southeast) Virginia, Louisiana, Alabama, and Mississippi; (Midwest) Nebraska, South Dakota, Wisconsin, Missouri, Minnesota, Ohio, Indiana, and Illinois. *Id.*

56. *Id.* The states as organized by geographic region that require nurse practitioners to have a collaborative agreement with a physician, or alternatively, the supervision or delegation of a physician when prescribing medications are: (Northeast) Pennsylvania, New York, New Jersey, Massachusetts, Delaware, and Connecticut; (Southeast) West Virginia, Virginia, Tennessee, South Carolina, North Carolina, Georgia, Florida, Louisiana, Alabama, Mississippi, Arkansas, Oklahoma, and Texas; (Southwest) California; (Midwest) Nebraska, South

practice laws overly restrict the practice of nurse practitioners because they prohibit nurse practitioners from autonomously treating patients for precisely diagnosable illnesses, such as strep throat, despite the shift in medicine from intuitive to precision.<sup>57</sup>

In contrast, Maine allows nurse practitioners to independently diagnose and treat patients without any physician involvement.<sup>58</sup> Nurse practitioners in Maine also have the authority to prescribe medications without physician or board of medicine involvement after completing specific state requirements.<sup>59</sup> Despite these state differences, nearly every state recognizes nurse practitioners as primary care providers.<sup>60</sup> Therefore, every state should fol-

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Dakota, Kansas, Wisconsin, Missouri, Minnesota, Michigan, Kentucky, Ohio, Indiana, and Illinois. *Id.*

57. CHRISTENSEN, *supra* note 2, at 64-65, 384.

58. BARTON ASSOCS., *supra* note 12. The federal district and states as organized by geographic region that allow nurse practitioners to independently diagnosis and treat patients without physician involvement are: (Northeast) Vermont, Rhode Island, New Jersey, New Hampshire, District of Columbia, Massachusetts, Maryland, and Maine; (Southeast) West Virginia, Tennessee, Arkansas, and Oklahoma; (Southwest) New Mexico, Nevada, Arizona, Utah, Colorado, and Hawaii; (Northwest) Washington, Oregon, Montana, Alaska, Idaho, and Wyoming; (Midwest) North Dakota, Michigan, Kentucky, and Iowa. *Id.*

59. *Id.* The federal district and states as organized by geographic region that grant nurse practitioners the authority to prescribe medications without physician or board of medicine involvement after completing specific state requirements are: (Northeast) Vermont, Rhode Island, New Hampshire, District of Columbia, Maryland, and Maine; (Southwest) New Mexico, Nevada, Arizona, Utah, Colorado, and Hawaii; (Northwest) Washington, Oregon, Montana, Alaska, Idaho, and Wyoming; (Midwest) North Dakota and Iowa. *Id.*

60. *Id.* The federal district and states as organized by geographic region that recognize nurse practitioners as primary care providers are: (Northeast) Vermont, Rhode Island, Pennsylvania, New York, New Jersey, New Hampshire, District of Columbia, Massachusetts, Maryland, Maine, Delaware, and Connecticut; (Southeast) West Virginia, Virginia, Tennessee, North Carolina, Georgia, Florida, Louisiana, Mississippi, Oklahoma, and Texas; (Southwest) New Mexico, Nevada, Arizona, Utah, Colorado, Hawaii, and California; (Northwest) Washington, Oregon, Alaska, Idaho, and Wyoming; (Midwest) South Dakota, North Dakota, Kansas, Wisconsin, Missouri, Minnesota, Kentucky, Ohio, Iowa, and Illinois. *Id.* The states as organized by geographic region that only imply nurse practitioners can be primary care providers are: (Southeast) Arkansas; (Northwest) Montana; (Midwest) Nebraska, Michigan, and Indiana. *Id.* The states as organized by geographic region that do not define whether nurse practitioners can be primary care providers are: (Southeast) South Carolina and Alabama. *Id.*

low Maine's example<sup>61</sup> by expanding its regulations and statutes that address nurse practitioners' scope of practice for the purpose of freeing up primary care physicians and increasing the number of affordable primary care providers.<sup>62</sup>

#### V. THE MISCONCEPTIONS OF STATE LEGISLATORS

Although framed as safety-based, the persistence of supervision and collaboration requirements must be weighed against the implications these state regulations and statutes have on the nurse practitioners' profession.<sup>63</sup> By requiring nurse practitioners to seek the consent of a physician prior to providing a new type of care, or when in any other way departing from the already established written protocol, limitations are unnecessarily placed on nurse practitioners.<sup>64</sup> Maintenance of a supervisory or collaborative relationship with a physician also adds significant labor costs to a nurse practitioner's practice.<sup>65</sup> Due to these requirements, physicians are effectively placed in a position to exercise control over both the scope of practice and financial viability of nurse practitioners,<sup>66</sup> rendering nurse practitioners dependent on physicians and further perpetuating the traditional dominant role of physicians over nurses.<sup>67</sup> Although independent practice<sup>68</sup> should not

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61. See *id.*; 02-380-008 ME. CODE. R. § 1(1)-(3)(A) (LexisNexis 2013).

62. See NAT'L GOVERNORS ASS'N, *supra* note 3, at 1, 10-11.

63. See Battaglia, *supra* note 45, at 1129-31.

64. *Id.* at 1138.

65. *Id.*

66. *Id.*; see Safriet, *supra* note 38, at 452.

67. Battaglia, *supra* note 45, at 1129, 1138; see Peter J. Hammer, *The Architecture of Health Care Markets: Economic Sociology and Antitrust Law*, 7 HOUS. J. HEALTH L. & POLICY 227, 240 (2007). Quoting a representative of the AMA: "We do not believe in the concept of independent physician extenders . . . We believe they should be dependent and supervised. . . I believe that you maintain control by maintaining control of the money." Susan E. Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325, 333-34 (1992).

68. Independent practice means the ability to diagnose, treat, and prescribe without the

signal that nurse practitioners are the perfect substitute for physicians,<sup>69</sup> there are certainly circumstances in which a nurse practitioner can provide comparable levels of care to a physician.<sup>70</sup>

Several studies<sup>71</sup> showed that nurse practitioners provide at least equal, if not better, quality of care to patients than physicians.<sup>72</sup> These studies proved nurse practitioners have patient satisfaction rates equal to or higher than physicians.<sup>73</sup> These studies also indicated that nurse practitioners are more capable of successfully managing patients with chronic conditions,<sup>74</sup> tend to spend more time with patients during clinical visits and consultations,<sup>75</sup> and are favorable to physicians in terms of achieving patient compliance with medical recommendations.<sup>76</sup> It is a misconception of state legislators to assume that state-imposed regulations and statutes, overly restricting nurse practitioners' scope of practice, are necessary for patient safety as studies showed nurse practitioners' care is more than comparable

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interference or hindrance of overly restrictive collaborative agreements that prevent nurse practitioners from providing complete primary care. Hansen-Turton et al., *supra* note 39, at 1246. Even with independent practice, nurse practitioners must practice within their scope and ability and make appropriate referrals of patients who need a different level or type of care. *Id.* In short, independent practice does not mean that nurse practitioners sever their connection with other care providers; rather, they must work in tandem with physicians and other providers to give optimal care to patients. *Id.*

69. Battaglia, *supra* note 45, at 1156.

70. *Id.*

71. Among the quality of care components that these studies measured are measures such as patient satisfaction, time spent with patients, prescribing accuracy, and the provision of preventive education. NAT'L GOVERNORS ASS'N, *supra* note 3, at 5. One study showed nurse practitioners practiced greater adherence to geriatric quality of care guidelines, and another study showed nurse practitioners are better able to provide preventive education through the delivery of anticipatory guidance. *Id.* at 6.

72. *Id.* at 5.

73. *Id.*

74. *Id.* at 6. Such chronic conditions include hypertension, diabetes, and obesity. *Id.* One study found that patients of independent nurse practitioners were better able to achieve weight loss than the control group under traditional physician-based care. *Id.*

75. *Id.* at 5, 7.

76. *Id.* at 7. Nurse practitioners were also more favorable than physicians in achieving reductions in patients' blood pressure and blood sugar. *Id.*

to physician-provided care.<sup>77</sup>

States need to eliminate mandatory physician supervision and collaboration requirements for nurse practitioners because these requirements can no longer be justified in light of the modern nurse practitioner's role in remedying the primary care calamity.<sup>78</sup> Considering the high quality of care nurse practitioners provide and the negative effects state-imposed regulations and statutes have on nurse practitioners, it follows that discarding these limitations by expanding nurse practitioners' responsibilities<sup>79</sup> can improve access to care,<sup>80</sup> free up primary care physicians to focus on diseases still in the intuitive realm of medicine,<sup>81</sup> and release nurse practitioners from a subservient role.<sup>82</sup>

## VI. THE NEXT STEP

Despite the given demand for the expansion of nurse practitioners' scope of practice, this change may be difficult to implement because such an expansion will likely pit specialists, primary care physicians, and nurse practitioners against one another before state legislatures.<sup>83</sup> Specialists and primary care physicians alike are currently blocking an increased role of nurse practitioners in the primary care market by raising concerns about patient

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77. See *id.* at 7-8. Nurse practitioners have demonstrated abilities and competencies on par with those of primary care physicians in clinical settings with studies showing not only similar patient outcomes, but also high patient satisfaction. Hansen-Turton et al., *supra* note 39, at 1244-45.

78. See Aiken, *supra* note 5, at 201 ("Supervision requirements were instituted based on the traditional role of nurses as complementary providers to physicians, but make less sense in the case of nurse practitioners . . . trained specifically to substitute for physicians in certain situations.").

79. Battaglia, *supra* note 45, at 1160-61.

80. See NAT'L GOVERNORS ASS'N, *supra* note 3, at 7-8.

81. See CHRISTENSEN, *supra* note 2, at 45, 123.

82. Battaglia, *supra* note 45, at 1160-61.

83. NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 1, at 7.



safety and lobbying for regulatory hurdles.<sup>84</sup> These turf wars are both costly and time consuming for all parties involved.<sup>85</sup> State legislators, having the authority to adopt and modify scope of practice acts regulating nurse practitioners, should follow the example set by Maine in deregulating the profession of nurse practitioners.<sup>86</sup> There should be collaboration between healthcare providers instead of turf wars,<sup>87</sup> and the modifications to scope of practice acts for nurse practitioners should reflect the changes in societal healthcare demands and advances in technology.<sup>88</sup> How states decide to move forward on this issue will have a profound effect on the ability of nurse practitioners to participate in efforts to incentivize better integration and coordination of services during the primary care shortage.<sup>89</sup>

## VII. CONCLUSION

Neither culture nor habit should imprison a primary care provider, especially in light of how far medicine has come along the spectrum of intuitive to precision medicine.<sup>90</sup> Even though medical school graduates will continue to choose specialties over primary care because specialists will remain an overpaid profession while primary care physicians remain an underpaid profession,<sup>91</sup> technology is now advanced to the point where a trained nurse

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84. CHRISTENSEN, *supra* note 2, at 145 n.20. These regulatory hurdles include devising new standard protocols of care that block participation by competitors and instituting stricter licensure and training standards. *Id.*

85. NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 1, at 7.

86. *See id.*

87. *Id.* at 8.

88. *Id.* at 7.

89. Yee et al., *supra* note 5, at 6.

90. CHRISTENSEN, *supra* note 2, at 65.

91. *Id.* at 129, 358; *see* Cheng, *supra* note 4, at 169-73. Because primary care providers earn lower salaries than specialist physicians, primary care is viewed as commanding a lower level of prestige than other specialties. Cheng, *supra* note 4, at 172. This perceived lower level of prestige in turn creates less competition for primary care residency positions, perpet-

practitioner can competently complete tasks that once required a physician.<sup>92</sup> Therefore, physician supervision and collaboration requirements are no longer necessary to ensure nurse practitioners provide a high quality of care to their patients.<sup>93</sup>

By removing these restrictive requirements, the nurse practitioners' profession can finally reflect its modern day reality and ultimately improve access to primary care.<sup>94</sup> Although physicians may perceive nurse practitioners as encroaching on their area of practice, the problem in primary care is far too great to let such turf wars stand in the way of change.<sup>95</sup> As professions evolve and new techniques are developed, scope of practice laws need to progress along with them.<sup>96</sup> Following Maine's expansion of its scope of practice for nurse practitioners<sup>97</sup> is an essential step in solving the primary care crisis<sup>98</sup> and advancing the practice of medicine.<sup>99</sup>

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uating the cycle of underpaid primary care physicians. *Id.*

92. See Safriet, *supra* note 38, at 452; see CHRISTENSEN, *supra* note 2, at 39, 357.

93. Battaglia, *supra* note 45, at 1148; NAT'L GOVERNORS ASS'N, *supra* note 3, at 10-11.

94. Battaglia, *supra* note 45, at 1148.

95. See NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 1, at 7; see NAT'L GOVERNORS ASS'N, *supra* note 3, at 2-3.

96. See Battaglia, *supra* note 45, at 1148.

97. See BARTON ASSOCIATES, *supra* note 12 (so long as the nurse practitioners demonstrate the requisite training and competence required).

98. See Yee et al., *supra* note 5, at 2 (stating a recent report recommended that states consider liberalizing scope of practice laws to permit more autonomy in nurse practitioners' practice as one way to help meet the growing demand for primary care services).

99. CHRISTENSEN, *supra* note 2, at 123, 128. Following an expansion in nurse practitioners' scope of practice, nurse practitioners will be able to perform more of the activities that primary care physicians once exclusively performed. *Id.* This will alleviate pressures on primary care physicians' workload and push nurse practitioners up the market to help primary care physicians effectively compete with specialists. *Id.* at 123. The more work primary care physicians can hand-off to nurse practitioners, the more competitive both primary care physicians and nurse practitioners can be during a primary care crisis. *Id.* at 123, 128.