Maine: Setting the Example for the Role of Nurse Practitioners

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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.¹ 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.² 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.³ In the face of such a crisis, the answer does not lie in convincing medical school students to choose primary care,⁴ but in shifting the focus to

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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.\textsuperscript{5}

As several medical treatments move away from intuitive medicine\textsuperscript{6} and into the realm of precision medicine,\textsuperscript{7} nurse practitioners have become increasingly capable of providing a wider range of treatments and procedures.\textsuperscript{8} Therefore, an important step in solving the primary care crisis is the expansion of nurse practitioners’ scope of practice,\textsuperscript{9} discarding the restrictive state-imposed physician supervision and collaboration requirements, to reflect the shift in medicine.\textsuperscript{10} 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.\textsuperscript{11} This type of scope of practice expansion is exemplified in Maine’s regulations and statutes regarding nurse practitioners.\textsuperscript{12} In Maine, after completing specific

\textsuperscript{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.

\textsuperscript{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. \textit{Id.}

\textsuperscript{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. \textit{Id.} at 44.

\textsuperscript{8}See \textit{id.} at 64-65.

\textsuperscript{9}Scope of practice includes a nurse practitioner’s practice authority, prescriptive authority, reimbursement, and costs. NAT’L GOVERNORS ASS’N, \textit{supra} note 3, at 9.

\textsuperscript{10}See NAT’L COUNCIL OF STATE BDS. OF NURSING, \textit{supra} note 1, at 3.

\textsuperscript{11}See NAT’L GOVERNORS ASS’N, \textit{supra} note 3, at 1.

\textsuperscript{12}See NP Scope of Practice Laws: Interactive Nurse Practitioner (NP) Scope of Pract-
state requirements, nurse practitioners can independently diagnose, treat, and prescribe medication to patients without physician involvement. 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.

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. Of these primary care specialists, only around thirty percent were in general practice or family medicine. 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. The steep tuition of attending medical school...
also contributes to medical students’ gravitation toward specialties as lucrative salaries help offset their seemingly insurmountable debt. The extreme disparity found in medical students electing specialties over primary care 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. Medical schools only begrudgingly yield to change and are good at reinforcing the status quo.

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. These reimbursement schemes provide few financial incentives for preventive ser-
vices essential to a primary care physician’s practice.26 Although the
PPACA attempts to rectify reimbursement issues and promote careers in
primary care,27 this act of encouragement will likely not be enough to re-
lieve the immense demands placed on the primary care sector.28 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 re-
sponsibilities of an already established group of primary care providers,29
the nurse practitioners.30 Unlike medical students, nurse practitioners al-
ready gravitate toward primary care.31 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.32 Appealing to
nursing students can ensure that the number of nurse practitioners in the fu-
ture continues to increase,33 helping to support the impending demands on
the primary care market.34

26. Id.

27. The PPACA contains several important provisions designed to help revitalize pri-
mary care, including increased payments to primary care providers, incentives to explore
different modes of primary care delivery such as the patient-centered medical home, redistrib-
ution 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 for-
giveness, 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

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
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. 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. Long relegated to a subservient role in healthcare delivery, nurse practitioners are now assuming increased levels of responsibility in patient care, completing many tasks that once required a physician. Due to this shift in medicine, nurse practitioners can fill the gap in the primary care workforce as the emerging primary care providers.

Nurse practitioners are also an attractive solution to the primary care workforce shortage because they command lower salaries and can be

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.


trained at a lower cost than physicians. 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. As the number of diseases progress from the realm of intuitive medicine into the realm of precision medicine, nurse practitioners will become the least costly of viable solutions to the primary care problem.

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.

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. The most substantial of these barriers is the host of state-imposed regulations and statutes, limiting a nurse practitioner’s scope of practice. Of these types of regulations are physician supervision and collaboration requirements. 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. 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. The degree of autonomy these statutes grant nurse practitioners in diagnosing, treating, and prescribing medications for patients without physician supervision and collaboration varies paying only for services provided by licensed professionals, they block nurse practitioners from doing certain procedures. 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.\footnote{51}

For example, nurse practitioners in California must be supervised by a physician, and in some cases, physicians are required to sign nurse practitioner charts\footnote{52} to qualify for reimbursement.\footnote{53} When prescribing medications, nurse practitioners in California must have a collaborative agreement with a physician, or alternatively, the supervision or delegation of a physician.\footnote{54} In New York and Illinois, nurse practitioners are required to establish a collaborative agreement with a physician in order to practice;\footnote{55} 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.\footnote{56} These states’ scope of

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\footnote{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).}

\footnote{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.}

\footnote{54}{Id.}

\footnote{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.}

\footnote{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, Massachussets, 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}
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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.57

In contrast, Maine allows nurse practitioners to independently diagnose and treat patients without any physician involvement.58 Nurse practitioners in Maine also have the authority to prescribe medications without physician or board of medicine involvement after completing specific state requirements.59 Despite these state differences, nearly every state recognizes nurse practitioners as primary care providers.60 Therefore, every state should fol-

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 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.

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. 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. Maintenance of a supervisory or collaborative relationship with a physician also adds significant labor costs to a nurse practitioner’s practice. 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, rendering nurse practitioners dependent on physicians and further perpetuating the traditional dominant role of physicians over nurses. Although independent practice should not

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.
68. Independent practice means the ability to diagnose, treat, and prescribe without the
signal that nurse practitioners are the perfect substitute for physicians, there are certainly circumstances in which a nurse practitioner can provide comparable levels of care to a physician. Several studies showed that nurse practitioners provide at least equal, if not better, quality of care to patients than physicians. These studies proved nurse practitioners have patient satisfaction rates equal to or higher than physicians. These studies also indicated that nurse practitioners are more capable of successfully managing patients with chronic conditions, tend to spend more time with patients during clinical visits and consultations, and are favorable to physicians in terms of achieving patient compliance with medical recommendations. 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

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. 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. at 5. 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.

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.\textsuperscript{77}

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 remediating the primary care calamity.\textsuperscript{78} 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\textsuperscript{79} can improve access to care,\textsuperscript{80} free up primary care physicians to focus on diseases still in the intuitive realm of medicine,\textsuperscript{81} and release nurse practitioners from a subservient role.\textsuperscript{82}

\textbf{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.\textsuperscript{83} 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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\item \textsuperscript{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., \textit{supra} note 39, at 1244-45.
\item \textsuperscript{78} See Aiken, \textit{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.”).
\item \textsuperscript{79} Battaglia, \textit{supra} note 45, at 1160-61.
\item \textsuperscript{80} See NAT’L GOVERNORS ASS’N, \textit{supra} note 3, at 7-8.
\item \textsuperscript{81} See CHRISTENSEN, \textit{supra} note 2, at 45, 123.
\item \textsuperscript{82} Battaglia, \textit{supra} note 45, at 1160-61.
\item \textsuperscript{83} NAT’L COUNCIL OF STATE BDS. OF NURSING, \textit{supra} note 1, at 7.
\end{itemize}
safety and lobbying for regulatory hurdles. These turf wars are both costly and time consuming for all parties involved. 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. There should be collaboration between healthcare providers instead of turf wars, and the modifications to scope of practice acts for nurse practitioners should reflect the changes in societal healthcare demands and advances in technology. 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.

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. 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, technology is now advanced to the point where a trained nurse

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.\textsuperscript{92} Therefore, physician supervision and collaboration requirements are no longer necessary to ensure nurse practitioners provide a high quality of care to their patients.\textsuperscript{93}

By removing these restrictive requirements, the nurse practitioners’ profession can finally reflect its modern day reality and ultimately improve access to primary care.\textsuperscript{94} 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.\textsuperscript{95} As professions evolve and new techniques are developed, scope of practice laws need to progress along with them.\textsuperscript{96} Following Maine’s expansion of its scope of practice for nurse practitioners\textsuperscript{97} is an essential step in solving the primary care crisis\textsuperscript{98} and advancing the practice of medicine.\textsuperscript{99}

\textsuperscript{92}See Safriet, supra note 38, at 452; see Christensen, supra note 2, at 39, 357.
\textsuperscript{93}Battaglia, supra note 45, at 1148; Nat’l Governors Ass’n, supra note 3, at 10-11.
\textsuperscript{94}Battaglia, supra note 45, at 1148.
\textsuperscript{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.
\textsuperscript{96}See Battaglia, supra note 45, at 1148.
\textsuperscript{97}See Barton Associates, supra note 12 (so long as the nurse practitioners demonstrate the requisite training and competence required).
\textsuperscript{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).
\textsuperscript{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.