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Expanding the Scope of Practice for Advanced Practice Registered Nurses: A

Legislative Call to Action

By A.J. Barbarito*

Part I: Introduction

Advanced Practice Registered Nurses (APRNs) are skilled clinicians, whose expertise could aid immensely in the expansion and affordability of health care in the United States. Unfortunately, their practice is often hobbled by cumbersome collaborative agreements with physicians. A 2011 Institute of Medicine (IOM) report on the future of nursing recommended *inter alia* that "[n]urses should practice to the full extent of their education and training."¹ This would entail uncoupling APRNs from physician oversight of their practice, as current regulation in most states mandates that APRNs must operate to some extent in collaboration with, and accountable to, a supervising physician.

While many states currently have legislation in place—or pending—granting APRNs the right to practice to the extent of their training, the expansion of APRN roles in the care of patients is not without controversy.² The IOM report received backlash from physician groups, including the American Medical Association, who urged that such expansion would not improve quality of care, ostensibly because nurses do not receive the level of training that physicians receive.³ However, such concerns are almost entirely unsupported by empirical studies. Moreover, this

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¹ NST. OF MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH S-4 (2011) [hereinafter IOM FUTURE OF NURSING REPORT], *available at*

http://www.thefutureofnursing.org/sites/default/files/Future%20of%20Nursing%20Report_0.pdf.

² NAT'L ASSOC. OF CLINICAL NURSE SPECIALISTS, SCOPE OF PRACTICE FAQs FOR CONSUMERS 2-3 <http://www.nacns.org/docs/toolkit/3A-FAQScope.pdf> (last visited Mar. 15, 2015).

³ Press Release, American Medical Assoc., AMA Responds to IOM Report on Future of Nursing (Oct. 5, 2010) *available at* <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>.

interference from physicians, in the face of ample evidence that APRNs supply care that is at least favorably comparable to that of physicians, calls into question whether physicians have patients' best interests in mind, or whether their attitudes and actions are in fact anti-competitive. The question then becomes whether physicians' opposition puts them at risk of antitrust liability.

This Note proceeds in three parts. Part II introduces the reader to APRNs, including their training, education and practice, and the data available on their competency as healthcare practitioners. It also discusses the clinician shortages and expanded Medicaid and insurance coverage that leads to the necessity of expanded access to health care.

Part III discusses the current legislative scheme that regulates the scope of practice for APRNs. It then explores the Institute of Medicine's report, and efforts from various agencies advocating the expanded scope of practice for APRNs. This Note calls upon current legislatures, especially New Jersey's, to amend laws governing the practice of nursing to expand their scope of practice.

Part IV discusses physician opposition to this legislative action, and opines that this is motivated by anticompetitive rather than patient care concerns; this section suggests possible remedies, concluding with the proposition that while antitrust actions may provide some limited remedies for isolated cases of blatant anti-competitive behavior, the issue must ultimately be resolved by state legislatures.⁴

Part II: APRN Background and Regulation

A: Introduction to APRN

⁴ This Note does not argue or advocate for expanded scope of practice for any professions aside from that of APRNs. While I acknowledge that certain other practitioners, including chiropractors, naturopaths, and various others argue for expanded scope of practice rights, these professions are starkly distinct from APRNs, and their arguments for expanded scope of practice are not meant to be supported by the research found in this Note, nor does this Note recognize such as "medical" practitioners.

“APRN” is a specific category of nursing professional as defined by most state practice laws.⁵ An APRN is a medical professional with an advanced nursing (post-graduate) degree in one of four specialties: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP).⁶ Each of these healthcare practitioner categories specialize in the care of at least one population, including family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women’s health/gender-related, or psych/mental health.⁷ There has been some discussion regarding whether APRNs should complete a residency program for clinical training, and there currently exist several such programs throughout the US.⁸ Many institutions conferring APRN degrees carry a credit load which, in other health care degree programs, would be equivalent to a doctoral degree.⁹

Each APRN specialist is trained in a specific area of health care. The CRNA is trained to provide anesthesia for a diverse spectrum of patients in diverse locations.¹⁰ He or she will administer anesthesia to both healthy and severely ill patients, for a wide variety of procedures, in settings that include “hospital surgical suites and obstetrical delivery rooms; critical access

⁵ Daniel J. Gilman & Julie Fairman, *Antitrust and the Future of Nursing: Federal Competition Policy and the Scope of Practice*, 24 HEALTH MATRIX 143, 145 (2014).

⁶ APRN Consensus Work Grp., Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education 5 (Nat’l Council of State Boards of Nursing 2008) [hereinafter NCSBN CONSENSUS MODEL], https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf (last visited Mar. 15, 2015).

⁷ *Id.*, at 6.

⁸ Kate Darby Rauch, *Are Residencies the Future of Nurse Practitioner Training?*, SCIENCE OF CARING (Jan., 2013), <http://scienceofcaring.ucsf.edu/future-nursing/are-residencies-future-nurse-practitioner-training#sthash.mROjZli6.dpuf>.

⁹ Am. of Colleges of Nursing, *The Doctor of Nursing Practice* (2013), <http://www.aacn.nche.edu/media-relations/fact-sheets/DNPFactSheet.pdf> (last visited Mar. 15, 2015); The subjects of whether the Doctor of Nursing Practice (DNP) degree should be a prerequisite to APRN status, and the AMA’s “Truth in Advertising” campaign focusing on allegedly misleading applications of the DNP degree are not addressed in this Note.

¹⁰ See NCSBN CONSENSUS MODEL, *supra* note 6, at 8.

hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons.”¹¹

The CNM provides a wide variety of care to women, “including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn.”¹² Their patients occasionally include the male partners of their female patients, for treatment of sexually transmitted diseases and reproductive health.¹³ The CNM practices in many settings, including “home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.”¹⁴

The CNS “is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities,” integrating care between and among the three spheres of influence: patient, nurse, and system.¹⁵ His or her primary goal is to improve patient outcomes and the quality of nursing care, and while the CNS has traditionally worked in hospitals, the role is expanding into nursing homes, schools, home care, and hospice.¹⁶ The CNS role has historically experienced ambiguity, such that they have assumed many roles, including “staff and patient educator, consultant, supervisor, project director, and more recently, case manager.”¹⁷ The CNS concept was developed in World War II, when the need emerged to have highly qualified nurses involved in patient care.¹⁸

¹¹ *Id.*; see also American Assoc. of Nurse Anesthetists, *Qualifications and Capabilities of the Certified Registered Nurse Anesthetist*, <http://www.aana.com/ceandeducation/becomeacrna/Pages/Qualifications-and-Capabilities-of-the-Certified-Registered-Nurse-Anesthetist.aspx> (last visited Mar. 15, 2015).

¹² See NCSBN CONSENSUS MODEL, *supra* note 6, at 8.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*, at 8-9.

¹⁶ *Id.*

¹⁷ Michalene Jansen et al., *Advanced Practice Nursing 21* (3rd ed. Springer Publ'g 2009).

¹⁸ *Id.*, at 20.

NPs are perhaps the most recognizable of the four APRN roles, and they are especially ubiquitous in their areas of specialty. NPs “diagnose; develop differential diagnoses; order, conduct, supervise, and interpret diagnostic and laboratory tests; and prescribe pharmacologic and nonpharmacologic treatments in the direct management of acute and chronic illness and disease,” and they perform all of these roles across virtually every medical specialty and subspecialty.¹⁹ NPs may practice autonomously or in collaboration with other healthcare professionals.²⁰

B: APRN Training

Regarding the sufficiency of APRN education and training, the American Association of Nurse Practitioners (AANP) highlights the fact that nursing students start their formal healthcare education before entering graduate school (as opposed to physicians, who begin such training in medical school), and this training includes “physical assessment skills, interpreting diagnostic test results, [and] evaluating the appropriateness of medications and patients’ responses to treatments in both hospital and community settings.”²¹ The AANP observes further that nursing education is based upon competency, rather than time, and quotes a physician from the American Academy of Family Physicians (AAFP)—an organization that actively opposes scope of practice reformation—criticizing the current method in medical education of using time, rather than competency, as the yardstick for measuring successful education.²²

¹⁹ *Id.*, at 16; *What’s an NP?*, AM. ASSOC. OF NURSE PRACTITIONERS (Mar. 15, 2015), <http://www.aanp.org/all-about-nps/what-is-an-np>.

²⁰ *What’s an NP?*, AM. ASSOC. OF NURSE PRACTITIONERS (Mar. 15, 2015), <http://www.aanp.org/all-about-nps/what-is-an-np>.

²¹ *Clinical Outcomes: The Yardstick of Educational Effectiveness*, AM. ASSOC. OF NURSE PRACTITIONERS (Mar. 15, 2015), <http://www.aanp.org/images/documents/publications/clinicaloutcomesyardstick.pdf>.

²² *Id.*, (“Both in medical student education and residency, we have clung to the belief that if you spend a certain amount of time learning about something, then you must know it,” he told AAFP News Now. “That’s as ridiculous as thinking that a teenager should be given a (driver’s) license just because he or she spent a set number of hours behind the wheel of a car”); see also Anna-Lena Nieminen, Bodil Mannevaara & Lisbeth Fagerström, *Advanced Practice Nurses’ Scope of Practice: A Qualitative Study of Advanced Clinical Competencies*, 25 *Scandinavian J. of Caring Sci.* 662, 661-670 (2011) (many researchers relate RNs’ clinical competence to the nurse-patient relationship while relating the quality of nursing care to a population’s health needs []). The description of clinical competence varies from tasks to be done to a holistic view that includes knowledge, skills, ability, and ethical conduct []. Several

C: APRN Regulation

In many states, APRNs are restricted by local regulatory schemes that prevent them from practicing to the full extent of their education. Specifically, “Scope of Practice”, a term used with all licensed health practitioners, describes “the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field.”²³ Under the current regulatory scheme of most states, even though APRNs receive training that qualifies them to practice in areas beyond these limits, they are either entirely denied the right to do so, or must work under restrictive collaborative agreements, wherein they ostensibly are supervised by a physician.²⁴ As will be demonstrated in this Note, these regulatory schemes have nothing to do with empirical evidence regarding patient outcomes, competency, or malpractice concerns; rather, they are simply an outgrowth of unsubstantiated and misleading claims by physicians’ groups that the traditional patriarchal system of physician-led healthcare teams must be preserved.

1- Expanding Scope of Practice - Access

researchers emphasize that both practical and theoretical knowledge are part of professional clinical competence []. Clinical competence is based on a nurse’s ability to integrate nursing science and other sciences into his/her clinical competence []. The practical knowledge in clinical nursing care is also formed through role models []. An RN’s clinical competence consists of his/her personal ability and capability in implementing knowledge in different nursing contexts and situations in cooperation with others).

²³ FED’N OF STATE MED. BOARDS, ASSESSING SCOPE OF PRACTICE IN HEALTH CARE DELIVERY: CRITICAL QUESTIONS IN ASSURING PUBLIC ACCESS AND SAFETY (2005), http://library.fsmb.org/pdf/2005_grpoI_scope_of_practice.pdf (last visited Mar. 16, 2015).

²⁴ AM. ACAD. OF FAMILY PHYSICIANS, GUIDELINES ON THE SUPERVISION OF CERTIFIED NURSE MIDWIVES, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS (2008), http://www.aafp.org/dam/AAFP/documents/news/NP_Info_GlinesNP-060710.pdf (last visited Mar. 16, 2015); Joanne Pohl et al., The Latest Data On Primary Care Nurse Practitioners And Physicians: Can We Afford To Waste Our Workforce?, HEALTH AFFAIRS BLOG (Jun. 18 2013) (“More than half the states require physician supervision or collaboration for an NP to practice, despite the lack of any data to support the need for such a regulation”).

The current impetus for APRN scope of practice expansion is the gap in access to quality medical care, especially primary care. The number of physicians entering into primary care or internal medicine is steadily decreasing, while the number of nurse practitioners (NPs) is increasing.²⁵ The AMA has cited experts predicting a shortage of more than 45,000 primary care physicians by 2020.²⁶ This shortage is attributed to several factors, including increased demand for healthcare brought on by the aging of the “baby boomer” generation as well as the influx of newly insured Affordable Care Act beneficiaries, and decreased supply, resulting from a large class of primary care physicians retiring (also baby boomers), and decreased interest from medical students in primary care, largely due to its low reimbursement rates.²⁷ While there is disagreement over the extent of the shortage, experts agree that poor urban and rural areas are most affected.²⁸ APRNs, if un-tethered from supervising physicians, would be able to expand into rural areas that physicians eschew.²⁹ Currently, 18% of NPs practice in such rural areas, while CNMs attend a “substantial portion of births” and CRNAs are the sole anesthesia providers in 85% of those rural areas.³⁰ This is possible because in many of these rural states, scope of practice for APRNs has already been expanded to allow either a more liberal collaborative agreement, or have altogether disbursed with collaborative agreements, allowing full scope of practice.³¹

²⁵ Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 24 Health Aff. 893, 893-894 (2010).

²⁶ Press Release, American Medical Assoc., AMA Urges Continued Support for Adequate Graduate Medical Education Funding to Meet Future Physician Workforce Needs (July 29, 2014) *available at* <http://www.ama-assn.org/ama/pub/news/news/2014/2014-07-29-support-graduate-medical-education-funding.page>.

²⁷ Mark D. Schwartz, *Health Care Reform and the Primary Care Workforce Bottleneck*, 27 J. of Gen. Internal Med. 469, 469-472 (2012); Stephen C. Schimpff, *Why is there a shortage of primary care physicians?*, KEVINMD.COM (Feb. 17, 2014) <http://www.kevinmd.com/blog/2014/02/shortage-primary-care-physicians.html>.

²⁸ The Editorial Bd., *Bottlenecks in Training Doctors*, N.Y. Times, July 19, 2014 at , http://www.nytimes.com/2014/07/20/opinion/sunday/bottlenecks-in-training-doctors.html?_r=1 (last visited Mar. 16, 2015).

²⁹ Sylvia Smith, *Nurse Practitioners Fill the Gap*, AARP THE MAGAZINE, AARP.ORG, (AUG.-SEPT., 2014), <http://www.aarp.org/health/healthy-living/info-2014/nurse-practitioners-fill-the-gap.html>.

³⁰ Kelly A. Goudreau et al., *Health Policy and Advanced Practice Nursing* 33 (Springer Publ'g 2013).

³¹ See discussion, Part III, *infra*.

2 – Economic Benefits

The other impetus for legislation is the possible economic benefits of expanded scope, though even the IOM report concedes that an analysis of those benefits is problematic.³² However, one study in 2009 projected that Massachusetts (which at the time was the only state to have passed sweeping health care legislation) could save \$4.2 to \$8.4 billion on health care between 2010-2020 by expanding scope of practice for NPs.³³ That study further proposed that encouraging use of CNMs for low-risk pregnancies and CRNAs for certain surgeries could similarly reduce costs.³⁴ Linked to this finding is the proposal, in the same report, that promotion of “retail clinics”; i.e., clinics found in retail shopping centers and drug stores, could save the State \$6 billion between 2010-2020.³⁵ The link stems from the fact that generally, NPs are the ones who staff such clinics, and they would need full prescriptive abilities to convey the benefits.³⁶ It should be noted, however, that the economic motive is secondary to the overall goal of promoting access to and quality of care, and since part of the agenda for APRNs is to achieve parity of reimbursement with physicians for equal service, the economic benefit could ultimately prove negligible.³⁷

Part III: Legislating Scope of Practice Barriers

A: Federal Legislation

³² IOM FUTURE OF NURSING REPORT, *supra* at 1-8.

³³ Christine E. Eibner et al, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, 103-104 (Rand 2009).

³⁴ *Id.*, at 108.

³⁵ *Id.*, at 87.

³⁶ *Id.*, at 85.

³⁷ Patricia L. Starck, *The Cost of Doing Business in Nursing Education*, 21 J. of Prof. Nursing 183, 185 (2005); IOM FUTURE OF NURSING REPORT at S-8.

The IOM report makes separate recommendations for federal and state legislative action. Regarding federal action, it recommends: (1) Expanding Medicare to cover APRN services currently allowed under state law, as PCPs are covered, and at the same rates; (2) Amending Medicare to authorize certain APRN admitting privileges and certifications; (3) Extending the ACA Medicaid reimbursement increases for primary care physicians to cover APRN services; (4) Limiting federal funding for nursing programs only to states that have adopted the National Council of State Boards of Nursing (NCSBN) advanced practice registered nurse model rules and regulations.³⁸

1: Expanding Medicare

Current Medicare Conditions of Participation enable CRNAs and CNMs to perform services without a collaboration agreement with physicians in order to be reimbursed, though neither will necessarily receive reimbursement equal to that of a physician performing the same procedure.³⁹ By contrast the Conditions of Participation require that an NP or a CNS must work in collaboration with a physician, *despite* the existence of a more permissive state scope of practice scheme.⁴⁰ Medicare reimburses the NP or CNS up to 85% of what a physician would earn for the same service.⁴¹ The committee advising Congress on the matter has not provided an analytical justification for the difference in reimbursement rates.⁴² Since insurance companies take their cues

³⁸ *Id.*; APRN Joint Dialogue Group Report, July 7, 2008 at 7; Robert Pear, *As Medicaid Rolls Swell, Cuts in Payments to Doctors Threaten Access to Care*, N.Y. Times, Dec. 27, 2014, http://www.nytimes.com/2014/12/28/us/obamacare-medicare-fee-increases-expiring.html?_r=2 (last visited Mar. 17, 2015)(the increased reimbursement expired on December 31, 2014).

³⁹ DEP'T OF HEALTH AND HUMAN SERVICES CTRS FOR MEDICARE & MEDICAID SERVICES, MEDICARE INFORMATION FOR ADVANCED PRACTICE REGISTERED NURSES, ANESTHESIOLOGIST ASSISTANTS, AND PHYSICIAN ASSISTANTS (2011).

⁴⁰ *At-a-Glance Billing Guidelines*, TEX. MED. ASS'N., <http://www.texmed.org/Template.aspx?id=2273> (last visited Mar. 17, 2015).

⁴¹ *Id.*

⁴² Amanda Cassidy, *Nurse Practitioners and Primary Care*, HEALTH AFF., Oct. 25, 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=79. (“The Medicare Payment Advisory Commission, the federal agency that advises Congress on Medicare issues, found that there was no analytical foundation for this difference.”).

from Medicare regarding reimbursement rates for APRN services, an increase in the Medicare reimbursement rate could therefore affect the insurance reimbursement rate.⁴³

2: Amending Medicare

The goal to amend Medicare was introduced because, as it is currently written, Medicare will only allow a physician (not an APRN) to certify patients for, *inter alia*, home health and hospice care.⁴⁴ This kind of care allows Medicare recipients to receive certain personal care services—including end of life and palliative care—at home, rather than in an extended-stay hospital or nursing home.⁴⁵ Approximately 33% of Medicare beneficiaries experienced some kind of adverse effect as a result of a stay at a skilled nursing home.⁴⁶ Furthermore, the vast majority of seniors favor granting more access for the elderly and infirm to at-home care.⁴⁷ Giving APRNs the ability to certify this type of care would improve access and expediency for this service.⁴⁸ Again, though, Congress has failed to act in this regard.

3: Reimbursement

⁴³ Lorraine Bock, *Changing Reimbursement Policies*, ADVANCE HEALTHCARE NETWORK FOR NPs AND PAs, <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/Changing-Reimbursement-Policies.aspx> (last visited Mar. 17, 2015); see also 42 USCS § 1395b-6 (LEXIS 2015)(establishing the Medicare Payment Advisory Commission, which advises Congress on payment policies under Medicare).

⁴⁴ 42 USCS § 1395f (LEXIS 2015); see also <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/27/how-obamacare-is-ramping-up-a-health-care-turf-war/>.

⁴⁵ Andrea Brassard, *Removing Barriers to Advanced Practice Registered Nurse Care: Home Health and Hospice Services*, 66 INSIGHT ON THE ISSUES 1, 2 (Jul. 2012) available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/removing-barriers-advanced-practice-registered-nurse-home-health-hospice-insight-july-2012-AARP-ppi-health.pdf.

⁴⁶ *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL 1, 17-22 (2014), <http://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>.

⁴⁷ Brassard, *supra* note 45, at 4.

⁴⁸ *Id.*

The third IOM recommendation called for extending to APRNs the ACA reimbursement for primary care physicians. The provision in question increased mandatory Medicaid rates paid to certain primary care physicians to equal the rates paid by Medicare for the same services.⁴⁹ This provision expired in 2014, however, after an extension failed to escape committee in the Republican-controlled Congress.⁵⁰ This recommendation was essentially no different from other reimbursement equity provisions envisioned by the Report, except that its acceptance could have theoretically increased health care access into underserved areas. Many of the underserved receive their health care from Medicaid-funded community health centers.⁵¹ Those health centers receiving the benefit of Medicaid expansion granted by the ACA saw an increase in staff in all areas *except* NPs, even though NPs account for a large portion of the providers in such facilities.⁵²

Additionally, given the ACA's use of the word "clinicians" rather than "physicians" in much of its language, there seems to be a presumption in favor of diversified healthcare practitioners.⁵³ Furthermore, the provision for Centers of Medicare and Medicaid Innovation (CMMI) have presumably left the door open for the inclusion of APRNs in future projects, once the second round of funding for those projects comes around.⁵⁴

4: Limiting Federal Funding to Consensus Model States

⁴⁹ DEP'T OF HEALTH & HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICAID PROGRAM; PAYMENTS FOR SERVICES FURNISHED BY CERTAIN PRIMARY CARE PHYSICIANS AND CHARGES FOR VACCINE ADMINISTRATION UNDER THE VACCINES FOR CHILDREN PROGRAM 1, 3 (2009), <http://www.beckersasc.com/docs/oldmedia/CMSFinalRulePCPMedicaid.pdf>.

⁵⁰ Pear, *supra* note 38.

⁵¹ THE KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND COMMUNITY HEALTH CENTERS: THE RELATIONSHIP BETWEEN COVERAGE FOR ADULTS AND PRIMARY CARE CAPACITY IN MEDICALLY UNDERSERVED COMMUNITIES 1, 2 (KAISER 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8293.pdf>.

⁵² *Id.*

⁵³ Jansen, *supra* note 17, at 90.

⁵⁴ *Id.*, The CMMI is program within the Centers for Medicare and Medicaid Services (CMS) created by the ACA, which allows more freedom for CMS to experiment with new and innovative approaches to healthcare. Innovations provided for in the legislation include, *inter alia*, insurance exchanges for those not covered by government or third party insurance programs, a Medicare accountable care organization pilot program, and a program to provide funding for the transitional care of patients being discharged from hospitals. The funding for these programs is not necessarily limited to only physicians.

The fourth recommendation—limiting federal funding [for what] to those states that have adopted the NCBSN Consensus Model—is arguably the most effective tool to wrangle the States into uniformity on the issue of APRN scope of practice.

a: The Consensus Model

The Consensus Model is the product of approximately 4 years of discussion between 23 nursing organizations and the National Council of State Boards of Nursing (NCSBN).⁵⁵ The NCBSN is an independent, not-for-profit association through which state boards of nursing act to standardize certain practices affecting nursing professions.⁵⁶ The NCBSN coalesced with these other nursing organizations to form the consensus model in order to rein in the chaotic nature of APRN regulation and implement a stable and systematic expression of the designation, finally bringing together a coherent system that covers licensure, accreditation, certification, and education (LACE).⁵⁷ The Model Act (for the practice of nursing) and Model Rules emerged from this effort.⁵⁸ As states implement the consensus model, state regulation nationwide will move closer to uniformity in scope of practice regulation.⁵⁹ Withholding federal funding for nursing education from those states that do not conform to the consensus model could be a very effective stick in creating state consensus; however, there is no sign at all of congressional action in this area.

5: Spurring Action

⁵⁵ *Id.*, at 57.

⁵⁶ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, <https://www.ncsbn.org> (last visited Mar. 19, 2015).

⁵⁷ Jansen, *supra* note 17, at 59.

⁵⁸ NCSBN CONSENSUS MODEL, *supra* note 6.

⁵⁹ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, <https://www.ncsbn.org/5397.htm> (last visited Mar. 19, 2015) (map showing the current landscape of implementation).

This leads to the question of what exactly is needed to spur Congressional action to meet the IOM goals. Health care is currently a huge source of contention in Congress, but nursing itself can be a bi-partisan issue. A brief overview of the regions allowing expansive scope of practice compared with stricter jurisdictions shows, that while the traditionally “red” southeast region is en masse the most restrictive region, traditionally “blue” stronghold states like New York, New Jersey, and California are also restrictive.⁶⁰ On the other hand, the Southeast (besides California) and the Northwest grant the most uniformly expansive scope of practice rights.⁶¹ The inference, given the demographics, is that the more rural states of the country (again, discounting the Southeast) are the most open to expansive scope of practice. It would be preposterous to propose that APRNs are simply more qualified to deliver medical care in rural areas than in urban ones; therefore, the only deciding factor seems to be that more populous states have some reason other than medical skill to limit APRN scope of nursing. The implication is antitrust, which will be discussed *infra*. In the meantime, the implication for Congressional action is that the matter is of bipartisan concern, and could probably be addressed without major partisan rancor, given enough interest. Perhaps it could even be addressed in legislation amending the ACA. Of course, the great disparity between the amounts of lobbying money contributed by the American Nurses Association (\$1,467,064 in 2014) versus the amount contributed by the AMA (\$19,650,000 in 2014) may help to explain the reluctance of Congress to address the issue.⁶²

⁶⁰ BARTON ASSOCIATES, <http://www.bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/> (last visited Mar. 19, 2015) (interactive graphic representing various scope of practice laws in U.S.).

⁶¹ *Id.*

⁶² OPENSECRETS.ORG, <http://www.opensecrets.org/orgs/summary.php?cycle=2014&id=D000000173> (last visited Mar. 19, 2015); *Id.*, at <http://www.opensecrets.org/lobby/clientsum.php?id=D000000068> (last visited Mar. 19, 2015).

B: Recommendations for the States

The IOM report recommends that state legislatures (1) Reform scope of practice regulations to conform to the NCBSM model Act and Rules; and (2) “Require third-party payers that participate in fee-for-service payment arrangements to provide direct reimbursement to [APRNs] who are practicing within their scope of practice under state law.”⁶³ This means that private insurance companies would have to reimburse APRNs directly for specific services if those services fall within a state’s scope of practice for APRNs, rather than requiring a collaborative agreement with a physician.

1: Reforming Scope of Practice Laws

a: Collaborative Agreements

A collaborative agreement is a metaphorical tether, binding APRNs to a supervising physician.⁶⁴ A typical collaborative agreement, such as the kind required in New Jersey, require the APRN and physician to establish joint protocols for the treatment of patients, and the immediate presence or electronic availability of the collaborating physician.⁶⁵ The more onerous of such statutes requiring agreements, like Missouri’s contain stringent geographic proximity requirements and bi-monthly review of patient charts.⁶⁶ The main issue with such agreements is that they potentially limit the services for and area in which an APRN can provide care, thus limiting consumers’ access, and limiting the APRN unnecessarily from full use of his or her training.⁶⁷

b: Regulatory Structure

⁶³ IOM FUTURE OF NURSING REPORT, *supra* at S-8.

⁶⁴ CITIZEN ADVOCACY CTR., SCOPE OF PRACTICE FAQs FOR CONSUMERS, ADVANCED PRACTICE REGISTERED NURSES 1, 2, <http://www.nacns.org/docs/toolkit/3A-FAQScope.pdf>.

⁶⁵ N.J. STAT. ANN. § 45:11-49 (LEXIS 2015); N.J. ADMIN. CODE 13:35-6.6 (LEXIS 2015) (regulates the standards for joint protocols).

⁶⁶ MO. REV. STAT. § 334.104 (LEXIS 2015).

⁶⁷ CITIZEN ADVOCACY CTR., *supra* note 64, at 2.

State statutes, along with regulations promulgated by state nursing boards, regulate nursing practice and scope.⁶⁸ In addition, states have medical practice acts that may affect nursing scope of practice by prohibiting the practice of medicine by all but medical doctors.⁶⁹ These can lead to murky territory, in which the exact scope of practice for APRNs is not fully delineated.⁷⁰ It is therefore the province of state legislatures to enact reforms to scope of practice laws. Consequently, it is in state legislatures where most of the battles are fought. The ultimate goal of such legislation is to achieve full scope of practice for APRNs, including prescriptive privileges, independent of collaborative agreements.⁷¹

c: The Consensus Model for State Regulation

The NCBSN tracks how compliant the states are with the Consensus Model.⁷² There are 11 states and 1 territory with a perfect NCSBN score for compliance.⁷³ Iowa practically achieved a perfect score, since the only requirement not met is the actual “APRN” title (Iowa’s designation is “Advanced Registered Nurse Practitioner” or “ARNP”).⁷⁴ However, the moniker “APRN” has some legal significance for those practitioners who work across state lines.⁷⁵ A perfect score means that the state/territory has adopted all 4 APRN titles and roles (CNP, CRNA, CNM, CNS, though some names may vary superficially), licensing, education, and certification requirements, and perhaps most relevant to the immediate discussion, allows independent practice and independent

⁶⁸ Karla Kelly, *Nurse Practitioner Challenges to the Orthodox Structure of Health Care Delivery: Regulation and Restraints on Trade*, 11 AM. J. OF L. & MED. 195, 199 (1985).

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, <https://www.ncsbn.org/738.htm> (last visited Mar. 20, 2015).

⁷² See NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra*, note 59.

⁷³ *Id.*

⁷⁴ Iowa Board of Nursing, *The Advanced Registered Nurse Practitioner*, IOWA.GOV, http://nursing.iowa.gov/nursing_practice/arnp.html (last visited Mar. 20, 2015).

⁷⁵ Jansen, *supra* note 17, at 327. (“Lack of uniform titling provided several disadvantages to APRNs who are required to use state-protected titles in business communications, particularly when practice is located across state lines”).

prescribing *without* written collaboration agreements.⁷⁶ A poor score means that the state has not adopted the nomenclature, and does not allow independent practice. Among the lowest scoring states are New Jersey, Michigan, Florida, and Alabama.⁷⁷ In between are states that, *inter alia*, allow independent practice but not independent prescriptive rights (Wisconsin), or fully meet all licensing and title specifications but allow no independence (Texas), or give expanded rights to some APRNs, but not others (North Carolina).⁷⁸

i: New Jersey Scope of Practice Reform

New Jersey's main sponsor of a bill eliminating collaborative agreements cites to a rural New Jersey APRN who was the primary provider for "thousands of patients," who had to stop providing care when her supervising physician retired.⁷⁹ Introduced in 2012 by Assemblywoman Munoz, the New Jersey Consumer Access to Healthcare Act would bring sweeping change to New Jersey scope of practice for APRNs.⁸⁰ Specifically, it would entirely eliminate the need for any collaborative agreement between any APRN (all roles) and a physician, and it would also allow full prescriptive privileges for qualifying APRNs.⁸¹ This would bring New Jersey up to almost complete compliance with the Model Rules; the only non-compliant portion is that the proposed act continues to refer to the subject as Advanced Practice Nurses (APN), rather than APRN.⁸²

The Executive Committee of the New Jersey Board of Medical Examiners opposed the Senate version of the Bill, expressing its opposition based upon 3 main concerns: that under certain circumstances a physician should be brought in to give treatment, and the Bill erodes those

⁷⁶ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *Major Components of the Consensus Model by State* (2014), https://www.ncsbn.org/2014.07_18_JulyMapWithPoints.pdf (last visited Mar. 20, 2015).

⁷⁷ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra*, note 59.

⁷⁸ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra*, note 76.

⁷⁹ Lisette Hilton, *New York/New Jersey legislation could test APN 'tether'*, NURSE.COM (Jun. 3, 2013), http://news.nurse.com/article/20130603/NY01/106030005#.VGFKb_TF-EM.

⁸⁰ A.B. 906, 216th Leg., Reg. Sess. (N.J. 2014).

⁸¹ *Id.*

⁸² *Id.*

circumstances; that the Bill could result in raised medical malpractice insurance premiums for physicians; and that consumers should be advised as to who (actual role of the practitioner and her education and title) is actually providing health care.⁸³ As to the first complaint, there is no rational explanation as to why a physician could not be brought in if needed, even under the new language of the Act.⁸⁴ The Act does not command APRNs to never contact a physician; it simply seeks to expand the scope of practice *to the extent of training*. It should also be noted that even physicians have a duty to refer patients whose care exceeds their competence, and face malpractice suits if they fail in that duty; there is therefore no reason that APRNs should not face the same liability.⁸⁵

Regarding the second objection, there does not appear to be evidence that relaxed licensing laws cause malpractice premiums to increase. According to the National Bureau of Economic Research, for example, while restrictive scope of practice laws tend to lead to greater health care costs, more liberal laws lead to no change in malpractice premiums.⁸⁶ Other sources show similar results.⁸⁷ However, this is an evolving area of the law, and its scope cannot be covered in this Note.

As to the objection that the public would not be adequately advised as to who provides their health care, that objection essentially tracks the AMA's "Truth in Advertising" campaign.⁸⁸ That campaign ostensibly seeks to keep health care consumers informed about who is providing

⁸³ Open Board Agenda, New Jersey Board of Medical Examiners (Jan. 13, 2013), http://www.state.nj.us/lps/ca/bme/agenda/bmeage_010913.pdf.

⁸⁴ David Gorsky, *Expanding the scope of practice of advanced practice nurses will not endanger patients*, SCIENCE-BASED MEDICINE (Jan. 6, 2014), <http://www.sciencebasedmedicine.org/expanding-the-scope-of-practice-of-advanced-practice-nurses-does-not-endanger-patients/> ("What happens when a *physician* encounters something in the course of diagnosis or treatment that goes very wrong and he doesn't have the training to handle? He calls in other physicians who *can* handle it").

⁸⁵ Tine Hansen-Turton, Jamie Ware & Frank McClellan, *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1251 (2010).

⁸⁶ MORRIS M. KLEINER ET AL., RELAXING OCCUPATIONAL LICENSING REQUIREMENTS: ANALYZING WAGES AND PRICES FOR A MEDICAL SERVICE, NBER WORKING PAPER NO. 19906, 1, 5 (Nat'l Bureau of Econ. Research 2014), <http://www.nber.org/papers/w19906.pdf>.

⁸⁷ MICHIGAN COUNCIL OF NURSE PRACTITIONERS, APRN SCOPE OF PRACTICE: ACCESS TO CARE AND MEDICAL MALPRACTICE, <http://www.micnp.org/files/Comparison%20of%20other%20states%20sheet.pdf>.

⁸⁸ AMA ADVOCACY RES. CTR., "TRUTH IN ADVERTISING" CAMPAIGN 1, 2 (AM. MED. 2012).

their health care, but could effectively work to punish nurses who may legitimately lay claim to the title “Doctor,” such as APRNs who also have achieved a doctorate degree.⁸⁹ While patients have a legitimate concern in knowing their provider’s qualifications, the proposed legislation in that campaign is largely duplicative of current state legislation which already protects patients from fraudulent representation of credentials, and it seeks to treat clinicians unequally, applying standards to nurses that are not applied to physicians.⁹⁰

ii: Other States’ Efforts

The continuing objections in other states echo the same themes as New Jersey. The Michigan State Medical Society calls its state scope of nursing practice proposal “unproven and controversial.”⁹¹ While it is controversial (because medical societies keep objecting to it), it is obviously not unproven, given the breadth of similar laws already enacted.⁹² Florida’s bill proposing expansion allows APRNs (in Florida, ARNPs) to practice independently, and to prescribe controlled substances and narcotics, leading the Florida Medical Association to insinuate Florida would “move backwards” in its fight to curb prescription medicine abuse.⁹³ The Association cited no study supporting the insinuation that expansion would lead to prescription drug abuse, nor is the contention supported elsewhere.⁹⁴ That bill subsequently died in committee.⁹⁵ The Massachusetts Medical Society also toes the line set by the AMA, “arguing [expanded scope of practice] was contrary to an optimal physician-led, team-based health care

⁸⁹ NATIONAL ASS’N OF CLINICAL NURSE SPECIALISTS, LEARN THE TRUTH ABOUT AMA’S TRUTH IN ADVERTISING CAMPAIGN, <http://www.nacns.org/docs/TruthTransparencyTalkingPoints.pdf>.

⁹⁰ *Id.*

⁹¹ *Put Patients First! Urge Your State Rep to Vote NO on Senate Bill 2*, MICHIGAN STATE MED. SOC’Y. (Aug. 25, 2014), <http://www.msms.org/AboutMSMS/News/tabid/178/ID/1375/Put-Patients-First-Urge-Your-State-Rep-to-Vote-NO-on-Senate-Bill-2.aspx>.

⁹² NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra*, note 76.

⁹³ FLORIDA MED. ASS’N., http://www.flmedical.org/Stop_7113.aspx (last visited Mar. 20, 2015).

⁹⁴ *Id.*

⁹⁵ FLORIDA HOUSE OF REPRESENTATIVES, <http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=52482> (last visited Mar. 20, 2015).

delivery model and was a possible threat to patient safety.”⁹⁶ Once again, no referral is made to any study revealing a possible threat.⁹⁷

The point is that while legislation on the issue is active in many states, states’ medical societies oppose expanded scope of practice.⁹⁸ And most of those medical societies have significant lobbying influence.⁹⁹ Consequently, much of the scope of practice legislation on the slate for 2014 died, either in committee, or was voted down, or vetoed.¹⁰⁰ Expanded scope of practice is getting heard in the states, but the opposition, coming almost solely from physicians’ groups, is as fierce as it is unfounded in science.

d: An Emerging Strategy

Perhaps the best strategy for APRN advocates, though, is a piecemeal strategy. The laws getting struck down are largely laws that propose sweeping legislation that immediately conforms to the Model Act.¹⁰¹ In addition to his statement about conferring with his chief medical officer, the Nebraska Governor spoke of his willingness to enact smaller changes.¹⁰² What may find success is tying independence to some sort of clinical experience regime, perhaps which will eventually be understood as a residency or equivalent. For example, as previously stated, successful scope of practice expansion has been achieved when the legislation requires nurses to

⁹⁶ *Statehouse Update: Practice Expansion for APNs Rejected*, MASSACHUSETTS MED. SOC., (Aug., 2014) <http://www.massmed.org/News-and-Publications/Vital-Signs/Statehouse-Update--Practice-Expansion-for-APNs-Rejected/#.VGKgyfTF-EM> (last visited Mar. 20, 2015).

⁹⁷ *Id.*

⁹⁸ *See, e.g.*, FLORIDA MED. ASS’N., *supra*, note 93; MICHIGAN STATE MED. SOC’Y., *supra*, note 91; New Jersey Board of Medical Examiners, *supra*, note 83.

⁹⁹ Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 304 (2002) (“Whenever scope-of-practice issues arise, legislators are bombarded by heavily-financed lobbying efforts emanating from state and national professional associations, individual health care providers (who are also voters), and interested citizens.”).

¹⁰⁰ *AANP gives thumbs down to Nebraska veto of NP practice bill*, NURSE.COM (Apr. 24, 2014) <http://news.nurse.com/article/20140424/NATIONAL06/140424001#.VGKktvTF-EM> (last visited Mar. 20, 2015) (After conference with his chief medical advisor, Nebraska’s Governor vetoed the expanded practice bill passed by his legislature).

¹⁰¹ NCSBN CONSENSUS MODEL, *supra* note 6.

¹⁰² NURSE.COM, *supra* note 100.

have a certain threshold of clinical experience within a collaborative agreement scheme before they may be un-tethered, and strike out on their own.¹⁰³ It has been observed that law passage is biased in some states toward incremental, rather than comprehensive change, and adding mandated hours of clinical experience may be the middle ground that ushers in more successful legislation.¹⁰⁴

2: Reimbursement from 3rd Party Payers

Finally, the IOM report recommends that states require 3rd party payers to pay direct reimbursement to APRNs.¹⁰⁵ This provision was added because “few if any third-party payers recognize nursing services that aren't bundled with medical management and, therefore, nursing services are not directly reimbursed.”¹⁰⁶ In short, nurses can't get paid unless a physician who does the billing on their behalf is supervising them. As such, APRNs received reimbursement “indirectly, incident to physicians, and at a considerably lower rate.”¹⁰⁷ Such reimbursement schemes create a *de facto* tether to physicians. Independence issues aside, the outcomes for patients tend to improve with intervention from nurses, and without an accounting mechanism for nurse intervention that direct reimbursement could supply, valuable care may be lost.¹⁰⁸

Private third party insurers are regulated by the individual states.¹⁰⁹ Federal mandates that typically govern third party reimbursement in the realm of Medicare and Medicaid are often blocked by discriminatory rules and regulations regarding “non-physician” and “mid-level”

¹⁰³ See, e.g., Adam Rubenfire, *Some N.Y. nurse practitioners to be freed of doc supervision in 2015*, MODERN HEALTHCARE (Dec. 30, 2014) <http://www.modernhealthcare.com/article/20141230/NEWS/312309974/some-n-y-nurse-practitioners-to-be-freed-of-doc-supervision-in-2015> (last visited Mar. 20, 2015) (New York law conditioning independent practice upon 3,600 hours of clinical experience).

¹⁰⁴ Jansen, *supra* note 17, at 394.

¹⁰⁵ IOM FUTURE OF NURSING REPORT, *supra* note 1, at S-8.

¹⁰⁶ Martha J. Price & Patricia H. Parkerton, *Care Delivery Challenges for Nursing*, 107 AM. J. OF NURSING (2007), http://journals.lww.com/ajnonline/Fulltext/2007/06001/Care_Delivery_Challenges_for_Nursing.22.aspx (last visited Mar. 20, 2015).

¹⁰⁷ ANN B HAMRIC ET AL., *ADVANCED PRACTICE NURSING: AN INTEGRATIVE APPROACH* 569 (5th ed. Elsevier Health Sciences 2013).

¹⁰⁸ Price & Parkerton, *supra* note 106.

¹⁰⁹ HAMRIC ET AL., *supra* note 107, at 569.

providers.¹¹⁰ Thus, there is an arbitrary reimbursement system in place which discriminates against APRNs, without regard for patient outcomes. Of course, this proposition calls forth the philosophical question of whether providers are paid for the quality of their outcomes, or the quality, quantity and cost of their educations; to wit: should a physician receive more reimbursement for her treatment of strep throat than a nurse practitioner for the exact same treatment, because the physician presumably has the greater education? Under a fee-for-service regime, does supposed expertise have a bearing on outcomes? Regardless of these more esoteric considerations, the point of the IOM recommendation is, presumably, to pay people directly for the health care they actually can provide, rather than filter that payment through unnecessary middlemen.

Part IV: Physician Opposition and Antitrust

A: Physician Opposition

The main opposition to expanded scope of practice comes from contentions by physicians that APRNs do not receive adequate training to be entrusted with the full scope of that training. The AMA listed the disparity in clinical experience between doctors and nurses as its main opposition to the IOM report.¹¹¹ In 2014, New York State passed legislation expanding practice for registered nurse practitioners.¹¹² One vocal opponent of that legislation cited the AMA verbatim in his scathing criticism of the new law.¹¹³ He further cited to a 1999 study suggesting that NPs may resort to more diagnostic tests, thus negating any economic benefits.¹¹⁴ However, no opposing party has actually cited to any research supporting the contention that APRNs provide

¹¹⁰ *Id.*

¹¹¹ Press Release, *supra* note 3.

¹¹² Rubenfire, *supra* note 103.

¹¹³ Sandeep Jauhar, *Nurses Are Not Doctors*, THE NEW YORK TIMES (Apr. 29, 2014)

http://www.nytimes.com/2014/04/30/opinion/nurses-are-not-doctors.html?_r=2 (last visited Mar. 20, 2015).

¹¹⁴ *Id.*

inferior care; in fact, studies tend to show the opposite. Specifically, a systematic review compiling nearly two decades of research found that “care delivered by APRNs and care delivered by physicians (alone or in teams without an APRN) produce equivalent patient outcomes.”¹¹⁵ Of course, this study focuses on the kinds of patients whom APRNs and physicians are qualified to treat in common; there are many high risk or severely compromised patients whom APRNs do not treat.

1: The Objective Evidence

The 2011 study, a meta-analysis examining 29 separate *patient outcomes* (as opposed to patient preferences) from a total of 69 studies conducted over 18 years, demonstrated that *in no category* did patients experience more adverse outcomes under the care of APRNs than under that of physicians.¹¹⁶ In fact, APRNs’ patients presented more favorable outcomes in certain categories.¹¹⁷ In a 2012 report critical of expanded scope of practice legislation, the Physicians Foundation—whose mission is to oppose expansion of non-physicians’ scope of practice—acknowledged that “the research literature shows, without exception, that within their areas of training and experience, nurse practitioners provide care that is as good as or better than that provided by physicians.”¹¹⁸ The report goes on to question the validity of *one* of those studies, which it claims—without substantiation—is the definitive study on the topic, and fails to even

¹¹⁵ Jansen, *supra* note 17 at 29-30; see also Jeffrey C. Bauer, *Nurse Practitioners as an Underutilized Resource for Health Reform: Evidence-Based Demonstrations of Cost-effectiveness*, J. OF THE AM. ACAD. OF NURSE PRACTITIONERS 22, 228, 228-231 (2010).

¹¹⁶ Jansen, *supra* note 17, at 29-30; E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. MICH. J.L. REFORM 939, 985 (1999) (“Outcomes studies are [a] kind of research intended to establish better correlations between what physicians do during clinical care and the results that patients actually experience, both long-and short-term”).

¹¹⁷ *Id.*

¹¹⁸ STEPHEN ISAACS & PAUL JELLINEK, ACCEPT NO SUBSTITUTE: A REPORT ON SCOPE OF PRACTICE 1, 42 (The Physicians Foundation, Nov. 2012) http://www.physiciansfoundation.org/uploads/default/A_Report_on_Scope_of_Practice.pdf.

mention the above 2011 study.¹¹⁹ The report suggests bias, observing without more that APRN advocates performed much of the research in the area.¹²⁰

The conflict of interest criticism asserted by the Physicians Foundation is ultimately disingenuous. A 1986 policy analysis submitted to Congress by the now-defunct Office of Technology Assessment (OTA) found that “the weight of the evidence indicates that, within their areas of competence, NPs... and CNMs provide care whose quality is equivalent to that of care provided by physicians.”¹²¹ The OTA was committed to providing objective and non-partisan information to Congress; it was not prone to a pro-APRN bias.¹²² While that report is nearly 30 years old, no physicians’ groups have put forward subsequent research to refute it, and it has been substantially upheld by subsequent studies. While at the end of the day this report does not include the most recent areas of practice, taken with the 2011 study, and the acknowledgement of the Physicians Foundation that all empirical evidence points inexorably to the fact of equivalent patient outcomes, and lacking *any* evidence to the contrary, physicians appear to base their opposition not upon an objective scientific standard, but merely upon their own unsubstantiated prejudices. Of course, it is quite possible that physicians view expanded scope of practice as a competitive threat to their business; if that is the case, then the issue demands antitrust analysis.

B: Antitrust

Antitrust, for our purposes, is about the competitive effects of certain types of conduct that potentially, adversely affect the price, quality, and availability of a product—in this case health

¹¹⁹ *Id.*

¹²⁰ *Id.*; While such a conflict of interest may present a negative connotation, the report fails to point to any research whatsoever in the area performed by anyone else who may be more neutral, and in fact lists as a goal for physicians, funding of such research.

¹²¹ U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS, 37 Health Technology Case Study 1, 5 (1986), <http://ota.fas.org/reports/8615.pdf>.

¹²² PRINCETON UNIV., *The OTA Legacy*, <https://www.princeton.edu/~ota/> (last visited Mar. 20, 2015).

care—thereby impinging upon the welfare of consumers.¹²³ Physicians and APRNs are competitors, not because they offer the exact same services to the same populations, but because their services are potential substitutes.¹²⁴ This is not to say that APRNs should replace physicians, nor that the competitors should not also collaborate, or even work for each other.¹²⁵ The purpose of this Note is certainly not to ignore any issues of public safety. Rather, all other factors being equal, this antitrust analysis seeks to expose harm to the consumer resulting from anticompetitive behavior which, but for under-rationalized or arbitrary regulations put in place by one interested competitor and sanctioned by governments, would not occur.

The IOM report speaks directly to matters of antitrust, where it urges the Federal Trade Commission (“FTC”) and Antitrust Division of the Federal Government Department of Justice to review current legislation and laws in the states for possible anticompetitive effects.¹²⁶ Furthermore, antitrust issues arise when one particular coalition of professionals gathers in order to undermine a competing coalition’s ability to compete. In this case, the American Medical Association and the assorted State medical societies/associations make up coalitions, though their efforts may not reach the level of antitrust; or if they do, the Noerr-Pennington Doctrine may protect those actions. Regarding legislation, the FTC has had a hand in guiding state legislatures away from passing anti-competitive laws.¹²⁷ The “advocacy” function of the FTC may prove to be exceedingly influential, and it has certainly taken up the call directed to it by the IOM.¹²⁸ The remainder of this note will focus briefly on the FTC’s role in antitrust action, and move into discussions of the Sherman Act generally, as well as the Noerr-Pennington and State Action

¹²³ See generally Daniel J. Gilman & Julie Fairman, *Antitrust and the Future of Nursing: Federal Competition Policy and the Scope of Practice*, 24 HEALTH MATRIX 143 at 154-155 (2014).

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ FUTURE OF NURSING REPORT, *supra* note 1 at S-9.

¹²⁷ Gilman & Fairman, *supra* note 123, at 154.

¹²⁸ *Id.*

Doctrines, which are the primary limitations to antitrust action, and finally a discussion regarding *N.C. State Bd. of Dental Examiners v. FTC*,¹²⁹ a case recently decided by the Supreme Court, which bears on the issue.

1: The FTC

Regulatory restrictions on APRN scope of practice have drawn attention from the FTC's competition advocacy program.¹³⁰ The FTC's interest in the issue is drawn from the FTC Act itself, which "prohibits '[u]nfair methods of competition' and 'unfair or deceptive acts or practices,' and gives the FTC a mandate 'to prevent persons, partnerships, or corporations' from engaging in such prohibited methods, acts, and practices."¹³¹ In the health care arena, the FTC has "investigated restrictions on the business practices of health care providers, scrutinized proposed mergers, and brought enforcement actions against health care providers that have violated federal competition law."¹³² The Commission has been enhanced by congressional legislation, such that "[e]conomic and policy research and competition advocacy thus are at the core of the FTC's statutory mission, alongside the Commission's civil law enforcement responsibilities."¹³³

The result is an FTC that may influence and enforce policy. Substantial challenges exist to enforcing competition through litigation, such that the FTC cannot always act as a litigious sword in the hands of regulators, but must instead sometimes work more passively, through legislatures and legislators, in order to promote competition policy at a formative level. The FTC's role in this

¹²⁹ *N.C. State Bd. of Dental Examiners v. FTC*, 191 L. Ed. 2d 35 (U.S. 2015).

¹³⁰ Gilman & Fairman, *supra* note 123, at 144.

¹³¹ *Id.*, at 149.

¹³² *Id.*

¹³³ *Id.*, at 150., see also Maureen K. Ohlhausen, *17th Annual Antitrust Symposium: 100 is the New 30: Recommendations for the FTC's Next 100 Years*, 21 GEO. MASON L. REV. 1131, 1132 ("the FTC should always consider the many non-enforcement tools it can use to help stop consumer harm before it arises, thus sparing consumers and businesses unnecessary losses and saving the taxpayer money that we would otherwise spend on litigation").

context has been discussed comprehensively elsewhere, and will not be further discussed at length here.¹³⁴

2: The Sherman Act §1, Generally

Section 1 of the Sherman Act makes illegal, and criminalizes contracts or conspiracies in restraint of trade.¹³⁵ A section one claimant must initially prove three elements: (1) an agreement or conspiracy between at least two persons or distinct business entities; (2) to harm or restrain competition; and (3) which actually injures competition.¹³⁶ Opposition to expanding the scope of APRNs' practice seems like a deceptively simple, *per se* instance of restraint of trade by the AMA and other medical societies, or state boards of medicine: (1) Physicians make up such societies or boards, and are persons or distinct business entities within the meaning of the statute, and have obviously agreed to work together in this regard.¹³⁷ (2) Their agreement is to advocate for policies, which work to the detriment of APRN competition with them. (3) This harms consumers, since without the ability to practice to the extent of their scope, APRNs cannot offer their services, even when those services match those of competing physicians. Antitrust may be unavailing in this context, though, because of two doctrines: the State Action Doctrine and the Noerr-Pennington Doctrine.

3: The Noerr-Pennington Doctrine

Briefly, the Noerr-Pennington Doctrine protects the First Amendment Right of citizens, including trade groups, to earnestly petition the government to adopt a particular course of action,

¹³⁴ See generally Gilman & Fairman, *supra* note 123.

¹³⁵ 15 U.S.C. § 1 (LEXIS 2015).

¹³⁶ Oltz v. Saint Peter's Community Hosp., 861 F.2d 1440, 1445 (9th Cir. Mont.1988).

¹³⁷ See American Needle, Inc. v. National Football League, 560 U.S. 183, 130 (2010) ("Agreements made within a firm can constitute concerted action . . . when the parties to the agreement act on interests separate from those of the firm itself" such that "the intrafirm agreements may simply be a formalistic shell for ongoing concerted action").

“no matter how anticompetitive the action sought.”¹³⁸ Its reach is sweeping, covering all three branches of government, as well as administrative agencies.¹³⁹ In *Eastern Railroad Conference v. Noerr Motor Freight*,¹⁴⁰ the case from which the doctrine takes its name, “railroads were genuinely lobbying the legislature for laws that would favor them at the expense of their competitors,” which given the First Amendment right to petition and our common understanding of representative government is a fairly intuitive right to afford protection.¹⁴¹ *United Mine Workers of America v. Pennington*¹⁴² was a similarly intuitive case, extending *Noerr* immunity to petitions of the Executive.¹⁴³ Finally, *California Motor Transport Co. v. Trucking Unlimited*¹⁴⁴ extended *Noerr-Pennington* immunity to entities interacting with the courts and administrative agencies, but applied the “sham” exception for the first time.¹⁴⁵ The “sham” exception stands for the principle that “when efforts to influence government action are considered ‘sham,’ the petition is stripped of its immunity.”¹⁴⁶ In other words, immunity is lost when advocacy efforts are an obvious charade, not pursued in good faith, but rather pursued as a means to obfuscate otherwise prohibited intentions.

a: The Sham Exception

¹³⁸ Marina Lao, *Reforming the Noerr-Pennington Antitrust Immunity Doctrine*, 55 RUTGERS L. REV. 965, 966 (2003).

¹³⁹ *Id.* at 966.

¹⁴⁰ 365 U.S. 127 (1961).

¹⁴¹ *Id.*; Lao, *supra* note 138, at 974.

¹⁴² 381 U.S. 657 (1965).

¹⁴³ *Id.*, Lao, *supra* note 138 at 976.

¹⁴⁴ 404 U.S. 508 (1972).

¹⁴⁵ *Id.*, Lao, *supra* note 138, at 975-76.

¹⁴⁶ Lao, at 967; *see, e.g.*, *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 511-512 (U.S. 1972).

Observed in the light of the sham exception, physicians' organizations' efforts to petition the legislature against APRN scope of practice are suspect. Assuming that physicians' societies and boards deserve the benefit of the doubt regarding their good faith belief that APRNs are insufficiently trained or competent to practice independently, one might think that they are being deliberately obtuse with regard to the objective research on APRN outcomes. However, the Supreme Court has eviscerated the sham exception to the point that it is essentially worthless in this context, even when Noerr-Pennington immunity stands to severely injure consumers.¹⁴⁷

In a legislative context, sham as an exception to Noerr-Pennington is entirely useless, even if it involves fraud or misrepresentation.¹⁴⁸ Even if, hypothetically, interest groups petitioning legislatures do so in bad faith, and use entirely false data to support their positions, Noerr-Pennington is an absolute shield against antitrust liability. There is simply no chance to pursue antitrust litigation in this context, nor is this Note meant to propose changes to the doctrine.

Nonetheless, the sham exception remains robust in the context of litigation or administrative processes.¹⁴⁹ Unfortunately, how this may apply to the immediate matter is unclear. The AMA and other such organizations are not bringing lawsuits against APRNs to enjoin their practice; if they were, then the sham exception might apply. Instead, there are currently physicians serving on state medical boards, whose recommendations as to what the practice of medicine is become the law. As state appointees, those regulators are shielded by the state action doctrine, and are thus immune from antitrust action... with a new exception, recently delineated, as shall be discussed *infra*.

3: The State Action Doctrine

¹⁴⁷ Lao, at 979.

¹⁴⁸ See, e.g., *City of Columbia v. Omni Outdoor Advertising*, 499 U.S. 365, 382 (U.S. 1991).

¹⁴⁹ *Id.* at 988-89; see, e.g., *Kottle v. N.W. Kidney Ctrs.*, 146 F.3d 1056, 1060-61 (9th Cir. 1998); *Baltimore Scrap Corp. v. David J. Joseph Co.*, 237 F.3d 394, 402 (4th Cir. 2001).

The State Action Doctrine, in the antitrust context, reinforces the principles of federalism immunizing state action from antitrust challenge. Thus, a state agency may theoretically engage in anticompetitive behavior without the risk of antitrust action, though it should be noted that “a state cannot ‘give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful.’”¹⁵⁰

The state agencies of concern to this Note are Boards of Medicine, which define the scope of the practice of medicine for a state.¹⁵¹ Board membership typically consists of volunteers, ordinarily appointed by the governor, most of whom are usually physicians, though several non-physicians often serve as well.¹⁵² In New Jersey, for example, the enabling statute gives the governor appointment rights of the Board of Medical Examiners (as it is called in NJ), and outlines all of the responsibilities of the Board; in particular, the Board decides the scope of practice of medicine, and enforces that scope through the Attorney General.¹⁵³ The statute specifically states that the “Governor shall give due consideration to, but shall not be bound by, recommendations submitted by the appropriate professional organizations of this State.”¹⁵⁴ In other words, professional (private) organizations have a voice in gubernatorial appointments to the boards. While it makes sense that the governor has advice regarding who the best candidate shall be for the position, it still raises some flags when a professional organization has a voice in who gets to compete with it. Regardless, although prudent policy may call this a conflict of interests, the state action doctrine renders it immune to judicial scrutiny. However, Justice

¹⁵⁰ N.C. State Bd. of Dental Examiners v. FTC, 717 F.3d 359, 366 (4th Cir. 2013) (citing Parker v. Brown, 317 U.S. 341, 351 (U.S. 1943)), *aff’d*, N.C. State Bd. of Dental Examiners v. FTC, 191 L. Ed. 2d 35 (U.S. 2015).

¹⁵¹ Oregon v. Ashcroft, 192 F. Supp. 2d 1077, 1092 (D. Or.2002) (“The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states”).

¹⁵² FED’N OF STATE MED. BDS., *Frequently Asked Questions About State Medical Boards*, <http://www.fsmb.org/policy/public-resources/frequent-questions#g1> (last visited Mar. 20, 2015).

¹⁵³ N.J. STAT. ANN. § 45:1-2.1 et seq. (LEXIS 2015).

¹⁵⁴ N.J. STAT. ANN. § 45:1-2.2 (LEXIS 2015).

Kennedy’s opinion in *N.C. State Bd. of Dental Examiners v. FTC* recently made it a bit harder for state boards to engage in anti-competitive behavior.¹⁵⁵

4: N.C. State Bd. of Dental Examiners v. FTC

The pertinent facts of the case arose when the North Carolina Board of Dental Examiners took upon itself to investigate, and then independently issue cease and desist orders to non-dentists engaging in the commercial business of teeth-whitening, which the Board considered to be the practice of dentistry.¹⁵⁶ As Justice Kennedy later observed, while North Carolina had delegated control to the Board over the practice of dentistry, the relatively new practice of teeth whitening was not included in the empowering act as “the practice of dentistry.”¹⁵⁷ The FTC charged the Board of “violating 15 U.S.C. § 45, the FTC Act, by excluding non-dentist teeth whiteners from the market” in violation of §1 of the Sherman Act.¹⁵⁸ The Board petitioned the 4th Circuit for review, seeking application of the state action doctrine.¹⁵⁹

a: The 4th Circuit Decision

First, the 4th Circuit upheld the earlier determination by the FTC, that as a “public/private hybrid entit[y]” the Board lacked government supervision, and was therefore a private actor.¹⁶⁰ In concluding that the Board was not exempt under state action, the Fourth Circuit looked specifically at the “Parker Doctrine,” which enumerates three situations under which an entity can claim immunity.¹⁶¹ The Board had claimed immunity under the second Parker situation—the

¹⁵⁵ See generally *Dental Examiners* 191 L. Ed. 2d 35.

¹⁵⁶ *N.C. State Bd. of Dental Examiners v. FTC*, 717 F.3d 359, 365 (4th Cir. 2013), *aff’d*, *N.C. State Bd. of Dental Examiners v. FTC*, 191 L. Ed. 2d 35 (U.S. 2015).

¹⁵⁷ *Dental Examiners*, 191 L. Ed. 2d at 46.

¹⁵⁸ *Dental Examiners*, 717 F.3d at 365.

¹⁵⁹ *Id.* at 366.

¹⁶⁰ *Id.*, at 368-370.

¹⁶¹ *Id.* at 366 (citing *South Carolina State Bd. of Dentistry v. FTC*, 455 F.3d 436, 442 (4th Cir. 2006)); *Hoover v. Ronwin*, 466 U.S. 558, 568, (U.S. 1984); *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105, (U.S. 1980); *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S.Ct. 1003, 1010, (U.S. 2013).

Midcal test—wherein “private parties can claim the *Parker* exemption if acting pursuant to a ‘clearly articulated and affirmatively expressed as state policy’ and their behavior is ‘actively supervised by the State itself.’”[*sic*]¹⁶² Recognizing that “fundamental national values of free enterprise and economic competition [] are embodied in the federal antitrust laws,” the Court sanctioned state-action immunity “only when [] clear that the challenged anticompetitive conduct [was] undertaken pursuant to a regulatory scheme that [was] the State's own.”¹⁶³

The Court went on to determine that the regulatory scheme in question failed the *Midcal* test, since the Board could not show that it was actively supervised by the State.¹⁶⁴ According to the 4th Circuit, the Board lacked supervision because its membership was elected exclusively by private actors—that is, only other dentists elected the Board, with no involvement of the Governor, nor any other elected official.¹⁶⁵ This was sufficient for the FTC—and subsequently the Fourth Circuit—to hold that the board was a private entity, even though it was created through an act of the State. However, while the concurring gloss from the 4th Circuit stressed that the ruling was narrow, and that had the Board been chosen by elected officials, *Midcal* would have been satisfied, the Supreme Court’s recent decision has broadened the ruling remarkably.¹⁶⁶

b: The Supreme Court’s Decision

¹⁶² *Dental Examiners*, 717 F.3d at 367 (citing *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum*, 445 U.S. 97, 105) (U.S. 1980)).

¹⁶³ *Id.*, at 367-68 (internal quotations omitted).

¹⁶⁴ *Id.* at 368.

¹⁶⁵ *Id.*, at 377 (KEENAN, C.J., concurring) (“Here, the fact that the Board is comprised of private dentists elected by other private dentists, along with North Carolina's lack of active supervision of the Board's activities, leaves us with little confidence that the state itself, rather than a private consortium of dentists, chose to regulate dental health in this manner at the expense of robust competition for teeth whitening services”).

¹⁶⁶ *See Id.*, 376-377.

In affirming the 4th Circuit, Justice Kennedy stressed that, in order to gain *Parker* immunity, it is necessary that a state agency prove “more than a mere façade of state involvement”; specifically, that “[the] States accept political accountability for anticompetitive conduct they permit and control.”¹⁶⁷ The Court recognized that the private concerns of active market participants, when those participants serve on state agencies, pose a danger to consumers if private actors work to further their own interests, rather than those of the state.¹⁶⁸ Therefore, the government must seek assurance that those private actors are in fact pursuing the state’s interests in addition to their own.¹⁶⁹ The Court went on to hold that state boards controlled by active participants in the market which the board regulates must satisfy the active market participation test of *Midcal* in order to enjoy *Parker* immunity.

The Court introduced a test for “active supervision” that would satisfy *Midcal*.¹⁷⁰ As a general proposition, such an inquiry is “flexible and context-dependent.”¹⁷¹ Supervision “need not entail day-to-day involvement in an agency’s operations,” but must probe “whether the State’s review mechanisms provide ‘realistic assurance’ that a nonsovereign actor’s anticompetitive conduct ‘promotes state policy, rather than merely the party’s individual interests.’”¹⁷² The Court identified four specific requirements of state supervision: first, the state supervisor must review the substance of an anticompetitive board decision, not simply whether it was procedurally proper; second, the supervisor must have veto power over, and power to modify, the decision; third, the supervisor must be an active participant in the decision, rather than simply having the potential to intervene; fourth, the supervisor may not itself be an active

¹⁶⁷ N.C. State Bd. of Dental Examiners v. FTC, 191 L. Ed. 2d 35, 49 (U.S. 2015).

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*, at 55.

¹⁷¹ *Id.*

¹⁷² N.C. State Bd. of Dental Examiners v. FTC, 191 L. Ed. 2d 35, 55 (U.S. 2015) (citing *Patrick v. Burget*, 486 U.S. 94, 100-101 (U.S. 1988)).

market participant.¹⁷³ The Court then iterated that further analysis would rely upon context and the specific circumstances of the case.¹⁷⁴

i: Implications of *Dental Examiners*

While the Court's decision in the case has not completely opened the door for APRNs to unilaterally expand scope of practice, it has limited the ability of state boards to act in an anti-competitive manner without the mandate of the state. The Dental Board was charged by the FTC when the Board unilaterally sought to enforce the Board's own definition of the practice of dentistry; a definition that was not statutorily enunciated because, as Justice Kennedy observed, the statute did not include "teeth whitening" in the definition.¹⁷⁵ The Board's violation of antitrust law was specifically their unsupervised action taken against competitors. If the Board had written the cease and desist letters under proper supervision, then the FTC would have had no case. Accordingly, state boards of medicine may not take such uncompetitive, unilateral action with regard to those they judge to exceed the scope of practice. But if such action is currently being taken, it is not immediately apparent.

The decision should force states to reexamine their current oversight of professional boards. While states probably have sufficient process to cover the Court's active supervision test under their Administrative Procedure Acts, it is obvious, given the facts of *Dental Examiners*, that there are some actions of state boards that may have otherwise been overlooked.¹⁷⁶ In New Jersey, for example, state boards are vested with investigative powers.¹⁷⁷ While state licensing boards must exercise these investigative powers through the attorney general, that process must

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*, at 46.

¹⁷⁶ See generally, John Gedid, *Administrative Procedure for the Twenty-First Century: An Introduction to the 2010 Model State Administrative Procedure Act*, 44 ST. MARY'S L. J. 241; this Note will not examine the sufficiency of each state's Administrative Procedures Act.

¹⁷⁷ N.J. STAT. ANN. § 45:1-18 (LEXIS 2015).

be examined in light of the *Dental Examiners* test to ensure proper oversight.¹⁷⁸ The New Jersey Board of Medical Examiners certainly falls under the auspices of *Dental Examiners*, since the Board is comprised of at least 16 MDs and/or DOs (Doctors of Osteopathy), all of who should be considered active market participants.¹⁷⁹ Furthermore, the Board is given the power to subpoena witnesses to appear before the Board.¹⁸⁰ It is not absurd to think that the Board could use this power in an intimidating, anti-competitive manner, just as the North Carolina Dental Board used cease and desist letters.

Ultimately, *Dental Examiners* calls for sufficient oversight of specific actions taken by State Boards. I do not contend that it reaches those medical societies and advocates covered by the Noerr-Pennington Doctrine, nor do I propose that it can erode legislation or regulations duly enacted by elected state actors. The decision affects actions of Boards acting in an anti-competitive manner, when they have not been specifically empowered so to do. If the New Jersey Board of Medical Examiners decided tomorrow to start sending letters to nurse practitioners demanding that they cease and desist treating patients, even when they are doing so under a state-approved collaboration scheme with a physician, then that would definitely fall under the kind of behavior prohibited by *Dental Examiners*.

I do not think one could successfully argue that *Dental Examiners* affects scope of practice statutes, since those are passed specifically by the legislature. Legislation of this kind is necessarily exempt from federal antitrust action due to the state action doctrine. State Boards of Medicine do not themselves create and pass scope of practice laws, and to the extent that they regulate the practice of medicine, those regulations must pass scrutiny by the legislature, thus

¹⁷⁸ *Id.*

¹⁷⁹ N.J. STAT. ANN. § 45:9-1 (LEXIS 2015).

¹⁸⁰ N.J. STAT. ANN. § 45:9-2 (LEXIS 2015).

satisfying the active supervision requirement.¹⁸¹ Only if it could be shown that a state board had such autonomy as to pass scope of practice regulations without meaningful review from the legislature could *Dental Examiners* overturn such legislation.

Part V: Conclusion

The facts favoring the expansion of the scope of practice for Advanced Practice Registered Nurses is compelling, and momentum is entirely in favor of expansion. The ball is in the courts of the legislatures, however, and though change may occur incrementally, it continues to roll in favor of expansion. Although *Dental Examiners* may prove a strong tool for antitrust litigants against specific anti-competitive actions taken by state boards of medicine, it is limited to those circumstances when boards actually take such action themselves, and should not affect scope of practice legislation. Since Noerr-Pennington allows any sort of misrepresentation to be made in support of the prospect that physicians only will be the gatekeepers to public health, the legislatures should allow themselves to be guided not by the campaign contributions of physicians' organizations, but by the social contributions of the nurses and their advocates.

The ultimate point of *Dental Examiners*, and the point of scope of practice legislation, is that legislatures, not private actors, should decide what is best for the public welfare. This is not to say that legislators are themselves all experts in the fields of medicine or nursing. Legislators are experts in the field of governing, and are entrusted with the just governance of the people, and with their welfare. They are also accountable to those people, which is why they are so entrusted. The Noerr-Pennington and state action doctrines represent the recognition that legislators must be free to govern as they see fit. I do not argue against that proposition, or those doctrines. It is apparent that the decision of what the proper scope of practice for APRNs is lies

¹⁸¹ See generally Gedid, *supra* note 176.

in the hands of legislators, not physicians or nurses. I only argue that such a decision must be properly informed by objective study and careful consideration, by the opinions of *both* physicians and nurses, and by the concern for the overall health and welfare of state populations, not by concern for the pocketbooks of physicians.