

**EXPANDING THE SCOPE OF PRACTICE FOR ADVANCED PRACTICE REGISTERED NURSES:
A LEGISLATIVE CALL TO ACTION**

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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.”² 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.³ 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.⁴ Such concerns are, however, almost entirely unsupported by empirical studies, and legislation should ultimately be passed in the States to expand scope of practice for APRNs to the extent of their education.

APRN Practice

“APRN” denotes 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 Many institutions conferring APRN degrees carry a credit load which, in other health care degree programs, would be equivalent to a doctoral degree.⁸

Each APRN specialist is trained in a specific area of medical care. The CRNA is trained to provide anesthesia for a diverse spectrum of patients in diverse locations.⁹ 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."¹⁰ 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, much like a hospitalist.¹¹ Finally, CNPs (or more commonly, "NP") "diagnose; develop differential diagnoses; order, conduct, supervise, and interpret diagnostic and laboratory tests; and prescribe pharmacologic and non-pharmacologic 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.¹²

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.”¹³ 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.¹⁴ As will be demonstrated in this article, 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.

The Need for Expanded Scope

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.¹⁵ While there is disagreement over the extent of the shortage, experts agree that poor urban and rural areas are most affected.¹⁶ APRNs, if un-tethered from supervising physicians, would be able to expand into rural areas that physicians eschew.¹⁷ Currently, eighteen percent of NPs practice in such rural areas, while CNMs attend a “substantial portion of births” and CRNAs are the sole anesthesia providers in eighty-five percent of those rural areas.¹⁸

The 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.¹⁹ In 2014, New York State passed legislation expanding practice for registered nurse practitioners.²⁰ One vocal opponent of that legislation cited the AMA

verbatim in his scathing criticism of the new law.²¹ He further cited to a 1999 study suggesting that NPs may resort to more diagnostic tests, thus negating any economic benefits.²² However, no opposing party has actually cited to any research supporting the contention that APRNs provide 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.”²³ 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.

The 2011 study, a meta-analysis examining twenty-nine separate *patient outcomes* (as opposed to patient preferences) from a total of sixty-nine studies conducted over eighteen years, demonstrated that *in no category* did patients experience more adverse outcomes under the care of APRNs than under that of physicians.²⁴ In fact, APRNs’ patients presented more favorable outcomes in certain categories.²⁵ 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.”²⁶ 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 mention the above 2011 study.²⁷ The report suggests bias, observing without more that APRN advocates performed much of the research in the area.²⁸

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.”²⁹ The OTA was committed to providing objective and non-partisan information to Congress; it was not prone to a pro-APRN bias.³⁰ While that report is nearly thirty years old, no physicians’ groups have put forward subsequent research to refute it, and it has been substantially upheld by subsequent studies. Thus, the position of the AMA and the Physicians Foundation—that APRNs are objectively incapable of providing care equal to that of physicians—appears untenable.

Institute of Medicine Recommendations for the States

The IOM report recommends that state legislatures (1) Reform scope of practice regulations to conform to the National Council of State Boards of Nursing (NCSBN) 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.”³¹ The NCBSN is a non-profit organization that coordinates state boards of nursing to solve common problems and matters of interest among them, ultimately creating this model legislation.³² 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 as they often do, even in states permitting untethered practice. A collaborative agreement is a metaphorical tether, binding APRNs to a supervising physician.³³ A typical collaborative agreement, such as the kind required in New Jersey, requires the APRN and physician to establish joint protocols for the treatment of patients, and the immediate presence or electronic availability of the collaborating physician.³⁴ The more onerous of such statutes requiring

agreements, like Missouri's, contain stringent geographic proximity requirements and bi-monthly review of patient charts.³⁵ 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.³⁶

State statutes, along with regulations promulgated by state nursing boards, regulate nursing practice and scope.³⁷ 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.³⁸ These can lead to murky territory, in which the exact scope of practice for APRNs is not fully delineated.³⁹ 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 proponents of such legislation is to achieve full scope of practice for APRNs, including prescriptive privileges, independent of collaborative agreements.⁴⁰

The NCBSN tracks how compliant the states are with the Consensus Model.⁴¹ There are eleven states and one territory with a perfect NCSBN score for compliance.⁴² Iowa almost 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").⁴³ However, the moniker "APRN" has some legal significance for those practitioners who work across state lines.⁴⁴ A perfect score means that the state/territory has adopted all four 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 prescribing *without* written collaboration agreements.⁴⁵ 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.⁴⁶ 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).⁴⁷

Anecdotal evidence from 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.⁴⁸ Introduced in 2012 by Assemblywoman Nancy Munoz, the New Jersey Consumer Access to Healthcare Act would bring sweeping change to New Jersey scope of practice for APRNs.⁴⁹ 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.⁵⁰ 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 Advanced Practice Nurses (APN), rather than APRNs.⁵¹

The Executive Committee of the New Jersey Board of Medical Examiners opposed the Senate version of the Bill, expressing its opposition based upon three main concerns.⁵² They are concerned that under certain circumstances a physician should be brought in to give treatment, and the Bill erodes those 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.⁵³ 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.⁵⁴ 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.⁵⁵

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.⁵⁶ Other sources show similar results.⁵⁷ However, this is an evolving area of the law, whose scope cannot be covered in this article.

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.⁵⁸ That campaign ostensibly seeks to keep health care consumers informed about who is providing 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.⁵⁹ 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.⁶⁰

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."⁶¹ While it is controversial (because medical societies keep objecting to it), it is obviously not unproven, given the breadth of similar laws already enacted.⁶² Florida's bill proposing expansion allows the expansion of APRNs (in Florida, ARNPs) to practice

independently and prescribe controlled substances and narcotics, leading the Florida Medical Association to insinuate that doing so would “move backwards” in Florida’s fight to curb prescription medicine abuse.⁶³ The Association cited no study supporting the insinuation that expansion would lead to prescription drug abuse, nor is the contention supported elsewhere.⁶⁴ That bill subsequently died in committee.⁶⁵ 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 delivery model and was a possible threat to patient safety.”⁶⁶ Once again, no referral is made to any study revealing a possible threat.⁶⁷

The point is that while legislation on the issue is active in many states, states’ medical societies oppose expanded scope of practice.⁶⁸ And most of those medical societies have significant lobbying influence.⁶⁹ Consequently, much of the scope of practice legislation on the slate for 2014 died, either in committee, or was voted down, or vetoed.⁷⁰ 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.

Perhaps the best strategy for APRN advocates, then, is a piecemeal strategy. The laws getting struck down are largely laws that propose sweeping legislation that immediately conform to the Model Act.⁷¹ As such, the Nebraska Governor spoke of his willingness to enact smaller changes.⁷² 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, successful scope of practice expansion has been achieved when the legislation requires nurses to have a certain threshold of clinical experience within a collaborative agreement scheme before they may be untethered, and strike out on their own.⁷³ 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.⁷⁴

Finally, the IOM report recommends that states require third-party payers to pay direct reimbursement to APRNs.⁷⁵ 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.”⁷⁶ 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.”⁷⁷ 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.⁷⁸

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.

The facts favoring the expansion of the scope of practice for Advanced Practice Registered Nurses are 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. A legislature's 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.

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² 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.

³ 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).

⁴ 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>.

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 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.

⁹ See NCSBN CONSENSUS MODEL, *supra* note 6, at 8.

¹⁰ *Id.*

¹¹ *Id.* at 8-9.

¹² *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>.

¹³ FED'N OF STATE MED. BOARDS, ASSESSING SCOPE OF PRACTICE IN HEALTH CARE DELIVERY: CRITICAL QUESTION IN ASSURING PUBLIC ACCESS AND SAFETY (2005), http://library.fsmb.org/pdf/2005_grpol_scope_of_practice.pdf (last visited Mar. 16, 2015).

¹⁴ 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").

¹⁵ Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 24 Health Aff. 893, 893-94 (2010).

¹⁶ The Editorial Bd., *Bottlenecks in Training Doctors*, THE NEW YORK TIMES (July 19, 2014), http://www.nytimes.com/2014/07/20/opinion/sunday/bottlenecks-in-training-doctors.html?_r=1.

¹⁷ 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>.

¹⁸ Kelly A. Goudreau et al., *Health Policy and Advanced Practice Nursing* 33 (Springer Publ'g 2013).

¹⁹ Press Release, *supra* note 4.

²⁰ 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>.

²¹ 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.

²² *Id.*

²³ Michalene Jansen et al., *Advanced Practice Nursing* 29-30 (3rd ed. Springer Publ'g 2009); *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, 228-31 (2010).

²⁴ Jansen et al., *supra* note 24, 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").

²⁵ *Id.*

²⁶ 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.

²⁷ *Id.*

²⁸ *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.

²⁹ 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>.

³⁰ PRINCETON UNIV., *The OTA Legacy*, <https://www.princeton.edu/~ota/> (last visited Mar. 20, 2015).

³¹ IOM FUTURE OF NURSING REPORT, *supra* note 2, at S-8.

³² NATIONAL COUNCIL OF STATE BOARDS OF NURSING, <https://www.ncsbn.org> (last visited Mar. 19, 2015).

³³ CITIZEN ADVOCACY CTR., SCOPE OF PRACTICE FAQs FOR CONSUMERS, ADVANCED PRACTICE REGISTERED NURSES 1, 2, <http://www.nacns.org/docs/toolkit/3A-FAQScope.pdf>.

³⁴ 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).

³⁵ MO. REV. STAT. § 334.104 (LEXIS 2015).

³⁶ CITIZEN ADVOCACY CTR., *supra* note 33, at 2.

³⁷ 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).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ NATIONAL COUNCIL OF STATE BOARDS OF NURSING, <https://www.ncsbn.org/738.htm> (last visited Mar. 20, 2015).

⁴¹ 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).

⁴² *Id.*

⁴³ Iowa Board of Nursing, *The Advanced Registered Nurse Practitioner*, IOWA.GOV, http://nursing.iowa.gov/nursing_practice/arnp.html (last visited Mar. 20, 2015).

⁴⁴ Jansen et al., *supra* note 23, 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").

⁴⁵ 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).

⁴⁶ *See* NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra* note 40.

⁴⁷ *See* NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra* note 45.

⁴⁸ 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.

⁴⁹ A.B. 906, 216th Leg., Reg. Sess. (N.J. 2014).

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Open Board Agenda, New Jersey Board of Medical Examiners (Jan. 13, 2013), http://www.state.nj.us/lps/ca/bme/agenda/bmeage_010913.pdf.

⁵³ *Id.*

- ⁵⁴ 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”).
- ⁵⁵ Tine Hansen-Turton, Jamie Ware & Frank McClellan, *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1251 (2010).
- ⁵⁶ 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>.
- ⁵⁷ MICH. 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>.
- ⁵⁸ AMA ADVOCACY RES. CTR., “TRUTH IN ADVERTISING” CAMPAIGN 1, 2 (AM. MED. 2012).
- ⁵⁹ NATIONAL ASS’N OF CLINICAL NURSE SPECIALISTS, LEARN THE TRUTH ABOUT AMA’S TRUTH IN ADVERTISING CAMPAIGN, <http://www.nacns.org/docs/TruthTransparencyTalkingPoints.pdf>.
- ⁶⁰ *Id.*
- ⁶¹ *Put Patients First! Urge Your State Rep to Vote NO on Senate Bill 2*, MICH. 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>.
- ⁶² See NATIONAL COUNCIL OF STATE BOARDS OF NURSING, *supra* note 40.
- ⁶³ FLA. MED. ASS’N., http://www.flmedical.org/Stop_7113.aspx (last visited Mar. 20, 2015).
- ⁶⁴ *Id.*
- ⁶⁵ FLORIDA HOUSE OF REPRESENTATIVES, <http://www.myfloridahouse.gov/Sections/Bills/billsdetail.aspx?BillId=52482> (last visited Mar. 20, 2015).
- ⁶⁶ *Statehouse Update: Practice Expansion for APNs Rejected*, MASS. MED. SOC., (Aug., 2014) <http://www.massmed.org/News-and-Publications/Vital-Signs/Statehouse-Update--Practice-Expansion-for-APNs-Rejected/#.VGKgyFTF-EM>.
- ⁶⁷ *Id.*
- ⁶⁸ See, e.g., FLA. MED. ASS’N., *supra* note 63; MICH. STATE MED. SOC’Y., *supra* note 61; New Jersey Board of Medical Examiners, *supra* note 52.
- ⁶⁹ 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.”).
- ⁷⁰ *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> (After conference with his chief medical advisor, Nebraska’s Governor vetoed the expanded practice bill passed by his legislature).
- ⁷¹ NCSBN CONSENSUS MODEL, *supra* note 6.
- ⁷² NURSE.COM, *supra* note 70.
- ⁷³ 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).
- ⁷⁴ Jansen, *supra* note 23, at 394.
- ⁷⁵ IOM FUTURE OF NURSING REPORT, *supra* note 2, at S-8.
- ⁷⁶ 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).
- ⁷⁷ ANN B HAMRIC ET AL., ADVANCED PRACTICE NURSING: AN INTEGRATIVE APPROACH 569 (5th ed. Elsevier Health Sciences 2013).
- ⁷⁸ Price & Parkerton, *supra* note 76.