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Expanding the Scope of Practice for Nurse Practitioners and Physician Assistants to Enhance Healthcare

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I. INTRODUCTION

Healthcare delivery depends on a sufficient supply of providers and adequate access for all patients. The United States spends more money "total and per capita" on health care compared to any other country; however, problems related to access and delivery continue to frustrate lawmakers due to the shortage of medical providers.[1] The nurse practitioner (NP) and physician assistant (PA) programs were developed in the 1960s to help address the shortage of physicians in rural and underserved areas of the country.[2] However, current practice restrictions limit the extent NPs and PAs can address that shortage.[3] More recently, the Patient Protection and Affordable Care Act (PPACA), enacted in 2010, increased insurance coverage, improved healthcare delivery methods and lowered costs.[4]

The COVID-19 pandemic highlighted the persistent lack of healthcare providers in the United States.[5] NPs and PAs could enhance the delivery of healthcare to patients in underserved areas of the country if allowed to practice the full extent of their training and capabilities. Each state regulates the degree of autonomy of NPs and PAs (APPs) through licensing and scope of practice laws that affect their ability to treat

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[1] Gabriel Scheffler, *The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform*, 10 U. C. IRVINE L. REV. 729, 730 (2020); *see NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (July 31, 2023, 04:23 PM), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (stating that in 2021, U.S. spent $4.3 trillion or $12,914 per person).

[2] Clay C. Johnson, *A Case for an Efficient System: How Relaxing Midlevel Provider Supervision and Prescriptive Authority Laws will Reduce Costs and Increase Access to Health Care in Alabama*, 45 CUMBERLAND L. REV. 565, 567 (2015).

[3] *Id.* at 594.

[4] Patient Prot. and Affordable Care Act, Pub. L. No. 111–148, 124, Stat. 119–124, 111th Cong. (2010) (hereinafter the PPACA).

[5] Benjamin J. McMichael, *The Access-To-Care Epidemic*, 56 WAKE FOREST L. REV. 547, 549 (2021); Benjamin J. McMichael, *Socially Distant Health Care*, 96 TUL. L. REV. 423, 423 (2021).

patients.[6] Licensing of healthcare professionals is necessary to protect the public's well-being.[7] Overregulation of NPs and PAs, however, limits their ability to meet the needs of the underserved throughout this country.[8]

Job descriptions for NPs and PAs have evolved over the decades for multiple reasons including public need, APP experience, and changes in state laws. Variations in state law restrictions on NP and PA practices result in problems for both patients and APPs providers alike.[9] Half the states have laws granting full practice independence to NPs, but the other half reduce or restrict the practice with collaboration and supervision agreements.[10] PA supervision parameters vary not only between states, but also between physician practices. Collaborative practice and supervisory agreements make it harder for NPs and PAs to establish practices in medically underserved areas, such as in Louisiana.[11]

The expansion of NP and PA practices face challenges on several grounds, such as competence, standard of care, and malpractice liability.[12] However, states with NP independent practice enjoyed greater access to primary care with lower cost and no reduction in quality of service.[13] Likewise, states with advanced PA practices have increased appointment availability, especially for the poor urban and rural areas.[14] The Veteran Affairs (VA) health system demonstrates how full practice authority for nurse practitioners and physician assistants nationwide can improve access and lower costs without compromising quality.[15] Allowing APPs to

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[6] Christopher Ogolla, *Litigating Hypocrisy: Turf Wars Between Health Care Professionals Regarding Diagnosis, Evaluation, and Treatment*, 50 U. TOL. L. REV. 67, 77 (2018); Roderick S. Hooker & Ashley N. Muchow, *Modifying State Laws for Nurse Practitioners and Physician Assistants Can Reduce Cost of Medical Services,* 33 NURSING ECON. 88, 88 (2015).

[7] Ogolla, *supra* note 6, at 70. This holds true for physicians and APPs alike.

[8] *Id.* at 76. Supervision and collaborative agreements are two such examples.

[9] Johnson, *supra* note 2, at 594.

[10] *See* A. J. Barbarito, *The Nurse Will See You Now: Expanding the Scope of Practice for Advanced Practice Registered Nurses*, 40 SETON HALL LEGIS. J. 127, 128 (2015) (stating that restrictive collaborative agreements require APPs to submit to a certain degree of supervision by physicians).

[11] Lucas Self, *Money in The Bank and Boots on The Ground: A Law-Policy Proposal to Make the Affordable Care Act Work in Louisiana*, 76 LA. L. REV. 547, 577–78 (2015).

[12] Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1245 (2010).

[13] Andrea Reino, *New Mexico: An Expansion of Scope of Practice Model*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 185, 196 (2013) (finding that New Mexico saw greater access to primary care with independent NP practice).

[14] Johnson, *supra* note 2, at 593 (noting increased scope of practice results in more PAs in underserved areas who can see patients sooner than physicians located farther away).

[15] Jessica Winslow, *Advanced Practice Nurses: The Solution to The VA Healthcare Crisis?*, 69 ADMIN. L. REV. 977, 995 (2017); Health Care Professional's Practice in VA, 38 C.F.R. §17.419 (2023).

provide care without physician supervision can shorten wait times and decrease health care expenses in the VA system.[16]

II. LACK OF HEALTHCARE ACCESS, HIGH COST AND VARIABLE QUALITY OF CARE

A. Access Problems

The U.S. spends the most money on healthcare and possesses extraordinarily talented physicians using the latest technology.[17] However, underserved areas remain in both rural and urban settings.[18] The country's need for primary care physicians outpaces the supply, especially in rural areas.[19] The demand for primary care providers continues to grow while the number of primary care physicians has progressively decreased.[20] Although the Department of Health and Human Services predicted an imminent physician surplus in the 1980s and 1990s, the 2000s revealed a critical primary care shortage expected to last for many years.[21]

Both rural and low-income urban patients are especially vulnerable to sickness due to inadequate access to primary care providers.[22] Efforts to increase the supply of primary care physicians have failed while the growth in numbers of primary care nurse practitioners and physician

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[16] Winslow, *supra* note 15, at 979.

[17] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 1 (stating that "$4.3 trillion…[spent] in 2021…18.3% of Gross Domestic Product (GDP)"); Matthew McGough et al., *How does health spending in the U.S. compare to other countries?*, PETERSON-KFF HEALTH SYS. TRACKER (Feb. 9, 2023), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/.

[18] McMichael, *supra* note 5, at 549; Hansen-Turton et al., *supra* note 12, at 1236.

[19] McMichael, *supra* note 5, at 557; *Occupational Employment and Wages*, U.S. BUREAU LAB. STAT. (May, 2020), https://www.bls.gov/oes/2020/may/oes_nat.htm#29-0000; *The Complexities of Physician Supply and Demand Projections From 2018 to 2033,* ASS'N AM. MED. COLL. (2020), https://www.readkong.com/page/the-complexities-of-physician-supply-and-demand-6449132. (projecting overall employment of physicians and surgeons to grow 3% from 2021 to 2031, slower than the average for all occupations).

[20] Hansen-Turton et al., *supra* note 12, at 1238; Richard A. Cooper et al., *Economic and Demographic Trends Signal Impending Physician Shortage*, HEALTH AFF. Vol. 21 No. 1, 140, 148 (Jan.–Feb. 2002), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.21.1.140; *The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care*, AM. COLL. PHYSICIANS (Jan. 30, 2006), https://assets.acponline.org/acp_policy/statements/impending_collapse_of_primary_care_medicine_and_its_implications_for_the_state_of_the_nations_health_care_2006.pdf.

[21] Hansen-Turton et al., *supra* note 12, at 1238.

[22] *See* Self, *supra* note 11, at 551 ("With too few doctors available, patients have to wait longer for treatment, or even forgo care altogether if a provider is simply unavailable in their area.").

assistants have been significant over the past two decades.[23] While very few young physicians are entering family practice, general internal medicine, and pediatrics, a much higher percentage of newly graduated NPs and PAs are choosing primary care.[24]

It takes longer to educate physicians than NPs or PAs.[25] NP programs are producing "three new primary care NPs to every one primary care physician."[26] Currently, over half of NPs provide primary care in the U.S.[27] About 48 percent of primary care providers (PCPs) are physicians while 42.9 percent of PCPs are NPs, and 8.2 percent are PAs.[28] In many areas of the country, APPs are becoming the principal source of primary healthcare.[29] The Veterans Affairs agency increased the staffing positions including NPs and PAs across the country to meet veterans' primary care

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[23] Hansen-Turton et al., *supra* note 12, at 1240 ("A 2008 Government Accountability Office report … noted that the annual growth in the number of… NPs… [was] 9.5%, while the… [growth in] physicians… [was] only 1.17%."); *See generally* Benjamin G. Druss et al., *Trends in Care by Nonphysician Clinicians in the United States*, 348 NEW ENG. J. MED. 130, 130 (2003); *see generally* Maggie Davis, *Amid a Physician Shortage, 51% of Primary Care Providers are Nurse Practitioners and Physician Assistants*, VALUEPENGUIN, https://www.valuepenguin.com/primary-care-providers-study (last modified Aug. 22, 2022).

[24] *See generally* Hansen-Turton et al., *supra* note 12, at 1239–41; *see also Physician Assistant and Nurse Practitioner Workforce Trends*, 72 AM. FAM. PHYSICIAN 1176 (2005), https://www.aafp.org/pubs/afp/issues/2005/1001/p1176.html ("PA and NP workforces exploded during the past 15 years and there are now, collectively, more NPs and PAs providing primary care than there are family physicians."); *see generally* Karen Hauer et al., *Factors Associated with Medical Students' Career Choices Regarding Internal Medicine*, 300 JAMA 1154, 1154 (2008), https://jamanetwork.com/journals/jama/fullarticle/182531; *see also* Ilene MacDonald, *More Patients Open to Primary Care Offered by Physician Assistants*, FIERCE HEALTHCARE (Oct. 20, 2014, 11:15 AM), https://www.fiercehealthcare.com/healthcare/more-patients-open-to-primary-care-offered-by-physician-assistants ("One third of PAs in practice today are in primary care. . . .").

[25] *See* Julie Monroe, *Nurse Practitioner vs. Doctor: In-depth Career Comparison*, NURSINGPROCESS.ORG (2023), https://www.nursingprocess.org/nurse-practitioner-vs-doctor.html (arguing that NPs and PAs can complete all their training (including undergraduate education) within 6 to 7 years while physicians typically must study for at least 12 years (including college) before they can practice medicine); *see also Become a PA*, AAPA.ORG, https://www.aapa.org/career-central/become-a-pa/ (last visited Nov. 11, 2023) (explaining that most PA programs are 3 academic years in length following an undergraduate degree).

[26] *See* Laurie Barclay, *American College of Physicians Issues New Policy on Nurse Practitioners in Primary Care*, MEDSCAPE (Mar. 2, 2009), https://www.medscape.com/viewarticle/588914?0=reg=1 ("Dr. Apold noted that 86% of the 140,000 US NPs address primary care issues in their practices, and that NP programs are educating 3 primary care NPs to every 1 primary care physician.").

[27] McMichael, *supra* note 5, at 556 (stating that more than 60% of NPs who are clinically practicing, deliver primary care).

[28] *See* Davis, *supra* note 23.

[29] *See id.* ("While NP and PA roles are growing, physician roles are shrinking[.]").

needs.[30] A greater primary care capacity in the United States is needed.[31] This need could be filled by NPs and PAs if all states allow for full independent practice to meet the needs of the underserved population.[32]

Increasing the number of NPs and PAs is not enough to meet the needs of underserved patients if APPs are not allowed to practice to the full extent of their capabilities.[33] Practice restrictions make it difficult for APPs to expand their much needed services to poor urban and rural areas.[34] In 2011, The Institute of Medicine recommended federal and state legislative action to reform NP scope of practice laws, reimburse NPs at the same rate as primary care physicians, and eliminate collaborative and supervisory agreements.[35] In states with less restrictions on APP scope of practice, patients' access to healthcare improved due to increased appointment availability, particularly patients with Medicaid, who struggle to find willing sources of care.[36] Greater availability of NPs and PAs translates to lower cost appointments and improves access for lower reimbursing patients (i.e., Medicaid enrollees) in states with expanded scope of practice laws for APPs.[37]

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[30] *See generally* Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, 128 Stat. 1756 (2014) (mentioning the staffing shortage in the health care system for veterans); RAISE ACT Public Law 115-119, 115th Congress (signed into law in 2022 by President Biden, the Act raised NP and PA salaries in the VA system to attract more APPs and address the physician shortage).

[31] Ann Davis et al., *Access and Innovation in a Time of Rapid Change: Physician Assistant Scope of Practice*, 24 ANNALS HEALTH L. ADVANCE DIRECTIVE 286, 309 (2015).

[32] *See* Ying Xue et al., *Full Scope-of-Practice Regulation is Associated with Higher Supply of Nurse Practitioners in Rural and Primary Care Health Professional Shortage Counties,* 8 J. NURSING REGUL. 5–13 (2018) ("The ability of nurse practitioners (NPs) to provide full care is governed by state scope-of-practice (SOP) regulation. . . [which] can influence supply of NPs in underserved areas can help guide effective health policies to reduce disparities in access to care."); *see also* Winslow, *supra* note 15, at 995 (defining "full practice authority" without "physician oversight").

[33] *See generally* Barbarito, *supra* note 10, at 133–34.

[34] *See id.* (explaining that loosening supervision requirements would allow NPs and PAs to expand into rural and urban practice settings that physicians avoid); *see, e.g.,* Johnson, *supra* note 2, at 578 ("In Alabama, nurse practitioners must practice, to some degree, in collaboration with a physician.").

[35] *See* Linda H. Aiken, *Nursing Education Policy Priorities, in* THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH, INST. MEDICINE 10, 485 (2011) (detailing specific recommendations for legislatures, organizations, and agencies).

[36] Michael R. Richards & Daniel Polsky, *Influence of Provider Mix and Regulation on Primary Care Services Supplied to US Patients*, 11 HEALTH ECON., POL'Y, & L., 193, 194 (2016) ("[I]n states where provider labor can be more easily exchanged, appointment availability is dramatically better with a mix of providers on staff–particularly for Medicaid patients, who often struggle to find willing sources of care.").

[37] *Id.* at 195.

NP and PA scope of practice laws need to be expanded to provide healthcare to people living in rural and other medically underserved areas. Restrictions on scope of practice in some states include (1) inability to prescribe medications, (2) inability to work independently without physician supervision, and (3) requirements to hold admitting privileges to hospitals.[38] Over forty million U.S. residents live in counties with a primary care physician shortage.[39] Attracting physicians to these rural and poor urban areas is difficult.[40] "One-third of NPs providing primary care in rural areas are not allowed to practice independently[,]" which adversely affects health care delivery.[41] This also detracts from the full utilization of NPs' education and skills.[42] Relaxing scope of practice laws by streamlining collaboration agreements, removing prescription authority bans, and granting admission privileges all help promote access to healthcare.[43]

B. Cost Problems

The high cost of healthcare in the United States adversely impacts all patients, especially those who are impoverished and uninsured. Health care spending accounts for approximately eighteen percent of the U.S. gross domestic product, with around twenty-one percent of those expenditures going towards provider services.[44] In 2011, the Institute of Medicine recommended that NPs and PAs should "work to the full extent

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[38] *See* Courtney Kahle, *Scope of Practice Constraints on Nurse Practitioners Working in Rural Areas*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 90, 94 (2013) (" Some states are beginning to remove restrictions [such as] lifting prescription authority bans, allowing NPs to have hospital admittance authority, and adjusting payer policies."); *cf.* Johnson, *supra* note 2, at 574–75 ("Nurse practitioners may prescribe medicines in collaborative practice, but '[t]he drug type, dosage, quantity prescribed, and number of refills shall be authorized in an approved protocol signed by the collaborating physician and the certified registered nurse practitioner.'").

[39] *Addressing the Nation's Primary Care Shortage: Advanced Practice Clinicians and Innovative Care Delivery Model*, UNITED HEALTH GRP. (2018), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2018/UHG-Primary-Care-Report-2018.pdf.

[40] *See* Johnson, *supra* note 2, at 593 ("Relaxing supervision laws governing midlevel provider practice both drives down costs in the health care market and increases access to health care in all areas of the state, especially rural and underserved areas that may have a hard time attracting physicians to practice primary care.").

[41] Kahle, *supra* note 38, at 97.

[42] Johnson, *supra* note 2, at 593.

[43] Kahle, *supra* note 38, at 98.

[44] Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, NAT'L BUREAU ECON. RSCH. 1, 3 (2014). In 2021, National Health Expenditures (NHE) grew to $4.3 trillion, and accounted for 18.3% of Gross Domestic Product (GDP). CMS.gov 2021.

of their training" to provide "timely, efficient, and cost-effective" care to the people of the U.S.[45] APPs are reimbursed by Medicare at eighty-five percent of the physician's fee schedule, while commercial carriers set their own rates.[46] Medicare reimburses NPs and PAs one hundred percent of the physician fee schedule if services are "incident to" billing where the physician is on site and the patient is established.[47]

Non-emergent office visits to either an APP or a physician could potentially cost the patient close to the same amount whether they are insured or not.[48] As stated earlier, retail medical clinics (RMCs) are typically staffed with APPs and provide care at a lower cost than alternative sources such as emergency rooms or urgent care centers (usually staffed with physicians).[49] However, RMCs have struggled due to low patient volume, low reimbursement rates, and unreliable outside funding.[50]

The rivalry between organized medicine and organized nursing is visible in some state practice restrictions of NPs and PAs. When states regulate medical professions through licensing, they potentially insulate one group (i.e., physicians), from competition with NPs and PAs.[51] Occupational licensing does, however, serve the public interest by

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[45] Taylor Pankau, *The Growing Use of Mid-Level Practitioners in The Delivery of Health Care*, 22 DEPAUL J. HEALTH CARE L. 129, 131-32 (2021).

[46] Johnson, *supra* note 2, at 572; *see also* Nurse Practitioner and Physician Assistant Payment Guidelines, CTRS. FOR MEDICARE & MEDICAID SERVS. 1, 9 (2022) (explaining that while the 85% reimbursement rule refers to Medicare, commercial insurers and Medicaid often base their billing practices on the CMS guidelines).

[47] Joy Luchico Austria, *Urging A Practical Beginning: Reimbursement Reform, Nurse-Managed Health Clinics, and Complete Professional Autonomy for Primary Care Nurse Practitioners*, 17 DEPAUL J. HEALTH CARE L. 121, 133 (2015); *see* "Incident to" Services 1–3, MLN MATTERS NO.: SE0441, CTRS. FOR MEDICARE & MEDICAID SERVS. (2013), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/se0441.pdf (explaining that supervising physicians must use their NPI to bill incident to professional services NPs and PAs provide. Physician must have personally performed an initial service and remains active in the treatment course); *see also* Alycia Bischof et al., *Post Covid-19 Reimbursement Parity for Nurse Practitioners,* 26 ONLINE J. ISSUES NURSING (2021), https://ojin.nursingworld.org/table-of-contents/volume-26-2021/number-2-may-2021/post-covid-19-reimbursement-parity-for-nurse-practitioners (explaining the care must be rendered under the direct supervision of the physician, physician need to be in the office suite).

[48] Austria, *supra* note 47, at 128 (explaining that low reimbursement rates for NP services and other variables might raise the price of clinic visits and cause self-pay patients and insured patients with cost-sharing responsibilities to pay the same price).

[49] Lauren Battaglia, *Supervision and Collaboration Requirements: The Vulnerability of Nurse Practitioners and Its Implications for Retail Health*, 87 WASH. UNIV. L. REV. 1127, 1158 (2010).

[50] Austria, *supra* note 47, at 139.

[51] Roger Blair et al., *Licensing Health Care Professionals, State Action, and Antitrust Policy*, 100 IOWA L. REV. 1944, 1954-56 (2015).

potentially protecting patients from incompetent practitioners.[52] Under the state action immunity doctrine exception to the antitrust laws, medical provider competition is replaced with licensing and regulation.[53] Medical provider licensing is actively supervised by the state to assure that the loss of competition is compensated by increased patient safety and quality of care.[54] If state medical boards (composed of physicians) restrict practices and licensure of NPs and PAs to prevent competition, the medical boards may lose protection from the antitrust laws.[55]

Although medical professional licensing is intended to weed out incompetents, it appears to lead to higher prices and reduced utilization without improving the quality of care.[56] States with reduced or restricted NP and PA practices had more expensive health care services with no effect on quality or outcomes .[57] In *N.C. State Board of Dental Examiners v. FTC*, the U.S. Supreme Court held that an official state regulatory board whose members are mostly market participants that are elected by other market participants are a "private actor" for purposes of federal antitrust laws.[58] A board viewed as a *private actor* would lose any protection and thus be subject to antitrust action under the State Action Doctrine.[59]

The *N.C. State Board of Dental Examiners v. FTC* case has ramifications for other state medical and nursing boards whose members are also market participants.[60] If a state medical board, composed solely of physicians attempts to restrict NP or PA practice, it could be subject to a federal antitrust law action.[61] When addressing medical licensing restrictions, physician groups stress quality of care, while nursing groups

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[52] *Id.* at 1960.
[53] *Id.* at 1967; *see also* Parker v. Brown, 317 U.S. 341 (1943) (showing that potentially anticompetitive action may be protected if there is "clear articulation" and "active supervision" by the state). The Sherman Act does not expressly prohibit a state from regulating its own economy.
[54] Blair et al., *supra* note 51, at 1967.
[55] *Id.* at 1964.
[56] *Id.* at 1967.
[57] Kleiner et al., *supra* note 44, at 1 ("Our analysis of insurance claims data shows that the more rigid regulations increase the price of a well-child medical exam by 3 to 16%. However, our analysis finds no evidence that the changes in regulatory policy are reflected in outcomes such as infant mortality rates or malpractice premiums.").
[58] N.C. State Bd. of Dental Exam'rs v. FTC, 574 U.S. 494, 506-07 (2015) (noting that dental and medical board members are primarily composed of practitioners in their respective fields).
[59] *Id.* (noting that medical boards often contain public members in addition to the practitioners in order to help guarantee impartiality).
[60] Ogolla, *supra* note 6, at 88-89.
[61] N.C. State Bd. of Dental Exam'rs, 574 U.S. at 506-07 (explaining that any practice limitations on non-physicians must serve the purpose of protecting patients' health and safety rather than just reduce competition).

point to anti-competitive behavior.[62] NP practice restrictions lead to an increase in the price of health care services (as measured by the cost of a well-child visit) by 3-16%.[63] Laws which expand NP and PA scopes of practice, free up primary care physicians and increase the number of affordable primary care providers in the state.[64]

C. Variable Quality of Care

An often-cited rationale for restricting NP and PA practice stems from their lack of knowledge and training as compared to physicians.[65] While there is no argument that physicians study extensively (medical school-4 years), and train longer (residency-3-7 years), than NPs and PAs, there is disagreement regarding the quality of primary care between the groups.[66] Historically, both NP and PA programs began with close supervision by physicians to ensure quality patient care.[67] In time, NPs and PAs strove for increased autonomy based on accumulated knowledge and experience. Opponents of APP independence, such as the American Medical Association (AMA), and the California Medical Association (CMA), argue that removal of physician oversight would compromise patient safety and quality of care.[68] When physician and APP services overlap, it may not be reasonable to presume they will be performed at the same level of competency.[69]

Advocates of greater NP and PA autonomy point to multiple studies comparing APP and physician care that do not show a statistically significant difference in patient safety or quality when comparing independent and supervised NP and PA practice.[70] Further studies

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[62] Ogolla, *supra* note 6, at 72.
[63] Blair et al., *supra* note 51, at 1954; Kleiner, et al., *supra* note 44 at 30.
[64] Adrienne Saltz, *Maine: Setting the Example for The Role of Nurse Practitioners*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 198, 198 (2013).
[65] Johnson, *supra* note 2, at 594.
[66] *Id.*
[67] *Id.* at 567.
[68] Benjamin J. McMichael, *Occupational Licensing and the Opioid Crisis*, 54 U.C. DAVIS L. REV. 887, 899-900 (2020).
[69] Tsvetelina Gerova-Wilson, *Nursing is Not a Lesser Included Profession: Why Physicians Should Not be Allowed to Establish the Nursing Standard of Care*, 16 QUINNIPIAC HEALTH L. J. 43, 66 (2012).
[70] Benjamin J. McMichael, *The Access-to-Care Epidemic*, 56 WAKE FOREST L. REV. 547, 564-65 (2021) (discussing multiple studies comparing patient outcomes including randomized trials, and systematic reviews with meta-analysis showed no differences between physicians and APPs); Ellen T. Kurtzman et al., *Does the Regulatory Environment Affect Nurse Practitioners' Patterns of Practice or Quality of Care in Health Centers?*, HEALTH SERVS. RES. 437, 442, 449 (2017); Jennifer Perloff et al., *Association of State-Level*

comparing NPs and physicians performing the same tasks found a similar quality of care between the two groups.[71] The American Medical Association (AMA) and the Institute of Medicine (IOM) both found that in ambulatory settings, where NPs had the same responsibilities and patient populations as physicians, patient outcomes were comparable.[72] Other research has shown the quality of care delivered by non-physicians to sometimes be even better than the care provided by physicians.[73]

A review of articles published from 1990 to 2009 showed the quality of care to be similar for NPs and physicians on matters of patient outcomes for morbidity and mortality.[74] The quality of care measures included patient satisfaction, number of unexpected emergency department visits, and length of hospital stay.[75] The review measured effectiveness of care by looking at patient blood pressure, blood glucose, and serum lipid levels.[76] Another review in 2018 found no statistically significant difference in patient outcomes for patients treated by NPs at rural health centers (RHCs) in states with different scopes of practice (more or less practice restrictions).[77] The outcomes measured included readmission rate and hospitalization rates for asthma, diabetes, pneumonia, and heart

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Restrictions in Nurse Practitioner Scope of Practice with Quality of Primary Care Provided to Medicare Beneficiaries, 76 MED. CARE RSCH. & REV. 597, 612 (2017).

[71] Reino, *supra* note 13, at 190.

[72] Aiken, *supra* note 35, at 486.; Hansen-Turton et al., *supra* note 12, at 1244 (explaining that the 2000 Journal of the AMA found in ambulatory settings, where NPs and physicians had same responsibilities, patient outcomes were comparable).

[73] Ogolla, *supra* note 6, at 91 (discussing that the main point is that studies show AAP quality of care to be as good as that of physicians when looking at primary care patients).

[74] Julie Stanik-Hutt et al., *The Quality and Effectiveness of Care Provided by Nurse Practitioners*, 9 J. FOR NURSE PRAC. 492, 496 (2013); Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial,* 283 J. AM. MED. ASS'N 59, 67 (2000); Elizabeth R. Lenz et al., *Diabetes Care Processes and Outcomes in Patients Treated by Nurse Practitioners or Physicians,* 28 DIABETES EDUCATOR 590, 591 (2002); Angela Y. Lambing et al., *Nurse Practitioners' and Physicians' Care Activities and Clinical Outcomes with an Inpatient Geriatric Population*, 16 J. AM. ACAD. NURSE PRAC. 343, 343–52 (2004); Miranda Laurant et al., *Substitution of Doctors by Nurses in Primary Care*, CD001271 COCHRANE DATABASE SYST. REV. (2005); Sue Horrocks et al., *Systemic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors,* 324 BRIT. MED. J. 819, 819–23 (2002).

[75] Stanik-Hutt et al., *supra* note 74, at 496; *see also* Horrocks et al., *supra* note 74, at 820 (evaluating numerous metrics which all supported high levels of patient satisfaction with NP care and quality).

[76] Stanik-Hutt et al., *supra* note 74.

[77] Judith Ortiz et al., *Impact of Nurse Practitioner Practice Regulations on Rural Population Health Outcomes,* 6 HEALTHCARE 65 (2018) (discussing that restricted practice requires NPs to work under supervision of physicians for their entire scope of practice while reduced practice allows NPs to perform some of their scope of practice without supervision).

failure.[78] Scope of practice expansion does not appear to reduce the quality of patient outcomes, but it improves provider supply, healthcare access, and utilization.[79]

Medical malpractice lawsuits regarding scopes of practice have increased over time as NP practice authority has expanded.[80] The most frequent allegation made against NPs to state boards of nursing related to prescribing practices outside their scope of practice.[81] The cost of claims against NPs is rising with the most frequent type of allegation related to diagnosis, followed by medication management and treatment and care management.[82]

A review of the National Practitioner Data Bank (NPDB) in 2016 showed that PAs and NPs were, per capita, "less likely to have made malpractice payments or have been subject to an adverse action than were physicians."[83] These differences do not imply quality of care differences because they did not compare solely primary care NPs and PAs to primary care physicians.[84]

Surgeons and other specialists are known to have higher claim rates due to the increased acuity of their patients.[85]

III. LEGAL LIMITS ON NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

NPs and PAs are both young specialties that originated in the 1960s.[86] The University of Colorado established the NP program in the 1960s to train nurses in primary care in response to a general shortage of physicians in rural areas.[87] Duke University established the PA program in the 1960s and populated the program with Navy corpsmen as students to address the physician shortage.[88] These groups of medical professionals were first viewed as "physician extenders" and then gradually as valuable and

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[78] *Id.* at 5 (Table 3).
[79] *Id.* at 6.
[80] Douglas M. Brock et al., *Physician Assistant and Nurse Practitioner Malpractice Trends*, 75 MED. CARE RSCH. & REV. 613, 613 (2016).
[81] NURSES SERV. ORG., *Nurse Practitioner Claim Report: 4th Edition – A Guide to Identifying and Addressing Professional Liability Exposures* (2017).
[82] *Id.*
[83] Brock et al., *supra* note 80, at 620-21.
[84] *Id.* at 615-23.
[85] Anupam B. Jena et al., *Malpractice risk according to physician specialty*, 365 N. ENGL. J. MED. 629 (Aug. 18, 2011) (discussing how surgeons and specialists treat people in intensive care units with high-risk patients who undergo complex medical procedures); *see also* Maria Panagioti et al., *Prevalence, severity, and nature of preventable patient harm across medical care settings: systematic review and meta-analysis*, 366 BRITISH MED. J. (2019).
[86] Johnson, *supra* note 2, at 567.
[87] *Id.*
[88] *Id.*

qualified healthcare providers in their own right.[89] Since their establishment in the 1960s, the NP and PA professions have grown and evolved from medical assistants to medical professionals with advanced education, clinical skills, and the ability to function independently in many instances.[90] NPs and PAs are now licensed to practice in every state and the District of Columbia.[91] Individual state licensure laws define what services non-physician providers, such as NPs and PAs, can provide.[92]

States have the constitutional authority to license all healthcare providers to improve quality and protect consumers' health and safety.[93] Licensing limits in the healthcare profession and restrictive rules on non-physicians' scope of practice can reduce their range of services depending on particular state laws.[94] In states with restrictions on APP practice, the laws may limit practice by requiring a collaboration agreement with a physician for the NP or PA to practice within that state.[95] State laws may also require plans for referral from an APP to a physician, along with consultation and a process for chart review. [96] Additionally, NPs and PAs may have specific prescription capabilities limited by state law.[97] Reduced or restricted practice states limit APP's ability to improve provider supply, healthcare access, utilization, and quality of care.[98]

NP and PA Practice Acts and related regulations in each state authorize practice, set forth conditions for obtaining a license, and outline educational and accreditation requirements.[99] In addition to describing the educational, training, and testing requirements, healthcare occupational

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[89] *Id.; see also History of the Profession*, BOSTON UNIV. CHOBANIAN & AVEDISIAN SCH. OF MED. PHYSICIAN ASSISTANT PROGRAM, https://www.bu.edu/paprogram-2/about-us/pa-profession/history-of-the-profession/ (last visited Dec. 22, 2023).

[90] Johnson, *supra* note 2, at 567.

[91] *Id.*

[92] Gabriel Scheffler, *Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing*, 29 HEALTH MATRIX: THE J. OF LAW-MED. 293, 313 (2019).

[93] *See id.* at 306–307 (explaining that the 10th Amendment to the U. S. Constitution allows states to establish laws and regulations to protect the health, safety, and welfare of their citizens).

[94] *Id.* at 303.

[95] *See, e.g.*, 63 Pa. Stat. §218.2 (2022) (explaining that part (b) states that a certified registered nurse practitioner may perform acts of medical diagnosis in collaboration with a physician and in accordance with regulations promulgated by the board).

[96] *See, e.g.*, Ohio Admin. Code 4723–8–04 (2022) (explaining Part (D)(7)(b), Criteria for referral of a patient by the…certified nurse practitioner…to a collaborating physician, Part (D)(7)(c), A process for the…nurse practitioner… to obtain consultation from a physician, and Part (D)(7)(d), A process for chart review in accordance with rule 4723–8–05).

[97] *Nurse Practitioner Practice Authority: A State-by-State Guide*, NURSEJOURNAL. (Sept. 23, 2022), https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/.

[98] Ortiz et al., *supra* note 77, at 65.

[99] Battaglia, *supra* note 49, at 1134–35.

licensing laws specify the range of services that providers may perform, known as the "scope of practice."[100] While some states have removed scope of practice restrictions on NPs, others have maintained supervision and collaboration requirements.[101] The state of New York undertook an intermediate approach by allowing experienced NPs to practice independently of physicians.[102]

State licensure of healthcare professionals is traditionally justified as protecting public health, safety, and general welfare.[103] While licensure may function to protect the public from "low-quality" practitioners, it does not guarantee that licensed practitioners are competent or safe.[104]

In the United States, the practice of medicine is considered to be exclusively within the purview of physicians. Thus, non-physicians are in violation if they practice medicine without a medical license.[105] APPs had to narrow their scope of practice and comply with laws requiring physician supervision and collaboration.[106] These regulations define a "scope of practice;" if a service is not expressly listed, the APP is not authorized to perform it, even if their training or experience would allow them to do so.[107] Physicians, conversely, are broadly licensed by the states to practice medicine and surgery.[108]

Initially, an APP's scope of practice was confined to their supervising physician; however, the physician shortages in the early 1970s expanded the APPs' roles.[109] Many states authorize APPs to diagnose patients and prescribe medications, subject to regulations put forth by the state medical and nursing boards.[110] State law requirements regarding "physician involvement" with NPs and PAs can vary from physical presence to mere

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[100] Scheffler, supra note 92, at 736–37.
[101] *See* Battaglia, *supra* note 49, at 1130 (explaining that states with full practice have no restrictions on NP scope of practice while states with restricted or reduced practice have some requirement of supervision from or collaboration with physicians); *see also Nurse Practitioner Practice Authority: A State-by-State Guide, supra* note 97 (providing a list of states by level of supervision).
[102] Grant R. Martsolf et al., *The Impact of the New York Nurse Practitioner Modernization Act on the Employment of Nurse Practitioners in Primary Care,* 60 THE J. OF HEALTH CARE ORG., PROVISION, AND FIN. 1, 2 (2023).
[103] Scheffler, *supra* note 1, at 306-07.
[104] *Id.* at 308–09.
[105] Scheffler, *supra* note 92, at 737.
[106] *Id.*
[107] Andrew I. Gavil & Tara Isa Koslov, *A Flexible Health Care Workforce Requires a Flexible Regulatory Environment: Promoting Health Care Competition Through Regulatory Reform*, 91 WASH. L. REV. 147, 161 (2016).
[108] *Id.* at 160.
[109] Scheffler, *supra* note 92, at 755.
[110] *Id.* at 759-60 (noting that states enacted amendments to their nurse practice acts in the first half of the 1970s to facilitate NPs taking on new diagnostic and treatment functions.).

phone accessibility.[111] States also vary concerning the supervision ratio of physicians to APPs and their physical distance from one another in practice.[112] From the 1980s until now, NPs and PAs have fought to end statutory constraints and expand practices to the full extent of their certification and licensure.[113] Over 80% of "tasks" in primary care can be performed by NPs and PAs without physician consultation.[114] Even in some states with NP-independent practice, the NP must document their "relationship" with a practicing physician for Medicare billing purposes.[115]

A. Nurse Practitioners and Evolving Scope of Practice

The NP movement was initially only supported by organized nursing, while the physician assistant program was supported by organized medicine.[116] The animosity between organized medicine and nursing led to the PA program working in concert with physicians. In contrast, the NP program was seen as a competitor with doctors in many areas of the country.[117] In addition to joining physician groups and hospitals, NPs

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[111] Michael B. Zand, *Nursing the Primary Care Shortage Back to Health: How Expanding Nurse Practitioner Autonomy Can Safely and Economically Meet the Growing Demand for Basic Health Care*, 24 J. L. & HEALTH 261, 273 (2011).

[112] *Id.* at 274. *See* Mo. Code Regs. Ann. tit. 20 § 2200–4.200(2)(B) (2010) (limiting maximum distance to 50 miles between collaborating physician and NP) *and* N.Y. EDUC. L. § 6902 (3)(e) (McKinney 2010) (requiring no more than 4 NPs to each physician in a practice agreement).

[113] Sermchief v. Gonzales, 660 S.W.2d 683, (Mo. 1983) (finding Missouri NP actions did not constitute the unlawful practice of medicine); Tit. 5 R.I. Gen. Laws § 5-34-39 (West 1956) (allowing Rhode Island NPs to prescribe any medication MD can prescribe); OR. REV. STAT. § 441.064 (2022) (allowing Oregon NPs to practice without supervision or collaboration agreements with physicians (full practice authority)).

[114] Susan Kendig & Alexander Krouse, *Nurse Practitioner and Physician Assistant Reimbursement: An Advanced Case Study*, 20170329 AM. HEALTH L. ASS'N (AHLA) SEMINAR PAPERS 12 (2017); Yihan Yang et al., *Nurse Practitioners, Physician Assistants, and Physicians Are Comparable In Managing The First Five Years of Diabetes*, 131 AM. J. MED. 276 (Sept. 08, 2017); Amanda Van Vleet & Julia Paradise, *Tapping Nurse Practitioners to Meet Rising Demand for Primary Care*, KAISER FAM. FOUND. (Jan. 20, 2015), https://files.kff.org/attachment/issue-brief-tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care; Mary O. Mundinger, *Advanced-practice nursing—Good medicine for physicians?*, THE NEW ENG. J. OF MED. (Jan. 20, 1994) (noting that "Physician only" services include surgery, medical specialties (i.e., Cardiology, pulmonology, radiology), and procedures such as endoscopy and cardiac catheterization).

[115] *Id. see* 42 C.F.R. § 410.74 (1997) and 42 C.F.R. § 410.75(c)(3)(ii) (1997).

[116] Davis, *supra* note 32, at 289.

[117] *Id.*

began to treat patients in nurse-managed health centers and retail-based health clinics.[118]

NP training programs take registered nurses who receive a postgraduate education (usually two to four years) and a master's degree in preparation for the national accreditation exam.[119] Each state's Nurse Practice Act defines the legal limits and scope of practice for advanced practice nurses (nurse practitioners, nurse anesthesia, nurse midwives).[120] Nurse Practice Acts authorize state nursing boards to establish rules for the nursing practice.[121] However, the state legislature and other state governing entities can amend the Nurse Practices Act to modify the NP scope of practice.[122]

NP scopes of practice vary widely from state to state. North Carolina's NP laws are an excellent example of restricted practice.[123] In North Carolina, NPs "shall be held accountable by both (medical and nursing) Boards, with mandated physician supervision and collaboration."[124] In Mississippi, "the NP shall practice in a collaborative relationship with a Mississippi licensed physician whose practice is compatible with that of

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[118] Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift: An Overview of the State-Level Legal Framework Governing Nurse Practitioner Practice*, 20 AM. BAR ASS'N 21, 22 (2008); Jack Ginsburg et. al, *The Nurse-Managed Health Clinic Investment Act of 2007*, NAT'L NURSING CTRS. CONSORTIUM, (Jan. 25, 2009) http://www.nncc.us/policy/NMHCAct.pdf; *Retail Health Clinics: State Legislation and Laws*, NAT'L CONF. OF STATE LEG., http://www.ncsl.org/research/health/retail-health-clinics-state-legislation-and-laws.aspx (noting that the first federally funded nurse-managed health center was created in 1977 as an affiliate of Arizona State University School of Nursing. Most nurse-managed centers provided care to underserved rural and urban communities. Since 2000, NPs have practiced at retail medical clinics (RMCs) at various locations across the U.S); Tine Hansen-Turton et. al., *Convenient Care Clinics: The Future of Accessible Health Care*, 10 DISEASE MGMT., 61, 61-73 (2007).

[119] Battaglia, *supra* note 49, at 1135.

[120] *Id.; see also* Randall S. Hudspeth & Tracy A. Klein, *Understanding nurse practitioner scope of practice: Regulatory, practice, and employment perspectives now and for the future*, 31 J. AM. ASSOC. NURSE PRACT. 468, 468-473 (2019) (explaining that clarification of scope of practice is important for patient safety and NP liability as state laws differ as to degrees of autonomy).

[121] Zand, *supra* note 111, at 269.

[122] Battaglia, *supra* note 49,. at 1135–36.

[123] 21 N.C. Admin. Code § 36.0802 (2004).

[124] *See id.* ("A nurse practitioner shall be held accountable for by both Boards for a broad range of personal health services for which the nurse practitioner is educationally prepared and for which competency has been maintained, with physician supervision and collaboration as described in Rule .0810 of this section.") (noting that other states with restricted practice and the associated nursing statutes and regulations can be found in the Appendix).

the NP."[125] Finally, full-practice states allow nurse practitioners to practice independently from physicians. New Hampshire is an example of full practice authority for NPs.[126] In New Hampshire, NPs may perform acts of advanced assessment, diagnosing, prescribing, selecting, administering, and providing therapeutic measures and treatment regimes, and obtain consultation as appropriate.[127]

Nurse Practice Acts do not expressly authorize particular types of care, which may cause problems if NPs are deemed to have overstepped their bounds of authorized practice.[128] In restricted practice states, NPs practicing "outside their scope" can be sanctioned by the nursing disciplinary board and the state medical board for practicing medicine without a medical license.[129] Nurse practitioners in some states may be required to practice with varying degrees of physician supervision; examples range from a physician reviewing a portion of NP charts, physician on-site time requirements, or mandatory collaboration between the NP and physician, depending on individual state requirements.[130]

Over the past several decades, NPs in many states have lobbied for and been granted increased autonomy in primary care medicine.[131] Multiple research studies have shown NP care to be high quality, cost-efficient, and

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[125] Miss. Code Ann. § 73-15-17 (1972). Title 30: Part 2840 Advanced Practice. Rule 1.3 Practice Requirements. Section C. (Refer to Appendix for other states with reduced practice and associated nursing statutes and regulations in: Nurse practitioner practice authority: state by state guide edited by Elizabeth Clarke in nursejournal.org).

[126] *Nurse Practitioner Practice Authority: A State-by-State Guide, supra* note 97.

[127] N.H. REV. STAT. ANN. § 326-B:11 (2015) (Refer to Appendix for other states with full practice and associated nursing statutes and regulations in: Nurse practitioner practice authority: state by state guide edited by Elizabeth Clarke in nursejournal.org).

[128] Battaglia, *supra* note 49, at 1136; Ritter, *supra* note 104, at 23; MD. CODE REGS. § 10.27.07.02.A (2007)(stating an NP may perform independently the following functions under the terms and conditions set forth in the written agreement (between the NP and a licensed physician): (1) Comprehensive physical assessment; (2) Establish medical diagnosis; (3) Order, perform and interpret laboratory tests; (4) Prescribe drugs; (5) Perform therapeutic measures; (6) Refer patients to other healthcare providers; (7) Provide emergency care).

[129] Battaglia, *supra* note 49, at 1136; N.C. GEN. STAT. ANN. § 90-18(c)(14). ("The following shall not constitute the practice of medicine: The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice when performed in accordance with rules and regulations developed by the North Carolina Medical Board and the Board of Nursing.").

[130] Battaglia, *supra* note 49, at 1130; ALA. ADMIN. CODE r. 610-X-8-.08(4) (1996). (1). ("The collaborative physician shall (a) Provide professional medical oversight and direction to the certified registered nurse practitioner.").

[131] Martzolf et al., *supra* note 102; Kansas Nurse Practice Act, 41 Kan. Reg. Issue 39 (Sept. 29, 2022). Full practice signed into law in 2022. Last amended Sept. 21, 2023. 60-11-101. ("Each APRN shall be authorized to make independent decisions about advanced practice nursing needs of families, patients, and clients and medical decisions. Each APRN shall be directly accountable to the consumer.").

capable of expanding patient access.[132] Administrative burdens arising from collaborative practice agreements can decrease patient satisfaction and reduce access to care in both physician and NP practices.[133]

B. Physician Assistants

The physician assistant program began as a way to fast-track primary care providers to respond to the physician shortage in the 1960s.[134] The training program initially started with Navy corpsmen who had some medical knowledge.[135] PA school admission requirements were expanded to include students with bachelor's degrees from an accredited college or university.[136] Physician assistants are practitioners who receive a PA postgraduate education (typically two years in length) and are awarded a master's degree.[137] In 1991, the American Academy of Physician Assistants drafted its Model State Legislation, which recommended the scope of PA practice consider training, experience, and the supervising physician's delegation of duties.[138]

Although PAs are legally required to collaborate with physicians, some states allow them a broader scope of practice and autonomy than others.[139] These states range in practice restrictions from reduced to moderate, advanced, and optimal levels of practice, depending on state laws and regulations.[140] Florida and Georgia are examples of reduced practice for PAs due to laws limiting the delegation of authority and/or restrictive supervision requirements.[141] New Mexico and California exemplify moderate practice environments with laws requiring additional

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[132] Kathleen Hoke & Sarah Hexem, *Expanding Access to Care: Scope of Practice Laws*, 45 J.L. MED. & ETHICS 33, 33 (2017), NGA paper: The role of nurse practitioners in meeting increasing demands for primary care (2012); Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1999-2008: A Systemic Review*, 29 NURSING ECONOMICS 1, 20 (2011); Lauren LeRoy et al., *The Cost and Effectiveness of Nurse Practitioners,* THE IMPLICATIONS OF COST-EFFECTIVENESS ANALYSIS OF MED.TECH.4 (1981).
[133] Hoke & Hexem, *supra* note 132, at 34.
[134] Ann Davis et al., *supra* note 31, at 288.
[135] *Id.* at 299.
[136] *Id.* at 297.
[137] *Id.*
[138] *Id.*
[139] *PA State Practice Environment*, AM. ACAD. OF PHYSICIAN ASSOC., https://www.aapa.org/advocacy-central/state-advocacy/state-maps/pa-state-practice-environment/ (last visited Aug. 31, 2023).
[140] *Id.*
[141] *PA State Practice Environment*, *supra* note 139; FLA. STAT. §458.347 (2023). (Physician Assistants (4)(h): "A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training").

administrative burdens that limit flexibility for PAs and their healthcare teams.[142] Michigan and Illinois allow advanced care through the laws allowing PAs to practice to the full extent of their knowledge and experience while mandating additional administrative requirements.[143] Finally, North Dakota, Wyoming and Utah provide "optimal" practice (per the AAPA) with laws allowing PAs to practice to the full extent of their education and training. However, the guidelines for collaboration and consultation are left up to the healthcare team.[144]

In the 1970s and 1980s, the regulation of the PA practice was not standardized. Therefore, the American Academy of Physician Assistants created "Guidelines" to help steer the state regulation of PAs.[145] Here, the AAPA sought to standardize the PA practice across the country to expedite increased flexibility of PA utilization and assist PA organizations in developing an optimal practice environment.[146] The cornerstone of the AAPA guidelines is that each PA's scope of practice is safely determined at the practice level.[147] However, determining the scope of a PA's practice previously varied from state to state, with input from the physician-PA team and a designated regulatory agency.[148] During the 1990s, most states granted PAs physician-delegated prescriptive authority and a more PA and physician-determined scope of practice.[149] Many factors, including state laws, facility credentialing, physician delegation, and PA education and training, determine the scope of practice for a physician assistant.[150]

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[142] *PA State Practice Environment*, *supra* note 139; CAL. CODE REGS. tit. 16, §1399.540. ("A physician assistant may only provide those medical services which he or she is competent to perform…and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant").

[143] *PA State Practice Environment*, *supra* note 139; MICH. COMP. LAWS §333.17047 (2017). ("A process between the physician's assistant and participating physician for communication, availability, and decision making when providing medical treatment to a patient"); Act of July 10, 2003, Pub. L. No. 093-0149, 2003 Ill. Gen. Assembly.

[144] *PA State Practice Environment*, *supra* note 139; UTAH CODE ANN. §58-70A-501. ("A physician assistant practicing independently may only perform or provide a health care service that: (a) is appropriate to perform or provide outside of a health care facility; and (b) the physician assistant has been trained and credentialled or authorized to provide or perform independently without physician supervision").

[145] Davis et al., *supra* note 32, at 293.

[146] *PA Scope of Practice Guideline*, AM. ACAD. OF PHYSICIAN ASSOC., (Sept. 2019), https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Scope-of-Practice_0117-1.pdf.

[147] *Id.* at 2.

[148] Davis et al., *supra* note 32, at 293.

[149] *Id.* at 295.

[150] *Id.* at 296; *see generally* COLO. REV. STAT. § 12-240-114.5 (2023) (defining scope of practice for physician assistants).

State laws also govern the licensure of PAs to practice and authorize the prescription of medicine.[151] PA programs, like NP programs, are structured to produce a graduate with the background of a general practitioner.[152] All states require that PAs practice with a physician or group of physicians and they are delegated tasks that form their "scope of practice." [153] While most advanced practice registered nurses (APRNs) tend to practice as NPs in primary care, PAs are more often practicing in specialized areas of medicine and the surgical subspecialties.[154] Exceptions to this are the advanced nursing subspecialties of nurse anesthetist and nurse midwife, which have separate and unique training programs.[155]

In some states, strict laws reduce the services that PAs may be otherwise qualified to provide and thus limit patient access to primary care.[156] Limitations on the number of PAs a physician can supervise also effectively restrict the PA's scope of practice.[157] Eliminating physician supervision requirements on PAs and expanding their scope of practice could expand consumer access to primary health care.[158]

The American Academy of Physician Assistants (AAPA) Model State Legislation contains six elements the Academy believes all state PA practice acts should include.[159] First, the AAPA prefers the term "licensed PA" in state laws because licensure "denotes the highest level of scrutiny of professional qualifications."[160] Second, state laws should authorize PAs to prescribe all controlled and noncontrolled medications and devices.[161]

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[151] *Id.* at 296; *see generally* KAN. STAT. ANN. § 65-28a08 (2015) (allowing PAs to prescribe drugs).
[152] *Id.* at 297.
[153] *Id.* at 298; *see generally* MD. CODE REGS. 10.32.03.07 (2023).
[154] Alexander T. Krouse & John R. Washlick, *Nurse Practitioner and Physician Assistant Integration: Advanced Compliance Issues*, AM. HEALTH L. ASS'N SEMINAR PAPERS 1, 2 (2017).
[155] *Nurse Anesthetist, Nurse Midwife, or Nurse Practitioner*, TRUITY , https://www.truity.com/career-profile/nurse-anesthetist-nurse-midwife-or-nurse-practitioner. (last visited Nov. 10, 2023).
[156] Jessica Wolf, *Eliminating Scope of Practice Barriers for Illinois Physician Assistants*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE Fall 2013, at 17, 18; *See generally* 225 Ill. COMP. STAT. ANN. 95/1 (1987) ("The practice as a physician assistant in the State of Illinois… is conducted at the direction of and under the responsible supervision of the physician").
[157] *Id.* at 26; *See generally* NEV. ADMIN. CODE § 630.495 (informing maximum 3 PAs to each physician); CONN. GEN. STAT. §20-12c(b) (stating physician can supervise as many physician assistants as is medically appropriate under the circumstances)
[158] *Id.* at 18.
[159] *The Six Key Elements of a Modern PA Practice Act*, AM. ACAD. OF PHYSICIAN ASSISTANTS, 1 (2017), https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Six-key-elements_0117-1.pdf.
[160] *Id.*
[161] *Id.*

Third, state laws should leave all PA practice determinations to the PA, collaborating physicians, and the healthcare team.[162] Fourth, state laws should allow for adaptable collaboration agreements to fit the needs of the practice setting and refrain from imposing rigid proximity requirements between physicians and PAs.[163] Fifth, state laws should allow healthcare teams to determine the ideal system for reviewing PA medical care and patient records rather than a mandated physician cosignatory quota.[164] Finally, state laws should not have a numerical limit on the number of PAs that one physician may collaborate with to promote flexibility and patient access.[165]

C. From "Extenders" to "Providers"

To meet the expanding needs of patients, NPs and PAs evolved from "physician extenders" to primary care providers.[166] The physician shortage of the 1960s continued, as the second half of the 20th century saw both an increase in specializing doctors and a decrease in the number of primary care physicians.[167] Both the NP and PA professions sought to fill the gaps in access to healthcare in underserved and rural areas.[168] Doctors and the American Medical Association (AMA) facilitated the PA movement because PAs were meant to work jointly with physicians rather than in competition with them.[169] Conversely, physicians and the AMA resisted the NP movement partly due to animosity between organized nursing and medicine, and seeing NPs as direct competitors rather than colleagues.[170]

Physicians have the exclusive right to "practice medicine," therefore many states require APPs to have collaboration or supervision agreements between themselves and a physician.[171] These supervision and/or collaboration requirements are based on patient safety and condition NP

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[162] *Id.* at 1-2.
[163] *Id.* at 2.
[164] *Id.*
[165] *Id.* at 3.
[166] *The Access-To-Care Epidemic*, *supra* note 5, at 555.
[167] Davis et al., *supra* note 32, at 288.
[168] *Id.*
[169] *Id.* at 289.
[170] *Id.*
[171] Battaglia, *supra* note 49, at 1138.; *See generally* MO. REV. STAT. §334.735(5)(2023) (stating PAs shall clearly identify themselves as PAs and not doctors. PAs shall not practice without physician collaboration); MO. CODE REGS. ANN tit. 20, §2200-4.200 (declaring NPs shall have a collaborative practice agreement with a physician).

and PA practice upon some level of physician involvement.[172] In the case of physician assistants, Model State Legislation by the American Academy of Physician Assistants (AAPA) embodies two core concepts: PAs should practice medicine in collaboration with their physician partners, and physician-PA teams should determine the PA's scope of practice.[173]

The proficiency and range of care offered by NPs and PAs have evolved and expanded such that physician supervision and collaboration agreements are unnecessary in some instances and counterproductive in others.[174] Supervision and collaboration agreements typically involve chart review or on-site time requirements.[175] The term "supervision," does not adequately describe the interaction between physicians and PAs as most states do not require physicians to be onsite with PAs to check every aspect of the their work, or approve each treatment plan.[176] States with collaboration agreements limit the number of APPs a single physician may "supervise."[177] Collaboration agreements can affect APP prescriptive authority and the accessibility to practice in some underserved areas of the nation.[178] Collaborative agreements may hold the physician responsible for the acts of the APP as their agent under the doctrines of "vicarious liability" and "respondeat superior."[179] Physicians may thus be hesitant to allow their NPs or PAs to work with any degree of independence for fear

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[172] Battaglia, *supra* note 49, at 1129 & 1137.; *See generally* MD. CODE REGS. 10.32.03.07 (Supervising physician shall accept responsibility for any medical acts performed by the PA and provide continuous supervision of the PA by on-site supervision or written instructions or electronic communication).; KY. REV. STAT. ANN. § 311.854 (West 2016) (stating a physician shall not supervise more than four PAs at any one time).

[173] Davis et al., *supra* note 32, at 294-5.; *See generally* PA Scope of Practice Guideline *supra* note 146 (AAPA, Model PA Practice Act, adaptable collaboration requirements and scope of practice determined at the practice level).

[174] Battaglia, *supra* note 49, at 1132-33.

[175] *Id.* at 1137.; *See generally* ALA. ADMIN. CODE r.610-X-5-.08(4) (2007) (declaring a physician must be present for at least 10% of NPs scheduled hours); ILL. ADMIN. CODE tit. 68, §1305.35(a)(2) (2007) (stating a physician must be present onsite at least once a month).

[176] Davis et al., *supra* note 32, at 329-30.; *See generally* MD. CODE REGS. 10.32.03.07 (2021) (discussing duty to provide on-site supervision of PAs).; NEV. ADMIN. CODE §630.370 (2023) (regarding duty to check aspects of PA's work); MO. REV. STAT. §334.735 (2023) (regarding duty to review PA's delivery of health care services).

[177] Johnson, *supra* note 2, at 576.; *See generally* 225 ILL. COMP. STAT. 95/7.0 (1987) (stating one physician may collaborate with a maximum of 7 FTE PAs).

[178] Johnson, *supra* note 2, at 594.; *See generally* 21 N.C. ADMIN. CODE 36.0809 (Aug. 1, 2021) (discussing the prescribing authority on rules governing writing prescriptions and ordering medications for patients).

[179] Johnson, *supra* note 2, at 573.; FLA. STAT. § 458.347 (2018) (describing how physicians are responsible and liable for the performance and the acts and omissions of the physician assistant).

of liability due to allegations of "failure to supervise" or "failure to follow the requirements of the collaborative agreement."[180]

Although the cost of providing healthcare continues to increase, reimbursement to healthcare providers for office visits has decreased.[181] NPs and PAs expect enhanced responsibilities regarding patient care to yield higher compensation.[182] Physicians feel they should be compensated for their higher level of education and training compared to NPs and PAs.[183] In fact, Medicare reimburses NP and PA office visits at just 85% of the physician rate for the same level of service in primary care patients.[184] Raising reimbursement of APPs to 100% of the physician fee schedule would result in equal pay for similar services.[185]

D. Retail Medical Clinics (RMCs)

There are several areas where NPs and PAs practice relatively independently, even in states with restrictive laws on APP practice.[186] NPs and PAs are staffing retail medical clinics (RMCs) to "provide convenient, speedy, and inexpensive medical care to patients across the country."[187] Some physician groups argue that these clinics are largely unregulated and pose a potential threat to patients' health.[188] However, legislation that proposes greater regulation of these health clinics may be subject to

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[180] Johnson, *supra* note 2, at 573-4.
[181] Gary Branning & Martha Vater, *Healthcare Spending: Plenty of Blame to go Around,* 9(8) *AM. HEALTH DRUG BENEFITS* 445, 445 (Nov. 2016); Nick Hut, *A Projected Medicare Physician Payment Decrease Spurs More Calls to Reform the System*, (July 24, 2023), hfma.org. (stating AMA noted that between 2001 and 2023, aggregate Medicare physician payment rate is 26% below the Medical Economic Index).
[182] Y Tony Yang & Mark Meiners, *Care Coordination and The Expansion of Nursing Scopes of Practice*, 42 J. OF L., MED. & ETHICS 93, 93 (2014).
[183] *Id.*
[184] CTRS. FOR MEDICARE & MEDICAID SERVS., *Medicare Claims Processing Manual,* Ch. 23, Part 30 (Rev. 12068) (June 2. 2023), https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c23.pdf.
[185] Yang & Meiners, *supra* note 182, at 96.; *See also* Debra Wood, *MedPAC Discusses Reimbursement Equality for NPs and PAs,* AMN HEALTHCARE (Apr. 12, 2013), https://www.amnhealthcare.com/amn-insights/news/medpac-discusses-reimbursement-equality-for-nps-and-pas/ (emphasizing differences in pay for different healthcare roles).
[186] Future of Nursing, *supra* note 35, at 23; *see generally* 49 PA. CODE § 21.282a (2009) (examining how this is a reduced practice state allowing NPs and PAs to expand practice and conduct procedures "provided they are acting withing the supervision and direction of the supervising physician.").
[187] Robyn E. Marsh, *The Health Care Industry and Its Medical Care Providers: Relationship of Trust or Antitrust?*, 8 DEPAUL BUS. & COMM L. J. 251, 251-252 (2010).
[188] *Id.* at 252.

antitrust scrutiny due to its restriction on commercial activity rather than a pure effort to regulate the professional practice of medical care.[189]

RMCs offer a narrow range of services for conditions that require no physician evaluation and no or minimal follow-up.[190] NPs practice under their own license, while PAs are licensed to practice only under the direction of a physician, although that supervision may be intermittent and from a remote location.[191] RMCs are typically staffed by NPs and PAs who are paid approximately half that of physicians.[192] RMCs are financially viable if they see an average of two or more patients an hour because of favorable qualities, including transparently low pricing, immediate evaluation, and short visit times.[193] NPs and PAs working at RMCs provide patient care in a "semi-autonomous" fashion, typically under the nominal supervision of a physician who is not onsite.[194] State laws regulate the degree of physician supervision of APPs that is required, which results in variability of RHC oversight across the country.[195]

IV. LIABILITY ISSUES RELATED TO PHYSICIAN AND APP RELATIONSHIPS

A. Malpractice Liability for NPs, PAs, and Physicians

Regardless of their practice environment, all medical providers owe a duty to their patients and can be held liable for medical malpractice if a breach of that duty causes injury.[196] Although some state laws and

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[189] *Id.* at 272.

[190] Kristin E. Schleiter, *Retail Medical Clinics: Increasing Access to Low Cost Medical Care Amongst a Developing Legal Environment,* 19 ANN. HEALTH L. 527, 529 (2010) (describing that typical visits at RMCs include evaluation and treatment of ear infection, sore throat, urinary tract infections, along with health screenings, blood pressure checks and vaccinations. These services are well within NP and PA scopes of practice. The major question concerns the degree of physician supervision (if any) required by each individual state's laws).

[191] *Id.* at 567.

[192] Thomas R. McLean, *The Schizophrenia of Physician Extender Utilization*, 20 ANN. HEALTH L. 205, at 206, 209 (2011) (detailing The Patient Centered Medical Home, which is a new approach aiming to deliver high quality, affordable care).

[193] *Id.* at 210.

[194] *Id.* at 212.

[195] Cynthia Liba, *Retail Therapy: How A Trip to The Store Can Make You Feel Better in The Evolving Health Care Landscape Created by The Affordable Care Act*, 33 L. J. & COM. 239, 248 (2015).

[196] *What PAs Need to Know About Malpractice Insurance*, AM. ACAD. OF PHYSICIAN ASSISTANTS (Dec. 7, 2020), https://www.aapa.org/news-central/2020/12/what-pas-need-to-know-about-malpractice-insurance/., [hereinafter *What PAs Need to Know*]; Donovan Weger, *Going Bare— Are Doctors Required to Have Malpractice Insurance?*, GALLAGHER HEALTHCARE (Mar. 20, 2017), https://www.gallaghermalpractice.com/blog/post/going-bare-

institutions do not require professional liability insurance (medical malpractice coverage), all providers should carry malpractice insurance during all periods in which they practice.[197] NPs and PAs working for hospitals or medical practices may be covered under company policies; however, it is wise to also have a personal policy for any claim not covered by the limits of the company policy.[198] The formal and informal associations between physicians and APPs affect their potential malpractice liability depending on the state requirements for collaboration and supervision.

B. Liability in States with Restricted Practice

Restrictive scope of practice laws often require NPs and PAs to work under the mandated supervision of physicians. This close relationship allows patients injured by NPs and PAs to potentially hold the physicians liable under the legal doctrine of vicarious liability.[199] In states with restricted practice, APPs may work under the direct close supervision of physicians, who have ultimate responsibility for the patient.[200] If an APP is carrying out the orders of the supervising physician, some courts have found a lack of evidence to support a verdict against the APP for liability.[201]

Restrictions on APPs in the form of collaborative agreements and supervision requirements make physicians susceptible to liability for NP and PA practice and conduct.[202] Collaborative agreements are not, however, a substitute for an NP's independent judgment. In cases where

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are-doctors-required-to-have-malpractice-insurance/. (showing that thirty-two states (i.e., California, Florida) do not require physicians to carry malpractice insurance, while 18 states (i.e., New Jersey, Colorado) require a minimum level of coverage).

[197] *What PAs Need to Know*, *supra* note 196; *see also* Weger, *supra* note 196 (showing that thirty-two states (i.e., California, Florida) do not require physicians to carry malpractice insurance, while 18 states (i.e., New Jersey, Colorado) require a minimum level of coverage).

[198] *What PAs Need to Know, supra* note 196.

[199] Benjamin McMichael, *Healthcare Licensing and Liability*, 95 IND. L. J. 821, 825-826 (2020).

[200] *Id.* at 825.

[201] Siegal v. Husak, 943 So. 2d 209, 211 (Fla. Dist. Ct. App. 2006). An NP working under the direct supervision of a physician in Florida, had made an incorrect diagnosis, however, the physician also saw the patient and approved the course of treatment. The court held that an NP, acting under the direction and orders of a physician in matters involving medical professional skill and judgement is absolved from liability for the acts so performed, absent independent negligence upon the part of the NP.

[202] Alice Gosfield, *Rethinking Nurse Practitioner Laws: Addressing Statutory Provisions Which Impede Growth, Innovation and Expanded Practice*, HEALTH L. HANDBOOK 3, (2020) (describing restrictions and susceptibility to liability in the first paragraph of the conclusion).

the NP saw, evaluated, and cared for the patient without physician involvement, courts held that the physician did not owe a duty to the patient because there was no physician-patient relationship.[203]

When the APP and the physician interact concerning patient care, all involved medical providers may be potentially liable for errors leading to patient injuries.[204] Some courts have held that even if no physician-patient relationship exists, a physician may still have a duty to a patient if the physician advises an NP, resulting in patient harm.[205] This duty potentially exists due to the foreseeability of the patient's reliance on the recommendations given to the NP by the physician.[206]

C. Liability in States with Full Practice

In states that require little or no control by physicians over NP and PA practices, the theories of respondeat superior and vicarious liability become more difficult to establish making physicians less likely to be held liable for APP actions, even in the face of collaboration agreements.[207] Under the theory of respondeat superior, physicians may be held accountable for the negligence of APPs if they are acting under the supervision of or in direct collaboration with the physician.[208] Courts look at both the written agreement and manner in which APPs provide care to patients with or without control and or knowledge of physicians associated with them.[209] As NPs and PAs increasingly use separate practice settings and bill distinctly for their services, neither APPs nor physicians would characterize their relationship as master-servant.[210]

Even in states with mandated supervision or collaborative agreements, physicians have only limited information about how NPs or PAs practice on a day-to-day basis. These agreements, however, may still demonstrate

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[203] Harper v. Hippensteel, 994 N.E. 1233, 1242 (Ind. Ct. App. 2013) ("A nurse practitioner saw and treated a patient who died after suffering an acute pulmonary embolism. The patient's estate then sued the physician because he had entered into a CPA with the NP and therefore owed a duty to the patient. The court held that the physician did not have a physician-patient relationship and thus did not owe a duty to the patient.").

[204] *Healthcare Licensing and Liability*, *supra* note 199, at 825.

[205] Erika Miller, *Torts: Just Walk Away: How an Overbroad Foreseeability of Harm Standard Could Kill "Curbside Consultations"—Warren V. Dinter, 926 N.W.2D 370 (Minn.2019)*, 46 MITCHELL HAMLINE L. REV., 690 (2020).

[206] Warren v. Dinter, 926 N.W. 2d 372, 374 (Minn. 2019).

[207] Battaglia, *supra* note 49, at 1142.

[208] *Healthcare Licensing and Liability*, *supra* note 199, at 821.

[209] Battaglia, *supra* note 49, at 1143 (providing example of nurse protocol agreement in Georgia).

[210] *Id.* at 1144 (noting that the label the parties give to a relationship is not dispositive as to whether an agency relationship exists); Restatement (Third) of Agency § 7.07(3)(a) (2006).

a physician's liability for APP malpractice without being directly involved in providing care to the patient.[211]

D. Delegable and Non-Delegable Duties

Healthcare delivery has been moving towards team-based care and delivery system delegation.[212] Physicians may delegate several tasks and responsibilities to APPs, including diagnosis and drug prescription, but not others, such as the performance of major operations.[213] The delegation of patient care duties makes medical offices and hospitals more efficient.[214] Even in states where NPs and PAs are supervised by physicians, more duties are now delegated to APPs for both efficiency and practicality.[215] Patients are open to the idea of expanded roles for PAs and NPs primarily due to their communication and patient education skills.[216]

Some physician duties are nondelegable. Regarding the delegation of duties from physicians to APPs, the Pennsylvania Supreme Court draws the line at obtaining informed consent for surgical procedures.[217] A physician may not delegate the informed consent discussion to an NP or PA.[218] An important issue is what other duties a physician can delegate (or not) to an APP (such as minor surgical procedures and interpreting radiologic studies and labs). In team-based care, physician delegation of duties to APPs is a necessary component of healthcare delivery.[219] The scope of these practice determinations is made at the practice level (between physicians and APPs) based on training and experience. Hospitals and surgery centers also control APP duties through credentialling.

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[211] *Id.*; *see* EMP. RELS. L. J. § 374 (2004) (stating that one purpose of respondeat superior liability is "to give greater assurance of compensation for the victim").
[212] Daniel Baker, *Excuse Me, Judge, But You're Standing in the Way of My Healthcare: The Supreme Court of Pennsylvania Halts Growth of Mid-Level Providers and Declares Only Physicians Can Obtain Patient Consent in Shinal v. Toms*, 63 VILL. L. REV. TOLLE 77, 97 (2018).
[213] *Id.* at 96.
[214] *Id.* at 76.
[215] *Id.*
[216] *Id.* at 97.
[217] *Id.* (In reference to Shinal v. Toms: explaining that without direct communication between physician and patient, the physician cannot be confident that the patient comprehends the risks, benefits, likelihood of success, and alternatives) (In all states it is the surgeon performing the procedure who must discuss the options, alternatives, benefits, risks, and possible complications).
[218] Shinal v. Toms, 162 A.3d 429, 461 (Pa. 2017).
[219] Baker, *supra* note 212.

V. CHANGES IN THE LAW, EPIDEMICS, AND ADVANCES IN TECHNOLOGY

A. Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA) expanded insurance coverage, creating millions more patients in need of primary care providers.[220] The PPACA also contains provisions that encourage the expansion of the scope of practice of NPs including the funding of nurse-managed health clinics (NMHCs), grants and loans for advanced nursing degrees, and money to hospitals to train NPs.[221] Thirty-five million Americans enrolled in health insurance plans while another twenty-one million enrolled in Medicaid expansion coverage under the PPACA, thus increasing the need for primary care providers.[222] Not all states have expanded Medicaid so that insurance coverage is not equally distributed across the U.S.[223] NPs and PAs can provide primary care for these newly covered patients, especially if they can practice to the full extent of their knowledge and training.

B. Epidemics and Other Unforeseen Events

The COVID-19 pandemic exposed critical shortfalls in U.S. healthcare and the need for more primary care providers.[224] Blanket waivers during the COVID-19 pandemic expanded the types of providers who could furnish and bill Medicare for telehealth services.[225] The waivers also allowed clinics to use NPs to the fullest extent possible, allowing

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[220] Matt Brothers, *The PPACA's Impact on the Scope of Practice of Nurse Practitioners*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 79, 79 (2013).
[221] *Id.* at 84.
[222] *New Reports Show Record 35 Million People Enrolled in Coverage Related to the Affordable Care Act, with Historic 21 Million People Enrolled in Medicaid Expansion Coverage*, U.S. DEP'T OF HEALTH AND HUM. SERVS., (Apr. 29, 2022), https://www.hhs.gov/about/news/2022/04/29/new-reports-show-record-35-million-people-enrolled-in-coverage-related-to-the-affordable-care-act.html.
[223] Courtney Kahle, *Scope of Practice Constraints on Nurse Practitioners Working in Rural Areas*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 90, 94 (2013) (regarding coverage in Arizona and other rural areas).
[224] *The Access-To-Care Epidemic*, *supra* note 5, at 549.
[225] *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, CTRS. FOR MEDICARE & MEDICAID SERVS., 1-47, (2022); *See also* Coronavirus Aid, Relief, and Economic Security Act 42 CFR § 482.12(c)(1)-(2) and §482.12(c)(4) (temporarily waiving the requirement that Medicare patients be under the care of a physician, allowing hospitals to use NPs and PAs to practice to the fullest extent possible).

physicians to direct their time to more critical tasks.[226] Many of the waivers introduced in 2020 expired in 2022.[227]

State and federal agencies enacted waivers during the pandemic to allow clinicians (physicians, NPs, and PAs) to practice in states other than those in which they held licenses.[228] NPs and PAs still needed to abide by the scope of practice restrictions (if present) in the states where they practiced. Emergency orders issued during the pandemic allowed these medical providers to practice telehealth in some states (e.g., Florida) where they were not licensed to meet patient needs.[229] The emergent nature of the pandemic permitted NPs and PAs to practice to the full extent of their knowledge and training regardless of their geographic location in the United States (facilitated by emergency orders and waivers). [230] Many states with emergency licensure waivers have either actively ended the emergency declarations or allowed them to expire.[231]

C. Advances in Technology

1. Telemedicine

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[226] *Id.* at 12.

[227] *COVID-19 Emergency Declaration Blanket Waivers*, *supra* note 225, at 13 (allowing NPs to practice to fullest extent possible was set to return to pre-public health emergency (PHE) at the end of the calendar year that the PHE ends).

[228] Kyle Faget, *Telehealth after COVID: Federal and State Considerations*, 15 J. HEALTH & LIFE SCI. L. 67 (2021).; Office of Governor Andrew Cuomo COVID-19 Exec. Order No. 202.5 (Mar. 7, 2020); Office of Governor Andrew Cuomo COVID-19 Exec. Order 202.10 (Mar. 23, 2020) (allowing licensed physicians in current good standing in any state to practice medicine in New York, expired on June 25, 2021).

[229] Faget, *supra* note 228, at 70; *See also* Office of Governor Ron De Santis and Dep't. of Health, COVID-19 Emergency Order, DOH No. 20-002 (Mar. 16, 2020) (enabling NPs and PAs not licensed in the state of Florida to provide health care services to a patient using telehealth).

[230] *Id.*

[231] Faget, *supra* note 228, at 70 (explaining that the status of each state regarding temporary suspension and waived practice agreement requirements for NPs can be found on the AANP website under COVID-19 State Emergency Response); *see U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19*, FED'N OF STATE MED. BD., https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf (last updated May 24, 2023); *see also Fact Sheet: COVID-19 Waivers Should Be Extended, Made Permanent or Enacted to Improve Patient Care*, Am. Hosp. Assoc., https://www.aha.org/system/files/media/file/2022/10/fact-sheet-covid-19-waivers-should-be-extended-made-permanent-or-enacted-to-improve-patient-care.pdf (Oct. 2022).

The explosion in telemedicine during the COVID-19 pandemic showed how APPs are particularly suited for this technology.[232] Telehealth usage had been increasing slowly before the pandemic, which caused a massive expansion and adoption of technology in all aspects of medical care.[233] Congressional lawmakers expanded Medicare and Medicaid coverage for telehealth services, and waivers were enacted on prior telehealth restrictions to meet patients' medical needs during the pandemic.[234] Federal agency changes (Office of Civil Rights, CMS, DEA), state law waivers, and federal financing initiatives were all necessary to expand telehealth during the pandemic.[235] While some emergency measures have been rescinded with the slowing of the pandemic, federal and state governments have amended some statutes to reduce barriers to telehealth use.[236] Telemedicine is a solution to the growing primary care shortages resulting from expanding Medicaid and private insurance coverage under the PPACA.[237] States with restrictive practice laws make it difficult for NPs and PAs to treat patients in rural areas or other situations where physician supervision is not readily accessible.[238] Telemedicine improves access to health care even in states with restricted scopes of practice and preserves supervision capabilities called for by law.[239] Telemedicine allows NPs and PAs to deliver primary care to patients in remote locations.[240] Telehealth technology also allows physicians to perform

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[232] Tyler Hanson, *Why the Use of Telemedicine can Alleviate the Burden of Current Scope of Practice Norms for Nurse Practitioners and the Primary Care Shortage in The United States*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 124, 133 (2013).
[233] Deborah Farringer, *A Telehealth Explosion: Using Lessons from The Pandemic to Shape the Future of Telehealth Regulation*, 9 TEX. A&M L. REV. 1, 3 (2021).
[234] *Id.* at 4; Consolidated Appropriations Act, 2021 Pub. L. No. 116-260, 134 Stat. 2624 (2020) (extending many telehealth flexibilities authorized during the COVID-19 public health emergency through December 31, 2024).
[235] Farringer, *supra* note 233, at 23; Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, 134 Stat. 281 (2020) (awarding nearly 165 million dollars to combat the covid 19 pandemic in rural communities); Exec. Order No. 13941, 85 Fed. Reg. 47881(2020) (improving access to health care through telehealth especially in rural areas).
[236] Farringer, *supra* note 223, at 39. For state laws enacted to include coverage and payment parity, *see e.g.* S.B. 20-212, 73rd Gen. Assemb., 2nd Reg. Sess. (Colo. 2020); H.B. 530, Reg. Sess. (La. 2020); H.B. 313, Gen. Sess. (Utah 2020); H.B. 4003, Reg. Sess. (W. Va. 2020); S.B. 402, Reg. Sess (Md. 2020); H.B. 5412, 100th Leg., Reg. Sess. (Mich. 2020); H.B. 5413, 100th Leg., Reg. Sess. (Mich. 2020); and H.B. 1682, 100th Gen. Assemb., 2nd Reg. Sess. (Mo. 2020) (removing requirements for previously established relationship or in-person visits).
[237] Hanson, *supra* note 232, at 125.
[238] *Id.* at 131.
[239] *Id.*
[240] Melinda Cooling et al., *Access to Care: End-to-End Digital Response for COVID-19 Care Delivery*, 18 J. NURSE PRAC. 232, 234 (Feb. 2022).

supervision and surveillance (in states that require it) of NPs and PAs virtually from anywhere in the country.[241]

2. Mobile Devices

Innovations like mobile health technology may enable the limited number of primary care providers to treat more patients and alleviate the primary care shortage in the United States.[242] The medical treatment abilities of NPs and PAs may be greatly amplified by medical apps that rely on artificial intelligence (AI) engines.[243] Evidence-based clinical decision support (CDS) has been embedded in electronic health records (EHRs) for many years.[244] Mobile devices can enable an NP or PA to remotely diagnose a patient's condition (using CDS or AI) and possibly recommend a treatment plan with or without the input of a physician.[245] The boundaries between CDS and AI are evolving and will affect APP's scope of practice.[246] Using EHRs with CDS and AI also brings up issues of privacy and security and the importance of informed consent.[247] Physicians, NPs, and PAs may need to join forces to prepare for increased mobile health and potential "providerless" medicine delivered by technology corporations.[248]

VI. THE EXPANSION IN SCOPES OF PRACTICE

The original state restrictions on APP scope of practice were to protect patient health and safety.[249] Some states gradually moved to expand APP scopes of practice under pressure from NP and PA groups and to meet the

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[241] Hanson, *supra* note 232, at 131.
[242] Fazal Khan, *The "Uberization" Of Healthcare: The Forthcoming Legal Storm Over Mobile Health Technology's Impact on The Medical Profession*, 26 HEALTH MATRIX 123, 126 (2016).
[243] *Id.*
[244] *Id.* at 137.
[245] *Id.* at 126.
[246] Julia Adler-Milstein et al., Discussion, *Meeting the Moment: Addressing Barriers and Facilitating Clinical Adoption of Artificial Intelligence in Medical Diagnosis*, NAT'L ACAD. MED. PERSPECTIVES (Sept 29, 2022). APPs and physicians are increasingly using AI-based decision making and predictive tools both in office and hospital settings. *See also* Louis Raymond et. al., *Nurse Practitioners' Involvement and Experience with AI-Based Health Technologies: A Systematic Review*, 66 APPLIED NURSING RSCH. 1 (Aug. 2022) (examining NPs' involvement with AI on clinical care and performance).
[247] Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d-2(c)(2); Health Information Technology for Economic and Clinical Health, 45 C.F.R 164 (2009).
[248] Khan, *supra* note 242, at 171-72.
[249] Scheffler, *supra* note 1, at 298.

needs of underserved patients.[250] Some state laws acknowledge the learning curve by requiring NPs to have collaboration agreements for the first five years of practice, with the potential for release from that requirement if approved by the care team physician and the state nursing board.[251] Other states allow unrestricted APP practice in office settings while requiring NPs and PAs to co-admit patients to the hospital with a physician who is a member of the medical staff.[252] Over the past decades, "full practice" states have passed laws allowing NPs to practice independently, without a physician-authorized prescribing protocol or a collaborative practice agreement.[253] In the United States, twenty-seven states (plus D.C.) allow NPs full practice, twelve states reduce NP practice and eleven states restrict NP practice.[254] Attempts to increase NP scope of practice and independence have failed in some states due to opposition from organized physician groups.[255]

A. The Spectrum of APP Laws Across the United States

NP and PA practice laws vary by state, ranging from highly restrictive to full autonomy.[256] As stated earlier, PAs have historically practiced dependent roles with a supervising physician.[257] In 2019, North Dakota

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[250] *See* Sermchief v. Gonzales, 660 S.W.2d 683, 689 (Mo. 1983) (discussing Missouri Supreme Court's decision to overturn lower court's decision and the impact on expanded NP roles under new state nurse acts).

[251] *E.g.*, VA. CODE ANN. § 54.1-2957(I) (West 2022) (requiring a collaboration agreement between an NP and a physician. If NP has practiced for five years or more, they may ask to practice without written agreement if approved by care team physician and Board of Nursing. Virginia is considered a restricted practice state by NP association).

[252] *E.g.*, OR. REV. STAT. § 441.064(3)(c) (2022) (requiring NPs and PAs to co-admit patients with a physician who is a member of the medical staff. NPs are allowed to practice in an expanded role. Oregon is considered a full practice authority state by the NP association).

[253] *E.g.*, KAN. STAT. ANN. §§ 65-1163,1164 (West 2022) (allowing, as of 2022, for NPs to practice independently, without a physician-authorized prescribing protocol or a collaborative practice agreement. NPs may prescribe drugs, including controlled substances).

[254] *Nurse Practitioner Practice Authority: A State-by-State Guide*, *supra* note 97.

[255] Colin Goodman, *Nurse Practitioners: Comparing Two States' Policies*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 168, 172-73 (2013). Oregon is a full practice state for NPs. The Oregon State Board of Nursing (comprised of nurses and two community members), has wide discretion in deciding the scope of practice of NPs. California is a restricted practice state for NPs. California code requires all NPs to collaborate with physicians. Previous bills to allow NPs to practice independently of physicians have been opposed by the California Medical Association and have all failed.

[256] *Scope of Practice Laws*, MERCATUS CTR. (Mar. 22, 2017), https://www.mercatus.org/research/policy-briefs/scope-practice-laws.

[257] Samuel J. Furci, *Physician assistants move from supervision to collaboration*, CREDENTIALING RES. CTR. (Apr. 15, 2020), https://credentialingresourcecenter.com/articles/physician-assistants-move-supervision-collaboration.

became the first state to remove the requirement of a written agreement between a PA and a physician to practice within the state.[258] North Dakota also removed all references to "supervision" and defined the PA scope of practice to align with the Modern PA Practice Act, as reflected in the AAPA Model State Legislation.[259]

The Modern PA Practice Act contains several specific components the AAPA believes all state PA practice acts should include.[260] One key component of the act is that state laws should authorize a PA to prescribe all legal medications, including controlled substances.[261] Another element is removing proximity requirements between PAs and collaborating physicians to promote efficiency and expand access to care.[262] Also included in the act is a provision leaving chart review and cosignatory requirements at the providers' discretion, rather than imposing state law requirements on charting and review activities.[263]

As mentioned throughout this paper, a crucial part of the act is to allow individual PAs and their collaborating physicians, rather than state law, to determine the PA's scope of practice. This would enable healthcare teams to customize practices to meet the needs of patients and adjust to both the education and experience of the PAs.[264] The number of PAs with whom a physician may collaborate should also be determined at the practice level, not by state regulation.[265]

Nurse practitioner scope of practice laws vary significantly from state to state, ranging from restricted practice (direct physician oversight) to full practice (autonomous).[266] Of the twelve states with restricted practice authority, California is representative of the limited scope of practice laws affecting NPs.[267] NP prescribing authority must be under an agreement with a physician.[268] In California, the scope of practice for NPs is the same as for RNs.[269] Some other restricted practice states require supervision

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[258] *PAs Celebrate a Year of Unprecedented Wins at the State Level*, AAPA (Jan. 28, 2020), https://www.aapa.org/news-central/2020/01/pas-celebrate-a-year-of-unprecedented-wins-at-the-state-level/.
[259] *Id.*
[260] *The Six Key Elements of a Modern PA Practice Act*, AAPA (2017), https://www.aapa.org/wp-content/uploads/2017/01/Issue-brief_Six-key-elements_0117-1.pdf.
[261] *Id.*
[262] *Id.*
[263] *Id.*
[264] *Id.*
[265] *Id.*
[266] Ortiz et al., *supra* note 77, at 77.
[267] *Nurse Practitioner Practice Authority: A State-by-State Guide, supra* note 97, *at 3.*
[268] Goodman, *supra* note 255, at 172.
[269] *Id.* at 171.

and/or collaborative agreements with physicians while expanding the NP scope to include the ability to diagnose and manage acute/chronic diseases.[270]

Reduced practice authority states have either a relaxation in the supervision/collaboration agreement requirement or an expansion in NP scope of practice.[271] Alabama is representative of a reduced practice state, requiring a collaboration agreement to practice and a minimum percentage of practice time under the direct supervision of a physician.[272] Although NPs are allowed some autonomy to see and treat patients remotely and without continuous oversight by physicians, they are not truly independent, nor do they have full scope of practice.

Currently, half of all states allow full practice authority to nurse practitioners.[273] In these states, NPs may perform full scope of practice without the need for supervision or collaboration agreements with physicians.[274] Maine is representative of states with full practice authority, as NPs may independently diagnose and treat patients without any physician collaboration.[275] NPs in Maine also have authority to prescribe medications without physician involvement once they have met all specified state requirements.[276]

The National Council of State Boards of Nursing (NCSBN) Model Act contains recommendations for NP scope of practice across the country.[277] The NCSBN Model Act supports full practice authority nationwide for NPs.[278] Under the Model Act, NP licensure is not contingent on collaboration with physicians or oversight by the state medical board in full practice authority states.[279] The NCSBN Model Act thus would not only allow NPs full authority to diagnose and treat patients, but also to order tests and prescribe medications under the exclusive licensure control of the state board of nursing.[280]

VII. LEGAL AND PRACTICAL IMPLICATIONS OF FULL PRACTICE AUTHORITY FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.

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[270] *Nurse Practitioner Practice Authority: A State-by-State Guide*, *supra* note 97, at 3.
[271] *Id.* at 2.
[272] ALA. ADMIN. CODE R. 540-X-7.23(9)(b) (2023); Johnson, *supra* note 2, at 578.
[273] *Nurse Practitioner Practice Authority: A State-by-State Guide*, *supra* note 97, at 21.
[274] *Id.* at 3.
[275] Saltz, *supra* note 64, at 199.
[276] *Id.* at 199-200.
[277] NAT'L COUNCIL OF STATE BD. OF NURSING, NCSBN Model Act, Art. 3, § 3(c) (2021).
[278] *Id.*
[279] *Id.* at Art. III §1-3.
[280] *Id.* at Art. III §2(b).

A. Legal Implications

In the VA health system and states with independent practice authority, there are legal implications for practitioners, patients, health care systems, and insurers.[281] Licensing, credentialling, and liability are important factors to consider when NPs and PAs practice without the supervision or collaboration of a physician, to ensure patient safety and quality care.[282] Expanding scope of practice laws for APPs along with tort reform, such as damage caps, can increase the supply of providers in underserved areas.[283] In the VA health system, the Federal Tort Claims Act (FTCA) and §1151 claims allow patients and their families to file claims against the U.S. government for personal injury due to medical malpractice.[284]

In non-VA health systems, patients and families may file medical malpractice-claims against their individual providers and the healthcare facilities.[285] Many states require NPs and PAs to carry professional liability insurance.[286] Even in states that do not require providers to maintain professional liability insurance, coverage is recommended to protect one's personal assets from a settlement or adverse decision.[287] Healthcare systems usually provide professional liability insurance to their employees, however, some policies may not give them the choice of whether to defend or settle a claim.[288]

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[281] Hansen-Turton, *supra* note 12, at 1251. Independent practice by APPs will bring up legal issues of; standards of care, expert witness qualifications, and duty to refer to physicians (among other things).

[282] *Occupational Licensing and the Opioid Crisis,, supra* note 68, at 895.

[283] Benjamin McMichael, *Beyond Physicians: The Effect of Licensing and Liability Laws on the Supply of Nurse Practitioners and Physician Assistants*, 15 J. EMPIRICAL LEGAL STUD. 732, 736 (2018) (stating how supervision and collaboration are functionally equivalent for the purposes of liability and when NPs, PAs, and physicians all practice independently, tort law can better discourage individual providers from the delivery of unsafe care); *Compare* N.Y. EDUC. LAW § 6902 (McKinney 2016) (referring to a collaborating physician), *with* TENN. CODE ANN. § 63-7-126 (2017) (referring to physician supervision). Collaboration describes the typical working relationship between APPs and physicians while supervision describes the specific oversight required by law.

[284] Fed. Tort Claims Act of 1946, 28 U.S.C. § 1346(b)(1); 38 U.S.C. § 1151 (FTCA and 1151 claims are explained further on the VA.gov website).

[285] B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPEDICS & RELATED RES., 2008, 339, 340-341.

[286] *E.g.,* KAN. STAT. ANN. § 40-3402 (2023) (requiring licensed healthcare providers to maintain professional liability insurance); *See also* NEV. REV. STAT. § 632.238 (2023) (requiring maintenance of professional liability insurance for NP).

[287] Nat'l Ass'n. of Pediatric Nurse Prac. ("NAPNAP"), *Position Statement on Malpractice Insurance for Nurse Practitioners*, 29 J. OF PEDIATRIC HEALTH CARE, Issue 4, A11, A11-12 (2015) (recommending the importance of professional liability insurance to protect NPs).

[288] Am. Acad. of Physician Assistants ("AAPA"), *What PAs Need to Know About Malpractice Insurance*, AAPA (Dec. 7, 2020), https://www.aapa.org/news-central/2020/12/what-pas-need-to-know-about-malpractice-insurance/.

B. Practical Implications

An increase in the number of NPs and PAs (with expanded scopes of practice) can help ease the shortage of primary health care providers in the United States. The potential added benefits of improved access to care could be a decrease in overall healthcare costs with no sacrifice in healthcare quality.[289] One current economic problem for rural health clinics is that Medicare and many third-party payors reimburse NPs and PAs at eighty five percent of physician's fee schedule.[290] Whether or not justified by the difference in education and training, the discrepancy in pay for similar services could make it more difficult for NPs and PAs to practice independently even in full practice authority situations.[291]

The rise in the percentage of employed physicians has also changed the practice environment for NPs and PAs. A majority of physicians in the 20th century were in private practice and paid by fee for service.[292] Nearly seventy five percent of U.S. physicians now work for hospitals, health systems, or corporate entities.[293] NPs and PAs have been and still are usually placed on salary by the medical practice or healthcare system they work for.[294] With the average primary care physician salary being twice that of the average NP or PA salary,[295] health care systems can employ two

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[289] McMichael, *supra* note 283, at 733.
[290] *CMS*, *supra* note 184.
[291] Johnson, *supra* note 2, at 571-72; *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants*, MED. LEARNING NETWORK (Mar. 2022) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf.
[292] Carol K. Kane, *Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners than Employees*, AM. MED. ASS'N ECON. & HEALTH POL'Y RSCH., 1, 7 (May 2019) (noting the decline in physicians as owners fell continuously from 1980s to the present).
[293] Susan Kelly, *Corporate employment of physicians surged during pandemic,* HEALTHCARE DIVE (Apr. 20, 2022), https://www.healthcaredive.com/news/corporate-hospital-employment-physicians-avalere/; PHYSICIAN ADVOC. INST., *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2021* (Apr. 2022), https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf.
[294] Kelli DePriest et al., *Nurse practitioners' workforce outcomes under implementation of full practice authority*, 68 NURSE OUTLOOK, 459, 464 Table 2, (Jul.-Aug. 2020) (indicating that self-employed NPs accounted for less than 20% in all states studied in this article, meaning that the rest are employed by medical practices or health systems); Bhavneet Walia et al., *Increased Reliance on Physician Assistants: an Access-Quality Tradeoff?*, 10 J. OF MKT. ACCESS & HEALTH POL'Y, 1 (2022);
[295] Elizabeth Clarke, *Differences Between a Nurse Practitioner and a Doctor,* NURSEJOURNAL (Nov. 23, 2022), https://nursejournal.org/nurse-practitioner/np-vs-doctor/.

APPs for the price of one physician.[296] Hospitals, health systems, and corporate entities are all increasing the number of NPs and PAs on their staffs to meet patient needs and decrease payroll expenditures.[297] Reimbursement parity by Medicare and other payors would incentivize healthcare system owners to hire more NPs and PAs and at higher salaries.[298]

VIII. MOVING TOWARDS UNIFORM STANDARDS OF CARE

Over the past two decades, changes in state and federal laws have not only increased NP and PA scopes of practice, but also brought attention to the need for a single standard of care for similar services.[299] The VA has authority to establish national standards of practice for healthcare providers in order to standardize medical practice in all VA facilities.[300] The VA allows both NPs and PAs to practice to the full extent of their education, training, and certification, without the clinical supervision of physicians.[301] The VA final rule excludes certified registered nurse anesthetists (CRNAs) from full practice authority in VA facilities.[302]

In non-VA facilities, NPs and PAs are providing primary medical care for the same medical conditions as physicians regardless of whether the state is full or restricted practice.[303] The standard of care each state adopts

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[296] U.S. BUREAU OF LAB. STAT., U.S. Dep't of Labor, *Occupational Outlook Handbook: Physicians and Surgeons* (Sep. 6, 2023), https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm.

[297] Bhavneet Walia et al., *supra* note 293; Brett Kelman & Blake Farmer, *ERs staffed by private equity firms aim to cut costs by hiring fewer doctors*, NPR (FEB. 11, 2023) https://www.npr.org/sections/health-shots/2023/02/11/1154962356/ers-hiring-fewer-doctors; G.T.W.J. van den Brink et al., *The cost-effectiveness of physician assistants/associates: A systematic review of international evidence*, PLOS ONE, (Nov. 1, 2021), at 1; Laura Ramos Hegwer, *NPs, PAs could reduce the costs for caring for complex patients*, HEALTHCARE FIN. MGMT. ASSOC. (Aug. 9, 2019, 10:01 PM), https://www.hfma.org/operations-management/cost-reduction/nps-pas-could-reduce-the-costs-of-caring-for-complex-patients/#.

[298] Alycia Bischof & Sherry A. Greenberg, *Post COVID-19 Reimbursement Parity for Nurse Practitioners*, 26 ONLINE J. OF ISSUES IN NURSING 1 (May 31, 2021), https://ojin.nursingworld.org/table-of-contents/volume-26-2021/number-2-may-2021/post-covid-19-reimbursement-parity-for-nurse-practitioners/.

[299] Hansen-Turton *supra* note 12, at 1251.

[300] Authority of Health Care Providers to Practice in VA, 38 C.F.R. § 17.419 (2020).

[301] Advanced Practice Registered Nurses, 81 Fed. Reg. 90198, 90199 (Dec. 14, 2016) (to be codified 38 C.F.R pt. 17). VA Interim Final Rule 38 CFR 17.419 (allowing for PAs to be granted full practice authority).

[302] Catherine Mumford, *Improving Veteran Access to Critical Care: Full Practice Authority and Nurse Anesthetists*, 32 BYU J. PUB. L. 305, 305 (2018).

[303] Todd Shryock, *Are primary care physicians being replaced?* MED. ECON. (Aug. 31, 2022), https://www.medicaleconomics.com/view/are-primary-care-physicians-being-replaced-.

as applicable to NPs and PAs will have a large impact on medical malpractice claims.[304] For example, the California Supreme Court has held that NPs and PAs do not share the same standard of care with physicians when medical services overlap.[305] Conversely, Louisiana courts have held that NPs and PAs may be held to the same standards as physicians when performing similar professional services.[306] When performing similar services, the question then arises as to whom the NP, PA, or physician will be compared to when determining the appropriate standard of care.[307]

An important issue is how courts define the legal standard of care.[308] The modern legal view of "standard care" is for the physician to use "minimally sound judgment and render minimally competent care in the course of services he provides."[309] Other factors pertinent to this issue are that "the care provided by the doctor may differ from the care of other physicians," however, "a bad outcome does not mean that the standard of care was not met."[310] Also, hindsight cannot be used to evaluate the conduct and judgment of the physician.[311] Finally, the use of clinical practice guidelines (CPGs) to help define standard of care has increased over the past two decades.[312] Currently, there is no set standard as to how these guidelines are used in court cases.[313]

When physicians, NPs, and PAs perform similar professional services and are held to the same standard of care, a further concern is the qualifications of any expert witness who testifies in a medical malpractice case as to that standard of care.[314] The general qualification for a medical expert is "a person who possesses special education and training that will

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[304] Hansen-Turton, *supra* note 12, at 1251.
[305] *Id.* at 1252; *See also* Fein v. Permanente Med. Grp., 38 Cal. 3d 137, 150 (1985) (holding that an NP should be held to the standard of care of a reasonably prudent NP and not, as a matter of law, be measured by the standard of care of a physician or surgeon).
[306] *Id.*; *See also* Butler v. La. State Bd. of Educ., 331 So. 2d 192, 196 (La. Ct. App. 1976), *writ refused sub nom.*, Butler v. La. State Bd. of Educ., 334 So. 2d 230 (La. 1976).
[307] *Id.* at 1251.
[308] Peter Moffett & Gregory Moore, *The Standard of Care: Legal History and Definitions: The Bad and Good News*, WEST J. EMERG. MED., 109, 109 (2011).
[309] Hall v. Hilburn, 466 So. 2d 856, 866 (1985).
[310] Moffett & Moore, *supra* note 308, at 111.; *See generally* McCourt v. Abernathy, 457 S.E. 603, 608 (1995).
[311] Johnston v. St. Francis Med. Ctr., Inc., 799 So.2d 671, 680 (La. App. 2 Cir. 2001) (explaining that hindsight bias is the tendency for people with knowledge of the actual outcome of an event to believe falsely that they would have predicted the outcome).
[312] Moffett & Moore, *supra* note 308, at 111.
[313] *Id.*
[314] Hansen-Turton, *supra* note 12, at 1251. *See also* Cox v. M.A. Primary and Urgent Care Clinic, 313 S.W. 3d 240 (2010) (holding that physician expert not familiar with the PA standard of care and thus was not competent to testify as such).

aid the court in determining whether there was a deviation from the accepted standard of care, and whether that deviation caused harm to the plaintiff."[315] All courts regard NPs as competent to testify to a NP standard of care, PAs as competent to testify to a PA standard of care, and physicians as competent to testify to a physician standard of care.[316]

Problems arise when parties to a malpractice claim use non-physicians to testify to a physician standard of care, non-NPs to testify to an NP standard of care, and non-PAs to testify to a PA standard of care.[317] Usually, courts do not permit NPs to testify as medical experts on the physician standard of care despite similarities in professional services.[318] Similarly, many courts have precluded physicians from serving as medical experts as to the nursing standard of care, even when they have knowledge of that standard.[319] Yet, PAs have not been allowed to testify as medical experts on physician standards of care in most courts.[320] One exception is Nevada's "medical procedure" approach which accepts a physician's testimony as to the standard of care of a physician or nurse if the

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[315] *Id.* at 1252.

[316] *Id.* at 1252-1255; Dooley ex rel. Est. of Pannell v. Cap-Care of Ark., Inc., 338 F. Supp. 2d 962, 966 (E.D. Ark. 2004). B. Sonny Bal, *The expert witness in medical malpractice litigation*, 467 CLIN ORTHOP RELAT RES. 383, 391 (2008). Cox v. M.A. Primary and Urgent Care Clinic, 313 S.W. 3d 240 (2010)

[317] Hansen-Turton, *supra* note 12, at 1253-1255; Cox v. M.A. Primary and Urgent Care Clinic, 313 S.W. 3d 240 (2010)

[318] *Id.* at 1254; Tucker v. Talley, 600 S.E.2d 778, 782 (Ga. Ct. App. 2004) (holding that members of different schools of practice are not competent to testify to each other's practices).

[319] Sullivan v. Edward Hosp., 806 N.E. 2d 645, 657-58 (Ill. 2004) (holding refused to qualify a physician as an expert on the nursing standard of care because he was not a licensed nurse); Land v. Barnes, No. M2008-00191-COA-R3-CV (Tenn. Ct. App. Sept. 10, 2008) in Analysis (finding plaintiff's physician medical expert to be sufficiently familiar with the standard of care for a nurse practitioner to provide relevant testimony); Simonson v. Keppard, 225 S.W. 3d 868, 872 (Tex. Ct. App. 2007) (finding the trial court had erred because the Plaintiff's expert, a physician, did not have knowledge of the standard of care applicable to a nurse practitioner). Courts do not agree as to qualifications for medical experts in cases of overlapping services, however, most require physicians when the defendant is a physician, NP when the defendant is a NP, and PA when the defendant is a PA. Ann Latner, *Who may testify about an NP's standard of care in a legal case?,* CLINICAL ADVISOR (Jan. 13, 2023), https://www.clinicaladvisor.com/home/my-practice/legal-advisor/standard-of-care-malpractice/.

[320] Cox v. M.A. Primary & Urgent Care Clinic, 313 S.W.3d 240, 261 (Tenn. 2010) (holding that Plaintiff's expert, a physician assistant, is not competent to testify as to causation in a medical malpractice case because PAs are only able to render diagnostic or therapeutic services under the supervision, control, and responsibility of a physician).

physician's experience, education, and training establish the expertise necessary to perform the procedure or render the treatment at issue.[321]

When physician, NP, and PA primary care services overlap, their medical care should be subject to the same standard of care. States are split as to what that standard of care is when physicians, NPs, and PAs are performing similar services.[322] Concerned about applying an unfairly high standard, the Illinois Supreme Court disallowed physician testimony in a nursing malpractice case.[323] The Rhode Island Supreme Court has stated that different professionals (NPs, PAs and MDs) rendering the same professional services, may be held to the to the same standard of care regardless of their titles.[324] When physician and APP services overlap, it is not always reasonable to presume they will be performed at the same level of competency.[325]

Allowing physicians, NPs, and PAs to testify on the standard of care in overlapping services cases carries the risk of establishing an erroneous standard if medical experts are not properly vetted.[326] Many studies over the years found the quality of primary care between physicians, NPs and PAs to be comparable, thus the standard of care must also be uniform when evaluating overlapping services.[327] A majority of states, (twenty-nine), along with D.C., have adopted a national standard of care for measuring a medical provider's clinical performance.[328] Alternatively, a minority of states (twenty-one), have adopted a "locality rule" in which the medical provider (physician, NP, PA) is held to that degree of diligence, learning, and skill possessed by the medical provider of the particular locality in

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[321] Staccato v. Valley Hosp., 170 P.3d 503, 504 (Nev. 2007) (holding that a physician or other medical care provider was qualified to testify as to the standard of care if they met the criteria stated, and whether their opinion would assist the jury).
[322] Tsvetelina Gerova-Wilson, *Nursing is Not a Lesser Included Profession: Why Physicians Should Not be Allowed to Establish the Nursing Standard of Care*, 16 QUINNIPIAC HEALTH L. J. 43, 44 (2013); *see* Fein v. Permanente Med. Group, 695 P. 2d. 665, 637-74 (Cal. 1985); *see* Belmon v. St. Frances Cabrini Hosp., 427 So. 2d 541 (La. App. 3rd Cir. 1983).
[323] *Sullivan*, 806 N.E.at 654 (quoting *Galluzzo*, 396 N.E. 2d 13, 16 ((Ill. 1979)).
[324] Janette A. Bertness, *Rhode Island Nurse Practitioners: Are They Legally Practicing Medicine Without a License?,* 14 ROGER WILLIAMS U. L. REV. 215, 243 (2009) (citing Sheeley v. Memorial Hosp., 710 A.2d 161, 166 (R.I. 1998)).
[325] Gerova-Wilson, *supra* note 322, at 72; *see also* Erin Sarzynski & Henry Barry,*Current evidence and controversies: advanced practice providers in healthcare*, 25 AM. J. MANAG. CARE 366, 366-368 (2019).
[326] *Id.* at 67.
[327] Inst. of Med. *supra* note 35, at 337 (finding that patient outcomes in this study and other studies have consistently comparable care by physicians, NPs, and PAs).
[328] McLean, *supra* note 192, at 227; *see also* C. Jerry Willis, *Establishing standards of care: Locality rules or national standards* (Feb. 2009).

which they practice.[329] In full practice authority states, there should ideally be one "national standard" for primary care providers regardless of their professional title (M.D., NP, or PA).

IX. RECOMMENDATIONS FOR WHAT A "DEREGULATED" PRACTICE ACT WOULD LOOK LIKE

To achieve a nationwide full practice environment for NPs and PAs, state legislatures would need a Model Act acceptable to a majority of all stakeholders, including NPs, PAs, patients, payors, and legislators. Once the Model Act has been created, it will have to be approved by the National Council of State Boards of Nursing (NCSBN) and the American Academy of Physician Assistants. Consensus among the parent organizations could help improve the chances of expanding scopes of practice for APPs in states with restricted or reduced practice. Finally, the provisions of the Act would need to be discussed and then voted into law by the individual states that do not already have full practice authority. Regardless of educational background, both NPs and PAs must have graduated from approved programs and been certified by their respective accrediting bodies. Further, NPs or PAs wishing to be licensed with full practice authority should need to show prior clinical experience in primary care after school training to ensure competence and patient safety.

Licensure of NPs and PAs should be broadly worded as "licensed health professionals" and not tied to any physician's license.[330] State laws should authorize NPs and PAs to prescribe, order, administer and dispense pharmacological agents including controlled substances and devices.[331] Scope of practice for experienced NPs and PAs should include the diagnosis and treatment of patients, independent of a physician.[332] Consultation and collaboration with other healthcare providers, including physicians, should be at the discretion of the NP or PA.[333] NPs and PAs

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[329] McLean, *supra* note 192, at 227; *see also* 61 AM. JUR. 2d. Physicians, Surgeons, & Other Healers § 200 (2002).

[330] *The Six Key Elements of a Modern PA Practice Act*, *supra* note 159, at 1 (using the term "licensed health professional" to denote a medical provider on par with a physician).

[331] NCSBN Model Act, *supra* note 277, at 5; *see also The Six Key Elements of a Modern PA Practice Act*, *supra* note 159, at 1.

[332] *Nurse Practitioner Practice Authority: A State-by-State Guide, supra* note 97 (noting that in full practice authority states, nurse practitioners are able to diagnose and treat patients on their own); *The Six Key Elements of a Modern PA Practice Act, supra* note 159, at 2.

[333] NCSBN Model Act, *supra* note 277, at 5 (discussing the removal of mandated collaboration agreements with physicians).

should be entitled to full reimbursement equal to that of physicians for similar services.[334]

NPs and PAs should be allowed to participate in practice ownership with other providers including physicians.[335] Supervising and co-signing by physicians of experienced NPs and PAs should no longer be required.[336] NPs and PAs should be held responsible (medico-legally) for their own actions.[337] NPs, PAs, and physicians should be held to the same standard of care when performing overlapping services.[338]

X. CONCLUSION

Health care would be enhanced by allowing experienced NPs and PAs full scope of practice, including the diagnosis and treatment of patients, independent of a physician.[339] Eliminating physician supervision requirements on NPs and PAs, and expanding their scope of practice could enhance consumer access to primary health care.[340] Professional regulation should allow experienced NPs and PAs to practice independently as multiple studies comparing providers (physicians, NPs and PAs) have shown no statistically significant difference in patient safety or quality when performing similar services.[341] When working as independent medical providers, NPs and PAs are solely responsible

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[334] *The Six Key Elements of a Modern PA Practice Act*, *supra* note 159, at 1-2. *See* Alycia Bischof & Sherry Greenberg, *Post COVID-19 Reimbursement Parity for Nurse Practitioners*, 26 ONLINE J.OF ISSUES IN NURSING (2021); *see also* Debra Wood, *MedPAC Discusses Reimbursement Equality for NPs and PAs,* AMN Healthcare, https://www.amnhealthcare.com/amn-insights/news/medpac-discusses-reimbursement-equality-for-nps-and-pas/ (April 12, 2013).

[335] *Id.* at 2. (discussing that NPs and PAs are currently barred from becoming equal shareholders in medical practices with physicians).; Kelli DePriest et al, *Nurse practitioners' workforce outcomes under implementation of full practice authority*. NURSING OUTLOOK (Jul. – Aug. 2020), 68(4): 459-467. *See also Practice Ownership: Legal and Business Considerations for the Nurse Practitioner Owner*, NURSE KEY, https://nursekey.com/practice-ownership-legal-and-business-considerations-for-the-nurse-practitioner-owner/ (Sept. 9, 2016).

[336] *The Six Key Elements of a Modern PA Practice Act*, *supra* note 159, at 2-3. (discussing the requirements for supervision and co-signatures by physicians).

[337] Battaglia, *supra* note 49, at 1142; *See also Liability Considerations as Nurse Practitioners' Scope of Practice Expands*, NURSES SERVS. ORG., https://www.nso.com/Learning/Artifacts/Articles/Liability-considerations-as-nurse-practitioners%E2%80%99-scope-of-practice-expands (last visited Nov. 26, 2023).

[338] Hansen-Turton, *supra* note 12, at 1252. Butler v. La. State Bd. of Educ., 334 So. 2d 230 (La. 1976). *See* NAT'L COUNCIL OF STATE BD. OF NURSING, *supra* note 277.

[339] *See* NAT'L COUNCIL OF STATE BD. OF NURSING, *supra* note 277, at 5; Davis et al., supra note 31, at 336.

[340] Wolf, *supra* note 156, at 26-27.

[341] *Occupational Licensing and the Opioid Crisis*, *supra* note 68 at 900.

(medico-legally) for their actions.[342] Finally, all autonomous providers (be they physicians, NPs, or PAs) should be held to the same standard of care for similar medical services.[343]

APPENDIX

List of states by level of supervision requirements for Nurse Practitioners:[344]

Restricted Practice: NPs must work under the supervision of a physician for all of their scope of practice in the following states:

California, Georgia, Michigan, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Vermont, Virginia

Reduced Practice: NPs can perform some of their scope of practice without physician supervision in the following states:

Alabama, Arkansas, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Jersey, Ohio, Pennsylvania, West Virginia, Wisconsin

Full Practice: NPs can perform the full scope of practice without a supervising or collaborating physician in the following states:

Alaska, Arizona, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Oregon, Rhode Island, South Dakota, Utah, Washington, Washington, D.C., Wyoming

List of states by level of practice for Physician Assistants:[345]

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[342] Battaglia, *supra* note 49, at 1142. *What PAs Need to Know, supra* note 196.
[343] Butler v. La. State Bd. Of Educ., 331 So. 2d 192, 196 (La. App. 3 Cir. 1976), cert. *denied*, 334 So. 2d 230 (La. 1976), *aff'd*, Belmont v. St. Frances Cabrini Hosp., 427 So. 2d 541 (La. App. 3 Cir. 1983).
[344] *Nurse Practitioner Practice Authority: A State-by-State Guide*, *supra* note 97, at 4-22 (showing the current state nursing statutes and regulations for every state, access the title: State-by-State NP Practice Authority, and select the state of interest).
[345] *PA State Practice Environment*, *supra* note 139 (showing the current state physician assistant scope of practice for every state, access the title: American Medical Association

Reduced Practice: Limited delegated authority and/or restrictive supervision requirement in the following states:

Washington, Montana, Nevada, Colorado, Kansas, Missouri, Kentucky, Pennsylvania, Maryland, Mississippi, Alabama, Georgia, South Carolina, Florida, Hawaii

Moderate Practice: State law and/or regulation requires additional administrative burdens that limit flexibility in the following states:

California, Idaho, Arizona, South Dakota, Nebraska, Iowa, Oklahoma, Texas, Louisiana, Indiana, Ohio, Tennessee, New York, New Jersey

Advanced Practice: PAs practice to the full extent of their education, training, and experience, but must comply with additional administrative requirements in the following states:

Oregon, New Mexico, Minnesota, Wisconsin, Illinois, Michigan, Arkansas, West Virginia, Virginia, North Carolina, Vermont, New Hampshire, Maine, Massachusetts, Connecticut, Rhode Island, Alaska

Optimal Practice: Advanced practice with guidelines being left to the healthcare team rather than state laws and regulations in the following states:

North Dakota, Wyoming, Utah

(AMA) Advocacy Resource Center, Physician Assistant scope of practice and view the chart).