

NURSE PRACTITIONERS IN PRIMARY CARE

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and

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There is a crisis in primary health care accessibility in the United States. Many commentators identify a lack of health insurance coverage as a major cause of inadequate health care; however, few acknowledge the impact that a shortage of primary care physicians has on the ability of consumers to receive timely and appropriate primary care, regardless of insurance status. If we improve access to primary care as contemplated by the implementation of the Patient Protection and Affordable Care Act,¹ we must also increase the number of primary care providers.² As we learned from Massachusetts, the expansion of health insurance exacerbates the need for primary care providers, and State political will is necessary to ensure providers are available.³

Emerging primary care providers, like nurse practitioners—nurses with master's-level education or beyond—are increasingly filling the gap in the primary care provider workforce. This Article describes the history and development of the role played by autonomous nurse practitioners and urges a critical analysis of barriers that warrant reform in order to promote the growth of an approach to health care that promises to pay substantial dividends in improving the health of our communities. Reducing disparities in access to health care will require more than

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1. Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (codified at 42 U.S.C. § 18023 (2010)).

2. MATTHEW BUETTGENS ET AL., URBAN INST. FOR ROBERT WOOD JOHNSON FOUND., AMERICA UNDER THE AFFORDABLE CARE ACT 5 (2010) (estimating that Affordable Care Act will help insure 27.8 million people who currently do not have insurance).

3. Gloria Craven & Stacey Ober, *Massachusetts Nurse Practitioners Step Up as One Solution to the Primary Care Access Problem: A Political Success Story*, 10 POL'Y, POL., & NURSING PRAC. 94 (2009).

increasing insurance coverage. It will also require that we increase the number of competent primary health care providers, and nurse practitioners are poised to meet the need.

I. INTRODUCTION

The idealized version of primary health care envisions a kindly gentleman—black tote bag in hand—visiting his patient’s home, admonishing the patient for his or her naïveté, and offering a prescription with the proverbial “take two and call me in the morning.” Yet this rose-colored account of access to primary care fails to reflect reality for most residents of the United States who need health care. Many residents do not have a primary care doctor, and the ones that do may experience the rushing through a primary care examination that often took weeks to schedule. Many consumers are desperate for access to basic health care and rely on the emergency rooms of hospitals to examine and treat primary care problems that become an unscheduled urgent care need.⁴ While inadequate health insurance is a contributing factor to a lack of primary health care, an insufficient supply of primary care physicians also plays a major role. The number of physicians providing primary care has steadily declined in recent years. Currently, fifty-six million Americans—almost one in five—lack adequate access to primary health care because of shortages of physicians in their communities.⁵

The following findings from a recent study illustrate the nature of the access problem: twenty-nine percent of people with Medicare said they had trouble finding a doctor who would take that insurance in 2007; two-thirds of Americans say they have a hard time getting medical care on nights, weekends, and holidays; only thirty percent of Americans say they can get in to see their doctor on the same day; almost half of emergency department patients in a 2006 survey said they thought their problem could have been handled by a primary care physician but they could not get an appointment; twenty-four Texas counties now have no primary care doctors at all; and in Alaska, not one of the 749 private-practice physicians was taking new Medicare patients for primary care in November 2007.⁶ These statistics cast a different light on the idealized picture of the traditional patient-physician relationship. Recall that in the old picture a nurse usually stood in the background in a starched white cap and dress. The nurse

4. See Linda F. McCaig & Eric W. Nawar, U.S. Dep’t of Health & Human Servs., No. 372, *National Hospital Ambulatory Medical Care Survey: 2004 Emergency Department Summary*, ADVANCE DATA FOR VITAL & HEALTH STAT. 2 (2006) (noting that data shows heightened emergency department use by those who identify emergency department as their regular source of care); Thomas Bodenheimer, *Primary Care—Will It Survive?*, NEW ENG. J. MED. 861, 862 (2006) (stating that “emergency departments are overflowing with patients who do not have access to primary care”); see also Stephen R. Pitts et al., *Where Americans Get Acute Care: Increasingly, It’s Not at Their Doctor’s Office*, 29 HEALTH AFF. 1620, 1624 (2010) (showing that emergency departments receive more visits for new health issues than primary care practices).

5. NAT’L ASS’N OF CMTY. HEALTH CTRS., ACCESS TRANSFORMED: BUILDING A PRIMARY CARE WORKFORCE FOR THE 21ST CENTURY 1 (2008).

6. Nancy Shute, *Can’t Find a Doctor? You’re Not Alone*, U.S. NEWS & WORLD REP., Mar. 19, 2008, <http://health.usnews.com/articles/health/living-well-usn/2008/03/19/cant-find-a-doctor-youre-not-alone.html?PageNr=1>.

played a critical role in providing quality primary care, and did so with personal concern and sensitivity. However, the hierarchical structure of medicine usually left the nurse's role unheralded.

The nursing profession, as a whole, has grown tremendously in scope and capacity since the days that the fictionalized Drs. Baker, Welby, and their colleagues were seeing patients.⁷ Since the early 1970's, nurse practitioners have assumed a prominent place in primary health care across the country, providing medical care and treatment independent of a physician's supervision. Policymakers have responded to this trend in the past twenty years by granting increased autonomy and authority to nurse practitioners. State legislatures have amended Nurse Practice Acts to reflect a nurse practitioner's expanded role in primary care, authorizing nurse practitioners to write prescriptions for primary care-related diagnoses in every state.⁸ Congress has made nurse practitioners eligible for direct reimbursement under Medicaid and Medicare Part B.⁹ Forty percent of Medicaid managed care companies now credential nurse practitioners as independent health care providers.¹⁰ Most recently, the Affordable Care Act provided more funding for advanced practice nurse education, nurse practitioner-led demonstration projects, and loan programs for nurses to pursue advanced nursing degrees.¹¹

The expansion of authority for nurse practitioners presents important economic and social implications warranting the attention of courts and legislatures. This paper describes and analyzes some of the most significant legal issues that flow from the restructuring of relationships among doctors, nurses, patients, hospitals, and third-party payers as a result of nurse practitioners assuming a more prominent role in the health care system as autonomous providers. The modern day picture reveals the stifling of nurse practitioner independent primary care caused by inconsistent state laws, insurance reimbursement practices, and a medical community that clings to outmoded notions of a physician-nurse hierarchy that is not consistent with meeting the needs of the consumer. The discussion occurs in the next four sections of this Article. Section II presents an overview of primary care health care trends and the primary care shortage. Section III explores the development of the nurse

7. Dr. Baker was a character in the television show *Little House on the Prairie*, a series based on the book *Little House On The Prairie*, which aired on the NBC network from 1974 to 1983; Dr. Welby was a character on the show *Marcus Welby, M.D.*, which aired on the ABC network from 1969 to 1976. The Internet Movie Database, *Little House on the Prairie*, <http://www.imdb.com/title/tt0071007/> (last visited Mar. 5, 2011); The Internet Movie Database, *Marcus Welby, M.D.*, <http://www.imdb.com/title/tt0063927/> (last visited Mar. 5, 2011).

8. CAROLYN BUPPERT, *NURSE PRACTITIONER'S BUSINESS PRACTICE AND LEGAL GUIDE* 197 (3d ed. 2008).

9. See The Balanced Budget Act, 42 U.S.C. § 1395x(s)(2)(K)(ii) (2006) (defining services of nurse practitioners as those provided by physicians); 42 U.S.C. § 1395l(a)(1) (discussing payment of benefits); 42 U.S.C. § 1395w-4 (presenting fee schedule for services).

10. Tine Hansen-Turton et al., *Insurer Policies Create Barriers to Health Care Access and Consumer Choice*, 24 *NURSING ECON.* 204, 207 (2006).

11. For a full description of the provisions as they relate to advanced practice nurses and nurse practitioners, see AM. NURSES ASS'N, *KEY HEALTH CARE REFORM PROVISIONS RELATED TO NURSES*, available at <http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform.aspx> (last visited Mar. 5, 2011).

practitioner role and nurse practitioner scope of practice. Section IV discusses professional challenges to the nurse practitioner in primary care practice. Finally, Section V concludes with a discussion of the necessary next steps to enable nurse practitioners to provide critically needed primary care in the United States.

II. PRIMARY HEALTH CARE TRENDS IN THE U.S. AND THE PHYSICIAN SHORTAGE

From 1981 through the mid-1990s the Department of Health and Human Services, academic researchers, and the Council on Graduate Medical Education predicted an imminent physician surplus.¹² In light of this conviction, several national organizations requested a reduction in physician enrollment, resulting in “essentially flat” enrollment into schools of medicine.¹³ At the same time, the development of managed care and health maintenance organizations (“HMOs”) increased the need for primary care providers.¹⁴ On March 24, 2009, Jeffrey P. Harris, MD, FACP, and president of the American College of Physicians (“ACP”) testified before the House of Representatives Energy & Commerce Health Subcommittee that “[w]e [Americans] are experiencing a primary care shortage in this country, the likes of which we have not seen. The expected demand for primary care in the United States continues to grow exponentially while the nation’s supply of primary care physicians dwindles.”¹⁵

Several factors contribute to the shortage of primary care physicians, including: reimbursements based on quantity of care with little weight given to quality of care; the growing burden of chronic illness on patients and their providers; an ever increasing student loan burden; and the financial lure that make specialty care more attractive to physicians than primary care.¹⁶ Congress responded to the primary care shortage with legislation to increase grants to community-based health centers, subsidize medical education costs, and assist medical schools’ efforts to recruit under-represented ethnic groups.¹⁷ These efforts have so far failed to stem the tide of departing primary care physicians. Projected estimates of physician shortages range from 50,000 by 2010, to 200,000

12. See generally U.S. DEP’T OF HEALTH & HUMAN SERVS., REPORT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE: SUMMARY REPORT, HRA 81-651 (1981); Jonathon P. Weiner, *Forecasting the Effects of Health Reform on US Physician Workforce Requirements: Evidence From HMO Staffing Patterns*, 272 JAMA 222 (1994); JONATHON P. WEINER, ASSESSING CURRENT AND FUTURE U.S. PHYSICIAN REQUIREMENTS BASED ON HMO STAFFING PATTERNS: A SYNTHESIS OF NEW SOURCES OF DATE AND FORECASTS FOR THE YEARS 2000 AND 2020, HRSA 94-576 (U.S. Dept. of Health & Human Servs., Bureau of Health Professions 1995); Council on Graduate Medical Education, Summary of Third Report: Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century, <http://www.cogme.gov/rpt3.htm> (last visited Mar. 5, 2011).

13. ASSOC. OF AM. MED. COLLS., AAMC STATEMENT ON THE PHYSICIAN WORKFORCE 1 (June 2006), <http://www.aamc.org/download/55458/data/workforceposition.pdf>.

14. *Id.*; Sandy Gamliel et al., *Managed Care on the March: Will Physicians Meet the Challenge?* HEALTH AFF., Summer 1995, at 131, 132.

15. *Making Health Care Work for American Families: Improving Access to Care, Hearing before H. Comm. on Energy and Commerce, Subcomm. on Health* (2009) (statement of Jeffrey P. Harris, President, American College of Physicians).

16. Bodenheimer, *supra* note 4, at 861–62.

17. See H.R. 410, 110th Cong. (2007) (increasing grants for medical school students); S. 896, 110th Cong. (2007) (providing for expansion for community health centers).

by 2020.¹⁸ Approximately thirty-five percent of currently practicing physicians nationwide are over the age of fifty-five and most of them will likely retire within the next decade.¹⁹ A 2008 survey of medical students revealed that only two percent plan to become primary care physicians.²⁰ The ACP has noted that “[p]rimary care is on the verge of collapse. Very few young physicians are going into primary care and those already in practice are under such stress they are looking for an exit strategy.”²¹ Increasing the number of nurse practitioners makes sense socially and economically. The lack of primary care providers has a devastating impact not only on individual patients and doctors, but also on our economy. Many Americans who lack a regular source of primary care rely on the hospital emergency rooms to meet their non-emergent medical needs.²² A 2003 study found that a full third of visits to emergency rooms could be classified as semi-urgent or non-urgent care, whereas only forty-seven percent—less than half—rose to the level of emergent or urgent.²³ Another study found that forty percent of all emergency department visits were for non-urgent conditions.²⁴ In total, use of the emergency room for primary care costs the health care system \$21.4 billion per year.²⁵

Individuals who use emergency rooms for their non-emergent health needs include both the insured and the uninsured.²⁶ However, as exemplified in Massachusetts’ attempt to insure all their citizens in 2006, insurance does not guarantee timely access to a primary care physician.²⁷ Health care expansion in Massachusetts led to a state law requiring insurers to reimburse nurse practitioners for primary care services.²⁸ While having health insurance seems to have a positive correlation on access to primary care for children,²⁹ for adults it often only allows a nominal relationship with a primary care provider that does not equate to access to a physician when needed. Approximately forty million Americans report that they do not have access to a regular primary care physician

18. Richard A. Cooper et al., *Economic and Demographic Trends Signal an Impending Physician Shortage*, HEALTH AFF., Jan.–Feb. 2002, at 140, 148.

19. AM. COLL. OF PHYSICIANS, THE IMPENDING COLLAPSE OF PRIMARY CARE MEDICINE AND ITS IMPLICATIONS FOR THE STATE OF THE NATION’S HEALTH CARE 2 (Jan. 30, 2006), http://www.txpeds.org/u/documents/statehc06_1.pdf (citing AM. MED. ASS’N, PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE U.S.).

20. Karen Hauer et al., *Factors Associated with Medical Students’ Career Choices Regarding Internal Medicine*, 300 JAMA 1154, 1157 (2008).

21. AM. COLL. OF PHYSICIANS, *supra* note 19, at 2.

22. COMM. ON THE FUTURE OF EMERGENCY CARE IN THE U.S. HEALTH SYS., HOSPITAL-BASED EMERGENCY CARE: AT THE BREAKING POINT 42 (Nat’l Acads. Press 2007).

23. McCaig & Nawar, *supra* note 4, at 6.

24. NEW ENG. HEALTHCARE INST., WASTE AND INEFFICIENCY IN THE U.S. HEALTH CARE SYSTEM, CLINICAL CARE: A COMPREHENSIVE ANALYSIS IN SUPPORT OF SYSTEM-WIDE IMPROVEMENTS 19 (2008) (citing Massachusetts Division of Health Care Finance and Policy, No. 7, Analysis in Brief (June 2004)).

25. *Id.*

26. Pitts et al., *supra* note 4, at 1623.

27. Craven & Ober, *supra* note 3, at 95.

28. *Id.*

29. Paul W. Newacheck et al., *Health Insurance and Access to Primary Care for Children*, 338 NEW ENG. J. MED. 513, 513 (1998).

or provider for their primary care and preventive health care needs.³⁰ In a 2006 poll conducted by USA Today, ABC, and the Kaiser Family Foundation, seventeen percent of Americans reported that they are not satisfied with their ability to get an appointment with a doctor when they need or want one.³¹ Medicaid patients have also reported difficulty in reaching a primary care provider when needed.³² Thus, even the insured can end up seeking their primary care in an emergency room.

The Affordable Care Act recognized the anticipated need for increased primary care providers. In passing the Act, Congress encouraged more reliance on nurse practitioners to meet the primary care needs of the U.S. population by authorizing funding for nurse-managed health clinics,³³ school-based health clinics,³⁴ and home-based primary care,³⁵ all of which can explicitly be led by nurse practitioners, by adding payment incentives to nurse practitioners, among other providers, that accept Medicare patients,³⁶ and by encouraging the advanced education of nurses through funding for advanced nursing degrees through loans and grants.³⁷ Currently nurse practitioners also meet the bill requirements for inclusion as Accountable Care Organizations for Medicare fee-for-service patients.³⁸

As the availability of physicians diminishes, greater numbers of patients will see nurse practitioners for their primary health care.³⁹ Moreover, the nurse practitioner workforce continues to grow at a healthy rate. A 2008 Government Accountability Office report addressing trends in the practice of primary care noted that the annual growth in the number of practicing nurse practitioners hovers near 9.5%, while the number of practicing physicians increases each year by only 1.17%.⁴⁰ Although it is undisputed that there is a shortage of general care nurses,⁴¹ according to Susan Apold, PhD, RN, ANP-BC, from the American College

30. Healthy People 2010, Leading Health Indicators, <http://www.healthypeople.gov/2010/LHI/> (last visited Mar. 5, 2011).

31. USA Today, *ABC News/USA Today/Kaiser Family Foundation Poll*, <http://www.usatoday.com/news/health/2006-10-15-health-poll1.htm> (last visited Mar. 5, 2011).

32. Allyson G. Hall et al., *Expanding the Definition of Access: It Isn't Just About Health Insurance*, 19 J. HEALTH CARE FOR POOR & UNDERSERVED 625 (2008).

33. Patient Protection and Affordable Care Act, Pub L. No. 111-148, § 5208, 124 Stat. 119 (codified at 42 U.S.C. § 18023 (2010)).

34. *Id.* § 4101.

35. *Id.* § 3024.

36. *Id.* § 5501; § 3114.

37. *Id.* §§ 5307-5312.

38. *Id.* § 3022.

39. See generally Benjamin G. Druss et al., *Trends in Care by Nonphysician Clinicians in the United States*, 348 NEW ENG. J. MED. 130 (2003); J.L. McCann et al., *Physician Assistant and Nurse Practitioner Workforce Trends*, 72 AM. FAM. PHYSICIAN 1176 (2005), available at <http://www.graham-center.org/online/graham/home/publications/onepaggers/2005/op37-workforce-trends.html>.

40. *Id.*

41. See generally Rebekah L. Fox & Kathleen Abrahamson, *A Critical Examination of the U.S. Nursing Shortage: Contributing Factors, Public Policy Implications*, 44 NURSING F. 235 (2009); Heather Janiszewski Goodin, *The Nursing Shortage in the United States of America: An Integrative Review of the Literature*, 43 J. ADVANCED NURSING 335 (2003); Heather K. Spence Laschinger & Joan Finegan, *Using Empowerment to*

of Nurse Practitioners, “NP programs are educating [three] primary care [nurse practitioners] to every [one] primary care physician.”⁴²

Historically, nurse practitioners have enjoyed expansion in their collaborative practice with physicians under federal law, but not independence. Prior to 1997 in rural areas or in areas designated as medically underserved—where demographic and geographic circumstances have contributed to a shortage of health care providers—small changes in federal law led to Medicare reimbursements for nurse practitioners at eighty-five percent of the prevailing physician rate when they provided primary care in rural areas or long-term care facilities.⁴³ After the Balanced Budget Act of 1997, nurse practitioners can still provide that care, but now obtain reimbursement under Medicare with no geographic distinctions.⁴⁴ In 1989, the federal government began providing direct reimbursement to nurse practitioners providing family, pediatric, and nurse-midwife care, and currently thirty-six states provide direct Medicaid reimbursement to all nurse practitioners.⁴⁵ The amount reimbursed by the states falls between seventy and one hundred percent.⁴⁶ Although these changes explicitly promoted nurse practitioners as primary care providers, these past federal provisions have not given nurse practitioners more independence because decisions about scope of practice are made at the state level.

Studies have shown that patients treated by nurse practitioners had similar medical needs and received similar care as patients treated by primary care physicians.⁴⁷ Thus, if these medically underserved areas represent microcosms of an emerging national picture of primary health care, we should be encouraged that in areas where nurse practitioners have expanded their service, they are “important contributors to the primary care workforce,”⁴⁸ capable of delivering high-quality health care services.

Build Trust and Respect in the Workplace: A Strategy for Addressing the Nursing Shortage, 23 NURS. ECON. 6 (2005).

42. Laurie Barclay, *American College of Physicians Issues New Policy on Nurse Practitioners in Primary Care*, MEDSCAPE MED. NEWS (Mar. 2, 2009), <http://www.medscape.com/viewarticle/588914>.

43. Joseph P. Colagrecio & Carl A. Kirton, *The Voice of Experience: The Nuts and Bolts of Advanced Practice for Nurse Practitioners*, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE 305, 314 (Mathy D. Mezey et al. eds., 4th ed. 2003).

44. *Id.*

45. *Id.*

46. *Id.*

47. See OFFICE OF TECH. ASSESSMENT, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 5 (1986) (summarizing studies that evaluate quality of care of nurse practitioners as opposed to physicians); Druss et al., *supra* note 39, at 136 (finding that patients treated by non-physician clinicians were “more similar than different” in demographics); Judith A. Hall, *Performance Quality, Gender and Professional Role: A Study of Physicians and Nonphysicians in 16 Ambulatory Care Practices*, 28 MED. CARE 489, 497 (1990) (finding that non-physicians showed superior performance to physicians in treating several primary care ailments); David S. Salkever et al., *Episode-Based Efficiency Comparisons For Physicians and Nurse Practitioners*, 20 MED. CARE 143, 152 (1982) (finding that nurse practitioner pediatric care was less costly than pediatrician care, and that difference could not be attributed to different patient characteristics or needs, and that quality of care and effectiveness looked same).

48. McCann et al., *supra* note 39.

III. THE EVOLUTION OF THE NURSE PRACTITIONER'S ROLE

Some nurses have practiced independently from doctors since the nineteenth century, particularly in fields outside of mainstream medicine, such as nurse midwifery.⁴⁹ However, advanced nursing education and practice did not gain significant recognition until after the Second World War, when military nurses were given federal funding to attend college.⁵⁰ Post-World War II, nurses expanded their reach by directing school-based clinics and home-based care.⁵¹ The opportunities for nurses in primary care grew again in the 1960s as the country experienced a physician shortage following the adoption of the Medicare and Medicaid programs in 1965, which spurred greater demand on the health care system than before.⁵²

In 1965 the University of Colorado introduced the first formal nurse practitioner educational program in the United States.⁵³ Other schools of nursing quickly followed. The general public reacted positively to the new nurse practitioner curricula and roles that developed from Colorado's program, as well as other creative academic nurse practitioner programs that followed, but the medical and academic communities were less enthusiastic.⁵⁴ Notwithstanding the initial resistance, nurse practitioner education programs continued to flourish.⁵⁵ "On February 17, [2009,] the American College of Physicians (ACP) released a new policy [statement] on nurse practitioners (NPs) in primary care."⁵⁶ According to the statement, "[t]he College recognizes the important role that [nurse practitioners] play in meeting the current and growing demand for primary care, especially in underserved areas. As trained healthcare professionals, physicians and [nurse practitioners] share a commitment to providing high-quality care."⁵⁷ Today some physicians are starting to view nurse practitioners as playing a "complementary" and "critical" role in primary care.⁵⁸

49. Ellen D. Baer, *Philosophical and Historical Bases of Advanced Practice Nursing Roles*, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE, *supra* note 43, at 37, 37.

50. *Id.* at 38.

51. *Id.*

52. *Id.*

53. Frances Hughes et al., *Research in Support of Nurse Practitioners*, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE, *supra* note 43, at 85, 85.

54. Diane O. McGivern et al., *Advanced Practice Nursing: Preparation and Clinical Practice*, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE, *supra* note 43, at 3, 4 (Mathy D. Mezey et al. eds., 4th ed. 2003).

55. As of 2002, there were 325 nurse practitioner programs being offered in colleges and universities, up from 274 in 1998, reflecting demand for nurse practitioners. *Id.* at 7.

56. Barclay, *supra* note 42.

57. *Id.* (quoting Michael S. Barr, MD, MBA, FACP).

58. *Id.* There is dissent in the physician community regarding nurse practitioners' role as independent primary care providers. The American Medical Association completely opposes the independent practice of nurse practitioners, and they assist local medical societies in "lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician." AM. MED. ASS'N, HEALTH AND ETHICS POLICIES OF THE AMA HOUSE OF DELEGATES H-35.988, H-

Nurse practitioners provide health care in a manner that emphasizes evaluation of the patient in her environment to aid their diagnosis and treatment.⁵⁹ This holistic approach to medical care represents the “nursing model [of care,] which emphasizes treatment of illness in the context of a patient’s total well-being and encourages patient education.”⁶⁰ Physicians and physician assistants provide care using the “medical model” that focuses on diagnosis and treatment of a disease in isolation.⁶¹ A 1994 report of the Institute of Medicine (“IOM”) validated the utility of blending the traditional medical model with the more context-reliant nursing model of care as a means of improving the quality of care that patients receive.⁶² However, as nurse practitioners move towards more independent practice, it will be important to maintain the nursing model approach to care in the medical model-driven environment of primary care because it is the nursing model that has consistently helped nurse practitioners achieve positive results.

Nurse practitioners are registered nurses who pursue additional, more comprehensive education and clinical training.⁶³ Nearly all currently practicing nurse practitioners have master’s degrees, and many have earned doctorates.⁶⁴ An evolving Doctorate of Nursing Practice is gaining support among certain facets of the nursing community,⁶⁵ but has not been universally accepted or endorsed.⁶⁶ Twenty-seven states presently require that nurse practitioners have a master’s degree.⁶⁷ Thirty-five states mandate that nurse practitioners pass a national certification exam, and the agencies that certify adult and pediatric nurse practitioners in turn require a master’s degree in order to be eligible for these specializations.⁶⁸

160.947 (2009), available at <http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf>. However, more similar to the College of Physicians’ acceptance of nurse practitioners in primary care, the American Academy of Family Physicians advocates the collaborative approach to care. R.L. Phillips et al., Robert Graham Ctr., *Trumping Professional Roles: Collaboration of Nurse Practitioners and Physicians for a Better U.S. Health Care System*, 15 AM. FAM. PHYSICIAN 1325 (2001), available at <http://www.aafp.org/afp/2001/1015/>.

59. McGivern et al., *supra* note 54, at 8.

60. HEALTH RES. & SERVS. ADMIN., NAT’L CTR. FOR HEALTH WORKFORCE ANALYSIS, BUREAU OF HEALTH PROFESSIONS, A COMPARISON OF CHANGES IN THE PROFESSIONAL PRACTICE OF NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE MIDWIVES 1992 and 2000, 8 (2002), <http://bhpr.hrsa.gov/healthworkforce/reports/scope/scope1-2.htm> (last visited Mar. 5, 2011).

61. *Id.* at 10.

62. See INST. OF MED., *DEFINING PRIMARY CARE: AN INTERIM REPORT* 15–33 (1994) (defining primary care to include partnerships with patients in contexts of families and communities).

63. BUPPERT, *supra* note 8, at 5.

64. *Id.*

65. See AM. ASS’N OF COLLS. OF NURSING, *AACN POSITION STATEMENT ON THE PRACTICE DOCTORATE IN NURSING* (2004), <http://www.aacn.nche.edu/dnp/pdf/DNP.pdf> (noting recent increases in interest in doctorates in nursing and stating suggestions for such programs).

66. See Greer Glazer, *Overview and Summary: The Doctor of Nursing Practice (DNP): Need for More Dialogue*, *ONLINE J. ISSUES IN NURSING*, Vol.10, No. 3 (Sept. 30, 2005), www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume102005/No3Sept05/tpc28ntr16023.aspx (summarizing articles questioning doctorate of nursing programs).

67. BUPPERT, *supra* note 8, at 5.

68. *Id.*

A nurse practitioner typically has authority to provide the following services: obtain medical histories and perform physical examinations; diagnose and treat health problems; order and interpret laboratory tests and x-rays; prescribe medications and other treatments; prenatal care; well-child care; immunizations and family planning services; gynecological examinations and pap smears; health promotion, illness prevention, patient education about health risks; and case management and coordination of services.⁶⁹ Nurse practitioners practice in a variety of settings, ranging from primary care practice offices to hospitals to long-term care to specialty practices, and also non-traditional models of care such as nurse-managed health centers⁷⁰ and convenient care clinics.⁷¹ Nurse-managed health clinics and convenient care clinics are unique because of the degree of autonomy with which nurse practitioners are able to practice at these sites, and are leading the way to nurse practitioner-led primary care practices.

Nurse practitioners have demonstrated abilities and competencies on par with those of primary care physicians in clinical settings. Data from a 1986 Office of Technology study conducted to analyze nurse practitioner quality of care indicated that nurse practitioner care was better than physician care in “assisting ambulatory patients with chronic problems such as hypertension and obesity,” and in communication, counseling, and referral of patients.⁷² 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 model of care and had the same degree of authority.⁷³ In 2002, the Centers for Medicare and Medicaid Services funded a demonstration project to evaluate patient outcomes at nurse-managed health centers that used the nursing model of care as opposed to the medical model of care.⁷⁴ This study found a high rate of patient satisfaction at the Centers,⁷⁵ corroborating earlier studies concluding that patients are generally satisfied with nurse practitioner-

69. *Id.* at 3–5.

70. There are an estimated 250 nurse-managed health centers throughout the United States, and they are operated “in partnership with the communities that they serve.” Tine Hansen-Turton, *The Nurse-Managed Health Center Safety Net: A Policy Solution to Reducing Health Disparities*, in *NURSING CLINICS OF NORTH AMERICA* 729, 730 (2005). The health centers provide primary care in areas underserved by health care services. *Id.*

71. Convenient care clinics are health care clinics that strive to meet the primary care needs of the community they belong to, and are usually located in places convenient to the public, like pharmacies. Tine Hansen-Turton et al., *Convenient Care Clinics: The Future of Accessible Health Care*, in *DISEASE MANAGEMENT* 61, 62 (2007). Services include diagnosis and treatment of the most common health problems and concerns experienced by patients, including: sore throats, immunizations, and preventive health care screenings. *Id.* at 62.

72. OFFICE OF TECH. ASSESSMENT, *supra* note 47, at 19–21.

73. See Mary O. Munding et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 *JAMA* 59, 59 (2000) (providing overview of study results and conclusions).

74. Funding for the study was appropriated through Public Law 107-116. OFFICE OF TECH. ASSESSMENT, *supra* note 47.

75. *Id.* at 20–21

directed care.⁷⁶ The patients treated during the study also exhibited a lower rate of hospitalization, and were more likely to use cost-effective generic medications.⁷⁷ Finally, a 2009 study found that nurse practitioners provide care equivalent to physicians in complexity as well as outcomes.⁷⁸ Thus, the expansion of nurse practitioners into primary care practice will serve to benefit the patient community and alleviate the primary care physician shortage.

IV. PROFESSIONAL CHALLENGES FOR THE NURSE PRACTITIONER

Nurse practitioners who provide independent primary care face several policy and legal challenges to actually providing the services. Most of the challenges arise from a fundamental lack of understanding about nurse practitioner education, training, abilities, and skill. This lack of understanding has prompted overly restrictive collaborative agreements, systems of reimbursement, and lack of clarity in scope of practice. Other challenges nurse practitioners face in providing independent care are unresolved medical malpractice issues specific to nurse practitioners, including: 1) the independent nurse practitioner standard of care; 2) expert witness qualifications for independent nurse practitioner care; 3) informed consent; and 4) duty to refer when a patient's needs exceed the scope of a nurse practitioner's practice area. As pivotal decision makers, judges and legislators need a better understanding of the issues nurse practitioners face in trying to provide primary care. In this section we discuss these identified challenges and offer possible legal and policy solutions.

A. Collaborative Agreements

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.⁷⁹

76. See Ramona Benkert et al., *Satisfaction with a School-Based Teen Health Center: A Report Card on Care*, 33 PEDIATRIC NURSING 103, 107 (2007) (showing high levels of satisfaction with nurse-managed school-based health centers); Maxwell Drain, *Quality Improvement in Primary Care and the Importance of Patient Perceptions*, J. OF AMBULATORY CARE MGMT., Apr. 2001, at 30, 42 (demonstrating that overall patient satisfaction, patient care scores, and likelihood of recommendation are almost identical for nurse practitioners and physicians).

77. TINE HANSEN-TURTON ET AL., NATIONAL NURSING CENTERS CONSORTIUM, THE NURSING CENTER MODEL OF HEALTH CARE FOR THE UNDERSERVED (2004).

78. Christine M. Everett et al., *Physician Assistants and Nurse Practitioners as a Usual Source of Care*, 25 J. RURAL HEALTH 407 (2009).

79. EILEEN M. SULLIVAN-MARX & DAVID KEEPNEWS, *Systems of Payment for Advanced Practice Nurses, in NURSE PRACTITIONERS: EVOLUTION OF ADVANCED PRACTICE*, supra note 43, at 401 (quoting Social Security Act).

Although most states mandate some form of a collaborative agreement, the scope of the agreement varies among them.⁸⁰ Twelve states do not require any form of collaboration for nurse practitioner–provided care.⁸¹ Twenty-four states require physician collaboration and fourteen states require direct supervision of the nurse practitioner when writing prescriptions.⁸² The required collaboration between physicians and nurse practitioners occurs in variations, ranging from monthly chart reviews to direct on-site supervision.⁸³ These collaborative practices may be described as supervision, delegation, or collaboration.⁸⁴

Independence in primary care practice has been described as when “the practitioner relies totally on individual skills” with “no need for interaction with other health [care] professionals.”⁸⁵ However, for the modern nurse practitioner practice, like nurse-managed health clinics, independence means the ability to diagnose, treat, and prescribe without the interference or hindrance of overly restrictive collaborative agreements that prevent nurse practitioners from providing complete primary care. Nevertheless nurse practitioners must practice within their scope and ability and make appropriate referrals of patients who need a different level and/or type of care, as discussed later in this Article. 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.

To rectify the problems that collaborative agreements pose to independent practice, states that have not already done so should allow nurse practitioners to practice independently by eliminating state-level restrictions to NP scope of practice. Mandatory collaborative agreements should be abolished, giving nurse practitioners the opportunity to provide independent primary care while utilizing the full capacity of their training. Nurse practitioners could then exercise discretion to collaborate with physicians where joint decision making benefits the particular patient receiving care.

B. Funding and Reimbursements

Although nurse practitioners have proven their competency and ability to provide primary care services, federal funding systems and reimbursement through Medicaid and Medicare, along with private-pay reimbursement systems

80. See BUPPERT, *supra* note 8, Chapter 2, App. 2-B (outlining state-by-state physician collaboration requirements); 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); Barclay, *supra* note 42 (stating “there is a great deal of variation in the law governing nurse practitioner practice from state to state”).

81. CATHERINE DOWER ET AL., CTR. FOR HEALTH PROFESSIONS, PROMISING SCOPES OF PRACTICE MODELS FOR THE HEALTH PROFESSIONS 3 (2007), http://www.acnpweb.org/files/public/UCSF_Chart_2007.pdf (listing eleven states that authorize nurse practitioners to practice independently).

82. NAT’L NURSING CTR. CONSORTIUM, STATE-BY-STATE GUIDE TO REGULATIONS REGARDING NURSE PRACTITIONER AND PHYSICIAN PRACTICE (2010).

83. Ritter & Hansen-Turton, *supra* note 80, at 24–25.

84. *Id.* at 24.

85. Virginia Arcangelo et al., *Collaborative Care Between Nurse Practitioners and Primary Care Physicians*, 23 PRIMARY CARE 103, 103 (1996).

and corresponding state regulations, do not always recognize the attributes that independent nurse practitioners bring to the primary care workforce.

Federal funding mechanisms also make it difficult for some nurse practitioners to provide independent primary care. Currently most independent nurse practitioners conduct their practice in nurse-managed health clinics for the poor, and many of these centers do not have access to the federal prospective payment reimbursements available to other safety-net providers.⁸⁶ Seventy-nine percent of the nationwide nurse-managed health centers are affiliated with academic schools of nursing,⁸⁷ which makes it difficult for them to fulfill the Federally Qualified Health Centers ("FQHC") governance requirements.⁸⁸ The inability to obtain reimbursement for services provided prevents nurse-led safety net providers from offsetting the cost of their mostly uninsured patients and forces them to rely on a patchwork source of income that must be reapplied for frequently and takes away from the services that the nurse-managed health center provides.⁸⁹ Another federal funding stream, patient-centered medical home demonstration projects, until recently was completely out of reach for nurse-led practices. The National Committee for Quality Assurance ("NCQA") has a Patient-Centered Medical Home⁹⁰ accreditation and certification program that can lead to additional funding through medical home demonstration project funding, but until November 2010 would only accredit physician-led practices.⁹¹ Today, eight nurse-

86. See Hansen-Turton, *supra* note 70, at 730 (stating that nurse-managed health centers act as critical but hidden safety nets).

87. INST. FOR NURSING CTRS., INSTITUTE FOR NURSING CENTERS: HIGHLIGHT REPORT FROM THE DATA WAREHOUSE 1 (2008), available at http://www.nursingcenters.org/PDFs/INC%20Highlight%20Report%2010_6_08.pdf.

88. This phenomenon is due to the requirements of federally qualified health centers or "look-alikes" as defined in section 330 of the Public Health Service Act. See 42 U.S.C. § 254b (2006) (defining what constitutes federal qualified health centers). One of the governance requirements that restrict nurse-led practices such as nurse-managed health centers from being included is having a Board of Directors with a majority makeup of consumers, which is impossible in the academic setting where most nurse-led centers exist. *Id.* § 254b(k)(3)(H)(i). Thus, the required "public agency" status is difficult for academic nurse-managed health centers to obtain.

89. See Tine Hansen-Turton et al., *Insurers' Contracting Policies on Nurse Practitioners as Primary Care Providers: Two Years Later*, 9 POL'Y, POL., & NURSING PRAC. 241, 242 (2008) (stating that nurse-managed health care centers do not receive all their deserved reimbursements and therefore must rely on private grants and donations).

90. The Patient Center Primary Care Collaborative, encompassing the American Academy of Family Physicians ("AAFP"), the American Academy of Pediatrics ("AAP"), the American College of Physicians ("ACP"), and the American Osteopathic Association ("AOA") has defined the Patient Centered Medical Home ("PCMH") as "an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family." Patient Centered Primary Care Collaborative, *Joint Principles of the Patient Centered Medical Home*, Feb. 2007, <http://www.pcpc.net/content/joint-principles-patient-centered-medical-home>. The NCQA has adopted this definition.

91. See NCQA, Accreditation, Certification, and Recognition, <http://www.ncqa.org/tabid/58/Default.aspx> (last visited Mar. 5, 2011) (detailing recognition requirements for patient-centered medical homes).

managed health clinics have received the PCMH certification, which again signals a federal-level policy shift in favor of nurse practitioner-led primary care.⁹²

Nurse practitioners are eligible under federal law to receive reimbursement through both Medicare and Medicaid, but the private managed care organizations (insurers) that local and federal governments contract with to administrate the services are not required to include nurse practitioners as primary care providers.⁹³ State laws also designed to prevent insurers from discriminating against types or classes of providers have had no impact on insurer credentialing policies,⁹⁴ and many state laws aimed at eradicating the discrimination of classes of providers are weak or not enforced.⁹⁵

According to the results of a 2007 insurer survey, seventy-three percent of insurers with Medicaid products credentialed nurse practitioners as primary care providers, as compared to thirty-three percent of insurers with Medicare products and forty-three percent of those with commercial policies.⁹⁶ Insurers are more than willing to have nurse practitioners provide care to the poor and disabled, as evidenced by the high percentage of nurse practitioners credentialed by Medicaid commercial insurers. However, insurers remain unwilling to authorize primary care by nurse practitioners for individuals with private health insurance, apparently adopting the view that nurse practitioners are “incapable of providing the full scope of services that a [physician] is able to provide.”⁹⁷

Some insurers candidly acknowledge that they only credential nurse practitioners as primary care providers in areas with physician shortages.⁹⁸ Even though insurers know that nurse practitioners fill gaps in primary care due to the physician shortage, they continue to discriminate against nurse practitioners because laws designed to stop provider discrimination lack true enforcement power and because insurers do not have a clear understanding of the capabilities of nurse practitioners. Adoption of stronger regulatory language specifically requiring the credentialing of nurse practitioners as primary care providers would eliminate the greatest challenge to the expansion of nurse practitioner independent practice and help insurers accept the fact that nurse practitioners are competent primary care providers.

92. For more information, please contact the National Nursing Centers Consortium.

93. See *Provider Discrimination Prohibited*, 42 C.F.R. § 438.12 (2008) (prohibiting discrimination “solely on the basis of” health care provider’s license or certification, may not be construed to require its insurer to “contract with providers beyond the number necessary to meet the needs of enrollees”); *Provider Antidiscrimination Rules*, 42 C.F.R. § 422.205 (2008) (prohibiting discrimination “solely on the basis of” health care provider’s license or certification, but stating that statute does not preclude MCO’s from refusing to admit providers that are “in excess of the number necessary to meet the needs of the plan’s enrollees”).

94. Hansen-Turton et al., *supra* note 89, at 244.

95. See Tine Hansen-Turton et al., *Insurers’ Contracting Policies on Nurse Practitioners as Primary Care Providers: The Current Landscape and What Needs to Change*, 7 POL’Y, POL., & NURSING PRAC. 216, 219 (2006) (noting that while twenty-three states have laws requiring insurance companies to contract with “any willing provider,” they do not often apply specifically to nurse practitioners, and those that explicitly do or might are ineffective).

96. Hansen-Turton et al., *supra* note 89, at 245.

97. Hansen-Turton et al., *supra* note 95, at 221.

98. Hansen-Turton et al., *supra* note 89, at 243.

C. Scope of Practice

Laws and regulations defining a nurse practitioner's scope of practice are "created and enforced at the state level."⁹⁹ The source of the definition differs, but all jurisdictions dictate scope of practice either in a statute or state code or in rules and regulations promulgated by medical and/or nursing boards.¹⁰⁰ The term "scope of practice" refers to the "permissible boundaries of practice for the health professional."¹⁰¹ However, in states where the scope of practice remains ill-defined, disputes often arise over what a nurse practitioner is legally able to do.¹⁰² The current lack of clarity grew out of a historical effort of physicians to limit the scope of practice of nurse practitioners. In the 1950s, physician groups introduced state-by-state legislation defining physician-only services, which included many things that nurses were already doing.¹⁰³ In response, the American Nursing Association ("ANA") created a model definition of nursing, which stated that nursing "shall not be deemed to include any acts of diagnosis or prescription of therapeutic or corrective measures."¹⁰⁴ Meanwhile, nurses continued to diagnose illness in the course of their practices.¹⁰⁵ Nurse practitioners have since been slowly changing the legal definition of the practice of medicine to broaden their authority.¹⁰⁶

Patients and nurse practitioners would benefit from a clear definition of scope of practice. For instance, in states where laws do not explicitly authorize nurse practitioners to perform primary care functions, insurers can deny or interrupt nurse practitioners from being covered providers.¹⁰⁷ In contrast, states that clearly define the nurse practitioner's authority provide a legal basis for the nurse practitioner claim of a right to inclusion on primary care provider panels.¹⁰⁸ Additionally a clear definition of permissible practice scope will minimize the risk of a medical malpractice claim based on the argument that a nurse exceeded her authorized legal authority and medical training with respect to the provision of particular care.

Medical malpractice claims against a nurse practitioner almost never rest on an allegation that the nurse has exceeded her scope of practice. Rather, legal challenges to the scope of the authority of nurse practitioners emanate from

99. Ritter & Hansen-Turton, *supra* note 80, at 23; *see also* DOWER ET AL., *supra* note 81, at 1 (describing determinations of scopes of practice as "state-based activity").

100. BUPPERT, *supra* note 8, at 38; *see also* DOWER ET AL., *supra* note 66, at 1 (indicating that while medical and/or nursing boards can determine nurse practitioner scope of practice, some exceptions to this general rule include federal organizations like the military, Veterans' Affairs and Indian Health Services).

101. BUPPERT, *supra* note 8, at 38.

102. *See id.* at 38-39 (discussing legal problems that arise with vaguely worded nurse practice acts).

103. Carolyn Buppert, *The Legal Distinction Between the Practice of Medicine and the Practice of Nursing*, J. FOR NURSE PRAC., 22, 23-24 (2008).

104. *Id.* at 23-24.

105. *Id.* at 24.

106. *Id.*

107. *Id.*

108. *Id.*

physician organizations¹⁰⁹ challenging the authority of nursing board regulations to define the nurse practitioner scope of practice.¹¹⁰ Notably, these challenges arose in the 1980s, and formal legal challenges to state Boards of Nursing authority have stopped. This may signify a greater acceptance of nurse practitioners by medical groups, but may also signal that medical groups have subsequently moved their battle efforts to the legislative and regulatory processes. The most common malpractice claims made against nurse practitioners by patients actually relate to improper diagnosis and treatment.¹¹¹ Cases that make it to the appellate level are often exploring who is the actual negligent party when a nurse practitioner is acting within her scope of practice and is under the supervision of a physician.¹¹² These cases find that when a nurse practitioner is acting under the direction of a physician, the physician is the liable party for the nurse's malpractice.¹¹³ There are no appellate cases on record where a nurse practitioner has been sued for negligence on the ground that he should not have engaged in independent practice.

There are a few options that could clarify nurse practitioners' scope of practice. First, states that do not have a statute defining the scope of practice should vest the authority to define a nurse practitioner's scope or its implementation in a Board of Nursing, and not the Board of Medicine. The latter is usually governed by physicians only and many physicians are also not well informed of or willing to accept the primary care capabilities of nurse practitioners.¹¹⁴ In contrast, a state's Board of Nursing will have a clear

109. State-level cases have been noted for Registered Nurses and their employers being found negligent when the Registered Nurses took on the role of Nurse Practitioners and made mistakes. For a brief overview of malpractice suits involving nurse practitioners, see Cathy A. Klein, *Surveying the Malpractice Terrain*, 27 NURSE PRAC. 62 (2002).

110. See *La. State Med. Soc'y v. La. State Bd. of Nursing*, 493 So. 2d 581, 582-83 (La. 1986) (discussing Louisiana Medical Society seeking to invalidate State Board of Nursing rule that created position of Primary Nurse Associate); *Sermchief v. Gonzales*, 660 S.W.2d 683, 683, 690 (Mo. 1983) (charging nurse practitioners in collaborative practice with physicians with violating their scope of practice for performing routine gynecological exams and tests, but finding that nurse practitioners were within legislative standard of their practice); *Bellegie v. Tex. Bd. of Nurse Examiners*, 685 S.W.2d 431, 433 (Tex. App. 1985) (holding that where group of individuals and medical association sought to invalidate State Board of Nursing rule that described scope of practice and duties of Advanced Nurse Practitioners, court ruled in favor of Board of Nursing).

111. See CNA HEALTHPRO, NURSE PRACTITIONER CLAIMS STUDY: AN ANALYSIS OF CLAIMS WITH RISK MANAGEMENT RECOMMENDATIONS 1994-2004 (2005) (analyzing malpractice claims against nurse practitioners); Kenneth P. Miller, *Malpractice Trends: Viewing the Data and Avoiding the Hot Seat of Litigation*, 5 J. NURSE PRAC. 662, 663 (2009) (stating that malpractice claims against all health care providers are rising).

112. See *Siegel v. Husak*, 943 So. 2d 209, 213 (Fla. Dist. Ct. App. 2006) (finding that nurse practitioner acted within her standard of care and cannot be held liable for misdiagnosis when under supervision of physician); *Adams v. Krueger*, 856 P.2d 864, 865-67 (Idaho 1993) (holding that since nurse practitioner acted under scope of her employment, liability of her improper diagnosis was properly given to her supervising physician).

113. *Adams*, 856 P.2d at 866-67; *Siegel*, 943 So. 2d at 213.

114. See Carol E. Fletcher et al., *Nurse Practitioners' and Physicians' Views of NPs as Providers of Primary Care to Veterans*, 39 J. NURSING SCHOLARSHIP 358, 359-60 (2007) (discovering that nurse practitioners saw their role as independent providers who utilize physician backup as needed, while physicians equated nurse practitioner's role to physician supporter or extender and not able to provide

understanding of a nurse's training and can fairly and effectively define the appropriate scope of practice. Second, legal authority to diagnose and prescribe has proved elusive and remains an important issue. Legislators and regulators should clarify this issue by recognizing that diagnosing and prescribing represent important and safe aspects of nurse practitioner practice.¹¹⁵ Alternatively, the authority of nurse practitioners to prescribe should be based on measures of competence like pharmacological exams. Ultimately, the public interest in safe and effective primary care will be best promoted by an approach already taken by several states that have conducted extensive scope-of-practice reviews of medical and nursing related professions, negating the necessity for hap-hazard incremental changes.¹¹⁶ If more states took a hard look at the scope of all their providers, the states could resolve discrepancies between statutes and regulations while appropriately dividing the scope of health care providers' authorities.

D. Medical Malpractice Law and Nurse Practitioner Practice

A nurse practitioner faces potential tort liability under the same rules as other health care providers. A health care provider can be held liable for harm suffered by a patient for: a medication error; inadequate patient monitoring; failure or delay in giving a diagnosis; committing a documentation or charting error; failure to consult or refer; incorrect use of equipment; failure to obtain informed consent; failure to follow up; or exceeding legal scope of practice.¹¹⁷ However, four specific issues require exacting analysis to accurately assess the potential malpractice liability of independent nurse practitioners and to make recommendations that support the growth of independent practice by nurse practitioners. The issues warranting most attention are: 1) the medical professional against whom the nurse practitioner will be compared when determining the appropriate standard of care; 2) the qualifications of the expert witness who testifies to the nurse practitioner's standard of care; 3) the doctrine of informed consent; 4) the nurse practitioner's duty to consult or refer; and 5) nurse practitioners and medical malpractice rates.

adequate primary care to veterans with co-morbid conditions); Valarie H. Ford & Cheryl Pope Kish, *Family Physician Perceptions of Nurse Practitioners and Physician Assistants in a Family Practice Setting*, 10 J. AM. ACAD. NURSE PRAC. 167, 168-69 (1998) (finding that physicians who had mostly limited experience in working with nurse practitioners considered nurse practitioners as useful when they "adhere[d] to guidelines and protocols" and that physicians generally had negative undertones regarding role of nurse practitioner).

115. Buppert, *supra* note 103, at 23.

116. See NAT'L COUNCIL OF STATE BDS. OF NURSING, CHANGES IN HEALTHCARE PROFESSIONS' SCOPE OF PRACTICE: LEGISLATIVE CONSIDERATIONS (2009), <https://www.ncsbn.org/ScopeofPractice.pdf> (describing collaborative project between many national professional boards that produced roadmap of considerations when a state is deciding to make these changes).

117. See generally Frank J. Cavico & Nancy M. Cavico, *The Nursing Profession in the 1990's: Negligence and Malpractice Liability*, 43 CLEV. ST. L. REV. 557 (1995) (noting different forms of malpractice by nurses).

1. Appropriate Standard of Care

In the United States, individuals who suffer harm while under the care of a health care provider may seek compensation if they can establish a prima facie case of negligence which requires proof that 1) the health care provider had a duty to the harmed person; 2) there was a breach of that duty because the provider was negligent in some way; 3) the breach was the actual and proximate cause of some specific harm; and 4) there was an actual loss or damage from the breach.¹¹⁸ Health care providers automatically have a duty of care to their patients as part of the “physician-patient relationship.”¹¹⁹ So, a breach of the standard of care, or negligence, occurs when the health care provider “failed to conform” to a reasonable provider’s conduct, thus breaching the duty to the patient.¹²⁰ A specialist in health care must exercise the care that a reasonable person “of the same medical specialty would use under similar circumstances.”¹²¹

Defining a nurse practitioner’s standard of care and deciding when negligence occurs requires an understanding of the scope and nature of the nurse practitioner’s practice.¹²² On one hand a nurse provides diagnoses and treatment that overlap with that provided by a physician. On the other hand, her approach and underlying philosophy often differ from that of the physician. The threshold issue is whether to judge the reasonableness of the nurse practitioner’s conduct by the conduct of another nurse practitioner or by the conduct of a physician who provides care for the same condition. The standard of care that a state adopts as applicable to the nurse practitioner will have a significant impact on medical malpractice claims. In part, because nurse practitioners and physicians share a standard of medical care in some instances, courts have answered the question differently as to whether to reference the conduct of a physician or another nurse practitioner. Courts often lack an appreciation of how two health care professionals may take different approaches to diagnose or treat the same condition, and yet both approaches find professional support as representing quality care rendered in the best interest of the patient.

For example, the California Supreme Court has concluded that nurses and physicians do not share a standard of care, even though certain elements of nursing and medical practice will overlap.¹²³ Consequently, “the ‘examination’ or

118. THOMAS C. GALLIGAN ET AL., *TORT LAW: CASES, PERSPECTIVES, AND PROBLEMS* 166–68 (4th ed. 2007).

119. *See, e.g.*, *Seeber v. Ebeling*, 141 P.3d 1180, 1189 (Kan. Ct. App. 2006) (summarizing that “where there is no ongoing physician-patient relationship, the physician’s express or implied consent to advise or treat the patient is required for the relationship to come into being. Stated otherwise, the doctor must take some affirmative action with regard to treatment of a patient in order for the relationship to be established.” (quoting *Adams v. Via Christi Regional Med. Center*, 19 P.3d 132 (2001))).

120. GALLIGAN ET AL., *supra* note 118, at 167; FRANK McCLELLAN, *MEDICAL MALPRACTICE: LAWS, TACTICS, AND ETHICS* 31 (1994).

121. BLACK’S LAW DICTIONARY 1045 (9th ed. 2009).

122. Susan E. Baker, Note, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325, 338 (1992).

123. *See Fein v. Permanente Med. Group*, 695 P.2d 665, 673–74 (Cal. 1985) (holding that previous court had erroneously given jury instruction that nurse practitioner’s conduct should be measured by

'diagnosis' of a patient cannot in all circumstances be said—as a matter of law—to be a function reserved to physicians, rather than registered nurses or nurse practitioners."¹²⁴ Yet, nurse practitioners increasingly perform care historically perceived as medical care provided by physicians, and in some states the practice of nursing is jointly regulated by the Boards of Medicine and Nursing,¹²⁵ bolstering the argument that nursing professionals may be held accountable to a physician standard of care. In Louisiana nurse practitioners have been held to a physician standard of care since 1976.¹²⁶ However, despite apparent similarities the nursing and medical professions are fundamentally different in their educational and practice approaches. Nurse practitioners provide parallel, not duplicative, primary health care services by their own standards, and neither nurses nor physicians should be judged according to the other's professional credo.

2. Expert Witness Qualifications

Following the determination of the appropriate standard, a decision must be made as to whether a nurse, physician, or both, are qualified to testify as an expert. The general standard for qualification is that the person possesses special education or training that will aid the court and/or jury in determining whether a deviation from the accepted standard has occurred, and whether any deviation has in fact caused harm to the plaintiff.¹²⁷ All courts regard nurse practitioners, as well as other nurses, as competent to testify to a nursing standard of care,¹²⁸

standard of care of physician, and recognizing that recent legislation had set forth nursing guidelines indicating that diagnoses given by nurse practitioners are function of nursing).

124. *Id.* at 674.

125. For a state-by-state account, see BUPPERT, *supra* note 8, at 114.

126. See *Butler v. Louisiana State Bd. of Educ.*, 331 So. 2d 192, 196 (La. Ct. App. 1976) (holding that "nurses and medical technicians who undertake to perform medical services are subject to the same rules relating to the duty of care and liability as are physicians in the performance of professional services"), *cert. denied*, 334 So. 2d 230 (La. 1976), *aff'd* *Belmon v. St. Frances Cabrini Hosp.*, 427 So.2d 541 (La. App. 3d Cir. 1983).

127. FED. R. EVID. 702 (stating that "[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case").

128. See, e.g., *Dooley ex rel. Estate of Pannell v. Cap-Care of Arkansas, Inc.*, 338 F. Supp. 2d 962, 966 (E.D. Ark. 2004) (holding that under Arkansas Malpractice Act, nurse practitioner could testify to "the degree of skill and learning ordinarily possessed and used by members of the profession of the medical care provider in good standing, engaged in the same type of practice or specialty in the locality in which he practices or in a similar locality" (quoting Ark. Code Ann. § 16-114-206(a))); *Griel v. Franklin Med. Ctr.*, 71 F. Supp. 2d 1, 10 (D. Mass. 1999), *aff'd* 234 F.3d 731 (1st Cir. 2000) (holding that acute care nurses are qualified to testify regarding standard of care of nurses distributing drugs); *Broehm v. Mayo Clinic Rochester*, 690 N.W.2d 721, 727 (Minn. 2005) (holding that geriatric nurse practitioner had sufficient training to offer opinion that hospital breached nursing standard of care); *Freed v. Geisinger Med. Ctr.*, 910 A.2d 68, 75 (Pa. Super. 2006) (holding that specialized knowledge required of nurses qualifies them as expert witnesses per Pennsylvania Rules of Evidence).

including general procedures in a medical setting,¹²⁹ unless they admit to not being familiar with a particular applicable or current standard of care.¹³⁰ Some courts have allowed nurse testimony on the standard of care of other medical professionals.¹³¹ Nonetheless, nurse practitioners are not usually allowed to testify to a physician standard of care, despite having familiarity with the medical model of care.¹³² In fact, most courts hold that only a physician is qualified to render testimony as to the standard of care for a physician.¹³³

Using the rationale that the evidence shows that a physician has sufficient familiarity with nurse practitioner practice, some courts have ruled that a physician possesses sufficient exposure to the nursing practice to assist the court and the jury in making a standard-of-care determination.¹³⁴ Yet, even with this

129. *See, e.g.,* *Avret v. McCormick*, 271 S.E. 2d 832, 833 (Ga. 1980) (qualifying nurse as expert witness to testify to reasonable care in how to keep needle sterilized); *Allen v. Family Med. Ctr., P.C.*, 652 S.E.2d 173, 176-77 (Ga. Ct. App. 2007) (stating that nurse was competent to testify to practice of intramuscular injections); *Berdyck v. Shinde*, 613 N.E.2d 1014, 1022 (Ohio 1993) (crediting nurse's testimony that pregnant woman with preeclampsia should have been observed for seizures); *Gaines v. Comanche County Med. Hosp.*, 143 P.3d 203, 206-07 (Okla. 2006) (qualifying nurse with eighteen years of experience in treating elderly and critically ill who was certified for wound care practice to give expert testimony as to practices of standard of care for nurse wound care). *But see* *Fountain v. Cobb Gen. Hosp.*, 306 S.E.2d 37, 39-40 (Ga. Ct. App. 1983) (refusing to find nurse competent to testify to anesthesia administration and timing of epidural catheter removal, and finding competent to testify to standard of nursing care only).

130. *Smith v. Am. Transitional Hosps., Inc.*, 330 F. Supp. 2d 1358, 1360-61 (S.D. Ga. 2004) (refusing to qualify nurse as expert on restraints after she stated twice in her deposition that she did not know what the applicable standard of care was for restraints); *Tuck v. Health Care Auth. of City of Huntsville*, 851 So. 2d 498, 503 (Ala. 2002) (refusing to qualify nurse as expert on restraints where she admitted she did not consider herself similarly situated to nurses who used restraints, and had not herself used restraints in previous year); *McDonald v. Glynn-Brunswick Mem'l Hosp.*, 418 S.E.2d 393, 394 (Ga. Ct. App. 1992) (refusing to qualify nurse as expert when she had not been licensed for eight years, and admitted that standard may have changed since she was last licensed).

131. *See, e.g.,* *HealthTrust, Inc. v. Cantrell*, 689 So.2d 822, 827 (Ala. 1997) (qualifying registered nurse to testify regarding standard of care of operating room technician because she was "similarly situated" health care professional); *Andrade Garcia v. Columbia Med. Ctr. of Sherman*, 996 F. Supp. 617, 626 (E.D. Tex. 1998) (applying Texas law to find that nurse was qualified to offer expert testimony regarding alleged departure from accepted standards of care for non-physicians, although not for physicians).

132. *See, e.g.,* *Jerden v. Amstutz*, 430 F.3d 1231, 1239-40 (9th Cir. 2005) (striking neurosurgical nurse practitioner's lay testimony because his opinion crossed line to expert testimony, which he was not qualified to give); *Tucker v. Talley*, 600 S.E.2d 778, 782 (Ga. Ct. App. 2004) (determining that registered nurse cannot testify to standard of care of physician because there was no overlap in function of physician and nurse, and upholding rule that members of different schools of practice are not competent to testify to each other's practices). *But see* *Harris v. Miller*, 438 S.E.2d 731, 742 (N.C. 1994) (holding that expert nurse anesthetist, with fifteen years experience, was qualified to testify to surgeon's standard of care in directing nurse anesthetist in operating room).

133. *See, e.g.,* *Cagnolatti v. Hightower*, 692 So. 2d 1104, 1109-10 (La. Ct. App. 1996) (recognizing that only physicians can testify to physician standard of care and pharmacologist could only testify to proper administration of medications); *Dombrowski v. Moore*, 752 N.Y.2d 183, 185-86 (N.Y. App. Div. 2002) (holding that, as lay witness, nurse could not testify as to general practices and statistics regarding standard of care of physician).

134. *See, e.g.,* *McMillan v. Durant*, 439 S.E.2d 829, 832 (S.C. 1993) (qualifying physician who taught nursing courses as expert regarding nurse practitioner standards); *Staccato v. Valley Hosp.*, 170 P.3d 503, 506-07 (Nev. 2007) (holding that expert qualifications turn on proposed witnesses special

reasoning the court may still preclude a physician from testifying as an expert witness to a nurse practitioner standard of care when the physician has not demonstrated that he/she has knowledge of the standard of care applicable to nurse practitioners or has not ever worked with or supervised nurse practitioners.¹³⁵ The Illinois Supreme Court has specifically held that a physician is not qualified to testify regarding the standard of care for the nursing profession because it is a separate profession with distinct licensing.¹³⁶ The court further stipulated that licensure in the same field and familiarity with “the methods, procedures, and treatments ordinarily observed by other health-care providers” are necessary for expert witness status to be acknowledged.¹³⁷ “Testimony from a physician about the standard of care may be subject to objection because the physician is not a nurse and does not have direct knowledge of nursing standards of care.”¹³⁸

An important policy determination that underlies both the standard of care and expert qualification issue is whether a physician can truly grasp and communicate nursing practice and principles if his education and training has allowed only limited exposure to those practices and principles. The American Association of Nurse Attorneys (“TAANA”) argues that only nurses should be permitted to provide expert testimony as to the nursing standard of care in malpractice actions, because “only the nursing profession has the right, duty and responsibility to determine the scope and nature of nursing practice including the standard of care for nurses.”¹³⁹ TAANA maintains:

It is clear that the profession of nursing, though closely related to the practice of medicine, is, indeed, distinct with its own licensing scheme, educational requirements, areas of specialization, Code of Ethics, models, theories and contract with society. The standard of care for nurses arises from the very nature and scope of nursing and is derived from the nursing process. . . . It is unlikely that any physician, unless

knowledge, skill, experience, education, or training, not credentials, and thus emergency room physician was able to testify to appropriate standard of care for nurse administering intramuscular injections); *Cooper v. Eagle River Mem'l Hosp., Inc.*, 270 F.3d 456, 463 (7th Cir. 2001) (upholding trial court's admission of physician's testimony regarding nurse practitioner's standards).

135. *Simonson v. Keppard*, 225 S.W.3d 868, 873–74 (Tex. App. 2007) (refusing to qualify neurosurgeon as expert on standard of care applicable to nurse practitioner where neurosurgeon did not state that he had any familiarity with standard of care for nurse practitioners).

136. *Sullivan v. Edward Hosp.*, 806 N.E.2d 645, 657–58 (Ill. 2004) (refusing to qualify doctor as expert on standard of care applicable to nurses because he was not licensed nurse and had not been licensed member of nursing school).

137. *Id.* at 655–56 (relying on three-step review of licensure, familiarity, and discretion to find expert witness should have been admitted); *see also Dolan v. Galluzzo*, 396 N.E.2d 13, 15 (Ill. 1979) (requiring expert to be licensed within community to testify to its standard of care); *Purtill v. Hess*, 489 N.E.2d 867, 869–70 (Ill. 1986) (laying out two-prong requirement that expert must be licensed within community and familiar with practice to testify to standard of care), *aff'd Jones v. O'Young* 607 N.E.2d 224, 225 (Ill. 1992).

138. *Sullivan*, 806 N.E.2d at 659 (quoting Paula Sweeney, *Proving Nursing Negligence*, 27 TRIAL 34, 36 (1991)).

139. AM. ASSOC. OF NURSE ATTORNEYS, TAANA POSITION PAPER ON EXPERT TESTIMONY IN NURSING MALPRACTICE ACTIONS (2004), http://associationdatabase.com/aws/TAANA/pt/sd/news_article/3453/_parent/layout_details/false.

he/she has completed a nursing program and has practiced as a nurse, can offer competent, reliable expert opinion on these nursing standards.¹⁴⁰

There are resources that help to delineate the nurse practitioner standard of care. In 2002, a national panel of nurse practitioner organizations and credentialing and certifying agencies collaborated with the U.S. Department of Health and Human Services to publish nurse practitioner specialty care competencies for the preparation of adult, family, gerontological, pediatric, and women's health nurse practitioners.¹⁴¹ Core competencies identified for specialty areas are intended to be used in conjunction with, while building on, those already identified as applicable for all nurse practitioners.¹⁴² Thus, ample resources exist to define a nurse practitioner's standard of care, and TAANA's argument for utilization of nurses for expert testimony at trial where a nurse practitioner is a defendant enables a court and jury to assess the reasonableness of a nurse's conduct without subjecting a nurse to the biases of a physician who has limited exposure to nursing education and training.

3. Informed Consent

To date, most courts and legislatures have viewed the physician as the health care provider who has the obligation to get an informed consent from the patient.¹⁴³ As nurse practitioners assume more authority to provide primary care, the duty of informing the patient will accompany the expansion, making informed consent a critical issue to their practice.

The traditional view of informed consent, still maintained in some jurisdictions, measures the duty of a health care provider by either the customary disclosure practices in the provider's community¹⁴⁴ or what a reasonable provider would disclose under the same or similar circumstances.¹⁴⁵ The modern doctrine

140. *Id.*

141. U.S. DEP'T OF HEALTH & HUMAN SERVS., NURSE PRACTITIONER PRIMARY CARE COMPETENCIES IN SPECIALTY AREAS: ADULT, FAMILY, GERONTOLOGICAL, PEDIATRIC, AND WOMEN'S HEALTH (2002), available at <http://www.aanp.org/NR/rdonlyres/C8CA2237-6997-4A7D-AF65-BCED283B549E/0/finalaug2002.pdf>.

142. *Id.* at 1.

143. See, e.g., *Liquito v. Siegel*, 850 A.2d 537, 543-44 (N.J. Super. Ct. App. Div. 2004) (summarizing state case law requiring doctor has duty to obtain informed consent from patient); *Valles v. Albert Einstein Med. Ctr.*, 758 A.2d 1238, 1245 (Pa. Super. 2000) (showing Pennsylvania law requires physician to obtain patient's informed consent); *Newell v. Trident Med. Ctr.*, 597 S.E.2d 776, 777-78 (S.C. 2004) (indicating physician has duty to get patient's informed consent).

144. See, e.g., *K.A.C. v. Benson*, 527 N.W.2d 553, 561 (Minn. 1995) (indicating that doctor must disclose risks that "a skilled practitioner of good standing in the community would reveal"); *Ross v. Hodges*, 234 So. 2d 905, 909 (Miss. 1970) (stating that question of whether there was informed consent "is whether Dr. Hodges disclosed to plaintiff sufficient information about the proposed operation to constitute informed consent" and that disclosure must conform to disclosure practices of other neurosurgeons in area).

145. See, e.g., *McGee v. Bonaventura*, 605 N.E.2d 792, 795 (Ind. Ct. App. 1993) (indicating that, in order for physician to give appropriate informed consent, he must disclose risks that "reasonably prudent physician" would disclose (citing *Culbertson v. Mernitz*, 602 N.E.2d 98, 104 (Ind. 1992)));

of informed consent, often called the reasonable patient standard, requires the health care provider giving treatment to inform her patient of the risks and benefits of a proposed medical procedure, alternatives available to the proposed treatment, and the risk of not undergoing the proposed treatment or procedure.¹⁴⁶ Even though most informed consent claims rest on an alleged failure to disclose the risks and benefits of a surgical or medical procedure, the Wisconsin and New Jersey Supreme Courts have held that where the risks and benefits are dependent on the skill and experience of the health care provider, a duty arises for that specific health care provider to fully disclose his or her experience.¹⁴⁷ Although the Washington and Pennsylvania courts have specifically declined to adopt this standard,¹⁴⁸ the view has been endorsed by legal researchers and could spread to other jurisdictions.¹⁴⁹ For purposes of maintaining good relationships with patients as well as risk management, it makes sense for nurse practitioners to discuss the nursing model of care with their patients to minimize future claims that the patient believed a nurse employed the same practices and standards of care as a primary care physician. The nursing approach to care warrants understanding and endorsement by patients who will choose to gain the benefits of a nurse practitioner as their primary care provider.

In specific situations that to date have related only to surgery, some informed consent cases require a physician to take account of the specific knowledge and experience limitations of the patient, and to provide information that will enable a person with limited education or resources to appreciate the risks and alternatives.¹⁵⁰ Research has shown that poor, undereducated, disabled, elderly,

Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960) (emphasizing that physician's duty to disclose is limited to that which "reasonable medical practitioner would make" under circumstances).

146. See, e.g., Canterbury v. Spence, 464 F.2d 772, 786-88 (D.C. Cir. 1972) (stating that test turns on "materiality to the patient's decision"); Scaria v. St. Paul Fire & Marine Ins. Co., 227 N.W.2d 647, 654 (Wis. 1975) ("The duty of the [health care provider] is to make such disclosures as appear reasonably necessary under circumstances then existing to enable a reasonable person . . . at the time of disclosure to intelligently exercise his right to consent or to refuse the treatment or procedure proposed.").

147. E.g., Howard v. Univ. of Med. & Dentistry of New Jersey, 800 A.2d 73, 83-84 (N.J. 2002) (answering question of whether physician's prior experience may be relevant to informed consent if it increases risk to patient from procedure in the affirmative); Adler *ex rel.* Johnson v. Kokemoor, 545 N.W.2d 495, 499, 505 (Wis. 1996) (concluding that evidence regarding physician's limited prior experience with particular procedure was admissible for purposes of informed consent claim when plaintiff also introduced statistical evidence demonstrating that physician's limited experience with this procedure increased risk to plaintiff); see also Barriocanal v. Gibbs, 697 A.2d 1169, 1172 (Del. 1997) (holding that surgeon deviated from informed consent standard by not telling patient that he had not recently performed the surgery).

148. Whiteside v. Lukson, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997) (refusing to adopt more expansive understanding of physician's duty to disclose); Duttry v. Patterson, 771 A.2d 1255, 1259 (Pa. 2001) (refusing to expand disclosure requirement).

149. E.g., Emmanuel O. Iheukwumere, *Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent*, 18 J. CONTEMP. HEALTH L. & POL'Y 373 (2002); Steven Rado, Note, *A Patient's Right to Know: A Case for Mandating Disclosure of Physician Success Rate as an Element of Informed Consent*, 18 HEALTH MATRIX 501 (2008) (advocating for disclosure of surgery success rates); Brad M. Rostolsky, Comment, *Practice Makes Perfect: Experience-Related Information Should Fall Within the Purview of Pennsylvania's Doctrine of Informed Consent*, 40 DUQ. L. REV. 543 (2002).

150. E.g., Ditto v. McCurdy, 947 P.2d 961, 969-70, 973-74 (Haw. Ct. App. 1997) (suggesting doctor's failure to ensure Korean immigrant with fourth grade education understood consent form

and some ethnic persons are vulnerable to low health literacy.¹⁵¹ This makes subgroups of persons less likely to understand what they are consenting to during treatment. Furthermore, these are the populations for which nurse practitioners often find themselves providing care. As nurse practitioners gain additional practice authority in primary care, they may incur a duty to meet the unique informational needs of these patients, including the need for a patient to understand the scope of their practice.

The nursing model of health care lends itself well to eliciting informed consent from all types of patients. Nurse practitioners maintain an open line of communication with patients and their families and are typically more accessible for follow-up conversations. However, nurse practitioners should go beyond communicating risks, benefits, and alternatives related to diagnosis and treatment. They should also inform the patient about their scope of authority and the important differences in the way in which nurse practitioners approach primary care as compared to physicians. Education about those differences is likely to reduce the willingness of a patient and a lawyer to bring a malpractice claim, and the inclination of a judge or jury to render a decision against a nurse practitioner who has conformed to standard nursing practices.

4. Duty to Advise and Refer

The other specific claim a nurse practitioner will face is that particular problems or signs and symptoms of disease may compel a referral to a physician or a particular health care specialist. The failure of the duty to appropriately refer has precipitated many medical malpractice claims against physicians.¹⁵² The duty to refer arises specifically in instances where the physician knew or should have known that she did not possess the requisite skills and experience to treat a particular ailment.¹⁵³ Courts are likely to find that nurse practitioners providing primary care also have a duty to refer in similar circumstances. A review of malpractice claims made against nurse midwives and nurse practitioners provides guidance as to the kinds of duty-to-refer tort claims nurse practitioners may

supported jury's findings of gross negligence); *Hidding v. Williams*, 578 So. 2d 1192, 1195-96 (5th Cir. 1991) (holding that plaintiff who signed consent form had successfully rebutted presumption of informed consent, due to his limited literacy skills); see also Frank McClellan, *Medical Malpractice Law, Morality and the Culture Wars: A Critical Assessment of the Tort Reform Movement*, 27 J. LEGAL MED. 33, 47 (2006) (arguing that "[a] patient's low health literacy may translate into the absence of informed consent, even where written consent is given").

151. Julie A. Gazmararian et al., *Health Literacy Among Medicare Enrollees in a Managed Care Organization*, 281 JAMA 545, 548-49 (1999); Mark V. Williams et al., *Inadequate Functional Health Literacy Among Patients at Two Public Hospitals*, 274 JAMA 1677, 1681 (1995); Jennifer Fisher Wilson, *The Crucial Link Between Literacy and Health*, 139 ANNALS INTERNAL MED. 875, 876 (2003).

152. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 781 n.22 (D.C. Cir. 1972) (indicating that discovery of patient's illness or issue calling for specialized treatment creates duty for general health care provider to advise patient to consult specialist); *Adler ex rel. Johnson v. Kokemoor*, 545 N.W.2d 495, 509 n.34 (Wis. 1996) (holding that "a physician's failure to refer may . . . be material to a patient's exercise of an intelligent and informed consent").

153. See, e.g., *Tucker v. Stetson*, 123 N.E. 239, 240 (Mass. 1919) (agreeing with lower court that physician can be found negligent for continuing to treat injury with sandbags, bandages, x-ray, and bed rest when surgical treatment was viable option); see also 35 A.L.R. 3d 349 § 5(a) (1971).

face.¹⁵⁴ Primary care physicians have faced the responsibility to limit access to unnecessary care and tests not worth the cost, along with a duty to refer patients for appropriate specialty evaluations that modern medical specialists and technology can provide. Nurse practitioners who expand their primary care practice will face similar dilemmas that they must resolve in accordance with reasonable medical standards adhered to in the nursing profession.

5. Nurse Practitioners and Medical Malpractice Rates

As long as the scope of authority of a nurse practitioner is properly defined, and a nurse practitioner acts within his scope of practice, professional liability insurance rates should reflect the risks of malpractice claims against nurses based on experience, and not speculation or bias. Toward this end, it is useful to analyze medical malpractice trends of nurse practitioners, in order to refute claims that nurse practitioners provide care substandard to the care provided by physicians or that they are less qualified primary care providers.

CNA Healthpro, a provider of liability insurance for nurse practitioners, released a study in 2005 identifying areas of higher risk for covered nurse practitioners.¹⁵⁵ Their claims data showed that, out of 523 open and closed claims qualifying under the criteria of the study, 44.7% were diagnosis-related and 25.4% were treatment-related.¹⁵⁶ Data collected by the American Academy of Nurse Practitioners (“AANP”)—a national governing body of the nurse practitioner profession—corroborate these findings, citing failure to diagnose or misdiagnosis as the most common causes of patient injury.¹⁵⁷ Findings from both CNA HealthPro and the AANP are comparable to figures released in 2009 by the National Practitioner Data Bank (“NPDB”), which also suggested that failure to diagnose and failure to treat/monitor were top reasons for malpractice claims against nurse practitioners from 2004–2008.¹⁵⁸ While there was a gradual escalation of nurse practitioner malpractice cases between 2004 and 2008, during the same period there was an overall increase for other providers, as well.¹⁵⁹ The largest numbers of claims came from states in which the nurse practitioner population is greatest and from settings where nurse practitioners are more likely

154. *Compare* Rivera v. County of Suffolk, 290 A.D.2d 430, 432 (N.Y. App. Div. 2002) (finding that if nurse practitioner was providing care without authority to refer, that fact by itself could establish defendant’s liability), *with* Moreland et al. v. Oak Creek OB/GYN, Inc., 2005 WL 994595, ¶ 28–35 (Ohio Ct. App. Apr. 29, 2005) (holding that nurse practitioner’s failure to refer may have been violation of state law, but it was not basis for civil liability, because standard of care was not determined by expert witness).

155. CNA HEALTHPRO, NURSE PRACTITIONER CLAIMS STUDY: AN ANALYSIS OF CLAIMS WITH RISK MANAGEMENT RECOMMENDATIONS 2 (2005), https://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/NursePractitionerClaimsStudy.pdf.

156. *Id.* at 12.

157. *See generally* Mary Jo Goolsby, Am. Acad. of Nurse Practitioners 21st National Conference, *Malpractice and Risk Management: A Look at Current Issues and Practices*, 8 MEDSCAPE NURSES (2006).

158. Kenneth P. Miller, *Malpractice Trends: Viewing the Data and Avoiding the Hot Seat of Litigation*, 5 J. FOR NURSE PRAC. 662, 663 (2009).

159. *Id.* at 663.

to practice, such as private physician practices.¹⁶⁰ Of the claims data reported, there are no estimates of how many claims are for nurse practitioners in independent practice. In practice, nursing malpractice cases are often brought against the institutions that employ the nurse practitioners and not against the individual nurses.¹⁶¹ Similarly, if a nurse practitioner works in a physician practice or has a physician supervisor, medical malpractice claims may be reported under that physician's name rather than for the nursing professional.¹⁶² The majority of malpractice suits are filed in state courts, which do not publish notice of lawsuits, making it difficult to track rates of different claim types at the outset of the litigation.¹⁶³ Approximately ninety percent of malpractice cases settle out of court and are typically protected by confidentiality provisions, generating no public reporting at all.¹⁶⁴ Even with these barriers to accurate reporting, there are a number of studies that show nurse practitioners have types of claims brought against them similar to primary care physicians. One study analyzed 5,921 indefensible negligence claims against primary care physicians and found that improper diagnosis (34%) and failure to monitor care (16%) were among the top justifications for medical malpractice claims.¹⁶⁵

Conversely and not indicated in the nurse practitioner malpractice data, the most common contributing factors associated with negligence that resulted in patient death were problems related to the patients' records (36%) and poor communication between providers (55%).¹⁶⁶ Although there is a perception that primary care errors are unlikely to cause significant harm,¹⁶⁷ these data illustrate that the accumulation of "even 'trivial,' frequent, error[s]" such as communication and documentation can contribute to severe outcomes.¹⁶⁸ In a separate study, five primary care providers taking part in a survey identified thirty percent of their errors as belonging to the overall category of communication errors.¹⁶⁹ Within that category, missing and incorrect case notes accounted for 15.2% of those errors.¹⁷⁰ Other research concluded that patients are more likely to bring

160. Goolsby, *supra* note 157.

161. *Id.*

162. Winifred Carson-Smith & Cathy Klein, *Legal File: NP Errors Lead to Litigation*, 28 NURSE PRACTITIONER: AM. J. PRIMARY HEALTH CARE 52, 53 (2003).

163. Klein, *supra* note 109, at 62.

164. *Id.*

165. R.L. Phillips et al., *Learning from Malpractice Claims about Negligent, Adverse Events in Primary Care in the United States*, 13 QUALITY & SAFETY IN HEALTH CARE 121, 124 (2004) (identifying "indefensible" negligence claims by peer physicians reviewing cases, deciding whether standard of care was adhered to).

166. *Id.* at 125.

167. See Greg Rubin, Letter, *Medical Errors: Terminology of "Error" Is Important*, 322 BRIT. MED. J. 1421, 1422 (2001) (arguing lower prevalence of adverse events in primary care as opposed to secondary care).

168. Phillips et al., *supra* note 165, at 126.

169. G. Rubin et al., *Errors in General Practice: Development of an Error Classification and Pilot Study of a Method for Detecting Errors*, 12 QUALITY & SAFETY IN HEALTH CARE 443, 445 (2003).

170. *Id.*

malpractice claims when the physician displays poor communication and interpersonal skills.¹⁷¹

Nurse practitioners can learn from this information. First, nurse practitioners must focus on the areas of their work they already know to be critical to quality care: communication, sharing of information with other providers, proper documentation, and appropriate referral. All are necessary in preventing actionable medical errors. Furthermore, nurse practitioners must watch for the commonplace mistakes that primary care physicians are making in charting and communication. Owing to the nature of their practice and care methodologies, nurse practitioners tend to fluidly incorporate compassion, communication, competence, correct charting, and good relationships with patients anyway. As long as nurse practitioners keep up their charting and communication skills and carefully monitor their diagnoses, treatment, and follow-up, as all competent health care providers should, then nurse practitioners will not be an added liability on the medical malpractice system.

As a relatively highly trusted provider, nurses may be less likely to elicit claims of malpractice. The “nursing model” approach to patient care deviates from the patriarchal “medical model,” and contributes to increased patient satisfaction and improved clinical outcomes. Ultimately, for nurse practitioners as well as any other health care professional, the chances of being subject to a medical malpractice claim can be drastically reduced by following the standard of care, adhering to proper charting practices, and taking the time to communicate thoroughly with patients.

V. CONCLUSION: HEALTH CARE REFORM, LAW REFORM, AND THE NURSE PRACTITIONER

In this Article we argue that nurse practitioners, properly authorized and acknowledged under the law of every state, serve an important role in helping individuals gain access to quality primary care. Those who oppose the expansion contend that it will result in a lowering of the quality of care.¹⁷² However, the inaccuracy of this statement is well-documented because it has been shown that nurse practitioners provide primary care just as well as, if not better than, physicians.¹⁷³

Nurse practitioners occupy a growing force in primary care. With the current state of health care, considerable inaccessibility within the system, the millions of potentially newly insured in 2014,¹⁷⁴ and growing dissatisfaction among the general population with the options available to them, the circumstances are ripe for a new provider to emerge as central to the practice of primary care across the country. Legal impediments to independent nurse practitioner and nurse-led practices persist, but data support the quality of the care provided by nurse

171. David M. Studdert et al., *Health Policy Report: Medical Malpractice*, 350 *NEW ENG. J. MED.* 283, 284 (2004) (citing two studies published in *JAMA*).

172. See generally Lyndia Flanagan, *Nurse Practitioners: Growing Competition for Family Physicians* (1998), available at <http://www.aafp.org/fpm/981000fm/nurse.html>.

173. See *supra* notes 72–78 and accompanying text for a discussion of studies of outcomes in nurse-managed health centers.

174. Craven & Ober, *supra* note 3.

practitioners. Nurse practitioners are rarely accused of medical malpractice and provide excellent quality of care.

Nurse practitioners are experts in their own profession and should be recognized as such by our state and federal policymakers. Federal health care officials are beginning to understand the crucial role that nurse practitioners play in primary care, as illustrated by the recent passage of the Affordable Care Act.¹⁷⁵ However, federal recognition of nurse practitioners as primary care providers is not enough. Nurse practitioners are integral primary care providers to our health care system, and Congress needs to recognize nurse practitioners in all funding demonstration projects for primary care providers; state governments have to eradicate restrictions on nurse practitioner scope of practice; courts have to shift their mindset to accept nurse practitioners as independent providers with their own standard of care; and health insurers, private and public, must recognize nurse practitioners as primary care providers at 100% of the reimbursement level of other providers, in order for the number of primary health care providers to catch up to the primary health care needs of our communities.

175. For a full description of the provisions as they relate to nurse practitioners, see AM. NURSES ASS'N, *supra* note 11.

