Nursing and the Privilege of Prescription, 1893-2000

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Today, the House of Delegates [Virginia] passed HB-818, broadened prescriptive authority, from the second to the third reading on a voice vote. There were no amendments. We have no way of knowing how many of the 100 Delegates voted for HB-818. We have heard from a number of Delegates who are voting against the bill that we don’t need their votes to get the bill passed. While none of us is taking anything for granted, we are cautiously optimistic about the House.

The next event: On Tuesday, we expect the bill will be voted on final passage from the House. That will be a recorded vote that we will distribute so you can see how your Delegate voted on HB-818.

There is some small chance that the bill could “go by for the day,” or not be voted until later in the week. We will keep you posted.

Prior to today’s vote, the Medical Society of Virginia had told us that they would have two amendments to HB-818 proposed on the floor today. One was to broaden prescriptive authority to include only Schedule V and VI drugs. The
other was to specify additional education that would be necessary for NPs with broadened prescriptive authority. One of the arguments used by physicians against any expansion of NP scope of practice is that if NPs want to be doctors (i.e., prescribe), they should go to medical school. Therefore, we speculated that the additional educational requirement would be graduation from an accredited medical school, which the Medical Society denied.

HB-818 was heard immediately following a protracted debate on a patient's right to sue their Health Maintenance Organization (HMO), which by the way passed . . . The Delegates clearly were tired of sitting, and many got up and walked around. Apparently, no one had the appetite for prolonged debate on HB818, and the Medical Society's amendments never were proposed.

Here is an abbreviated version of the debate on this bill. Please keep in mind that accuracy is not always the hallmark of good debate on the floor. . . .

In February 2000, e-mails about prescriptive authority for NPs were flying, most informing nurse practitioners of the latest news from the state capitol, where some NP representatives were closely following what was occurring on the House floor. Clearly, nurse practitioners across the Commonwealth of Virginia wanted their delegates to the House of Representatives to vote for a bill expanding NPs’ prescriptive privileges. For years, nurse practitioners had been restricted from prescribing certain categories of drugs they needed to prescribe if they were to provide comprehensive care. In fact, NPs in thirty-four other states had broader prescriptive authority than did NPs in Virginia.

Since the implementation of the Controlled Substance Act of 1970, federal law categorized prescription drugs into two types: (1) legend drugs (like antibiotics—medicines that could be dispensed only by prescription, but which were not narcotics), and (2) narcotics or controlled substances listed on five schedules. Schedule I substances included illegal drugs like heroin; Schedule II were “drugs with significant addictive potential,” like morphine, fentanyl, and oxycodone (commonly known as Percodan); Schedule III were drugs that had “some potential for abuse,” including Tylenol with...
codeine, and opium combinations (Paregoric); Schedule IV drugs had “low potential for abuse but could lead to physical or psychological dependence,” like alprazolam (Xanax), diazepam (Valium) and lorazepam (Ativan); Schedule V drugs included “drugs determined to have low abuse potential but designated for regulation by individual states and localities” because they contained limited quantities of certain narcotics. These drugs included antidiarrheal compounds and cough medicines with codeine.

By 2000 non-narcotic legend drugs (like amoxicillin and other antibiotics) had become known as Schedule VI drugs. Schedule VI drugs also included over-the-counter medicines like ibuprofen (Advil). The Virginia Medical Society’s proposed amendment (that did not actually get to the floor) was to add only “Schedule V and VI” drugs, allowing NPs to prescribe such medicines as cough medicine with codeine (Schedule V), as well as antibiotics and drugs widely available to the public for self-administration—like aspirin, Vaseline, zinc oxide ointment, milk of magnesia, hydrogen peroxide, castor oil, Vicks VapoRub, and so on (Schedule VI). With the exception of antibiotics, the latter included drugs nurses had been dispensing and furnishing for over a century (see chapter 1).

Nurse practitioners in Virginia were not pleased with the Medical Society’s proposed amendment. Some, including acute care nurse practitioners (ACNPs), were working in hospital settings caring for acutely ill patients and needed to order narcotic drugs like fentanyl to relieve pain or drugs like Ativan to control seizures. Others were following patients in subspecialty clinics in cardiology, neurology, and oncology. Their patients needed a wide variety of medicines ranging from those in Schedule II to those in Schedule VI. For example, a cardiac patient often needed nitroglycerin tablets (Schedule VI) but could also require a Schedule II drug like morphine if he had an episode of severe chest pain. For nurse practitioners working in primary care settings, the right to prescribe a wide range of drugs was also important in order for them to administer comprehensive care in a timely manner. For example, patients sometimes needed Schedule III drugs like Tylenol with codeine for pain that was unresponsive to over-the-counter analgesics. Other patients with protracted coughs might need a cough medicine containing codeine. As more primary care providers were treating patients with psychological disorders, these NPs might also need to prescribe any of a wide variety of Schedule IV drugs (e.g., Xanax or Ativan).

The NPs in Virginia were asking for the privilege to prescribe all schedules of drugs, limited only by their supervising physician. In the nurses’ proposal, the nurse practitioner would be permitted to prescribe only what her supervising physician agreed was “appropriate based on the kind of practice, the NP’s experience and education, and the level of trust” the physician had in the NP. In addition, as one nurse noted, “The Board of
Medicine and the Board of Nursing would jointly decide, in regulations, what additional education would be necessary for nurse practitioners with broadened prescriptive authority.” Nurse practitioners in Virginia were determined to get HB818 passed. They went so far as to meet with Emily Couric, the state senator for the 25th district, in her Charlottesville office the week before the Senate debate to discuss “the potential benefits such legislation would have for increasing access to health care services, particularly in rural and underserved areas.” Following the meeting, Senator Couric wrote to the NPs, assuring them that she would keep their “comments in mind” during the proposed debate.

Acknowledging and Authorizing Prescribing Practices

Since 1965, when the first PNPs began to practice, nurse practitioners had been striving for the legal authority to prescribe. The issue, of course, was not whether NPs could and did prescribe, but rather, whether states would “acknowledge and authorize their prescribing practices.” Except for Idaho, which was the first state to recognize diagnosis and treatment as part of the scope of practice of specialty nurses in 1971, and North Carolina, which explicitly authorized nurse practitioners to prescribe drugs in 1975, state legislatures had been slow to respond.

Convincing state legislatures to pass laws and reimbursement policies that would support NP practice was not easy. The major issue was, as usual, control of medical practice and the degree of independence a nurse practitioner should be allowed. Generally, state medical practice acts broadly defined the physician’s scope of practice to include curing, diagnosing, treating, and prescribing. It was hard for the nurses not to be accused of practicing medicine if they did any of these activities. The issue could not simply be ignored. Nurse practitioners were already de facto prescribing, and physicians could accuse them of “practicing medicine without a license.” As was true in the 1920s and 1930s, if the state laws regulating nursing practice did not specifically grant nurses the rights to diagnose and prescribe, nurses and physicians would have to turn to the courts for a decision whenever nursing practice was questioned.

Sermchief v. Gonzales

As had been true in previous decades, in 1980 the Missouri Courts would be asked to decide on a question of nursing practice. That year, the Missouri State Board of Medicine charged two nurse practitioners working
in a women’s health clinic of practicing medicine without a license. In the course of their work at the clinic, the NPs, Ms. Solari and Ms. Burgess, had been taking health histories, doing breast and pelvic examinations, ordering laboratory tests, providing information to patients about contraception, and “dispensing certain designated medications . . . pursuant to written standing orders and protocols signed by physicians.”

The court ruled against the nurses, finding them guilty of practicing medicine without a license. Its decision was based on the statute for the practice of medicine in Missouri in 1980, which included the following section:

> It shall be unlawful for any person not now a registered physician within the meaning of the law to practice medicine or surgery in any of its departments, or to profess to cure and attempt to treat the sick and others afflicted with bodily or mental infirmities, or engage in the practice of midwifery in this state, except as herein provided.

The court had also used the statute on nursing practice in Missouri on which to base its decision. That statute included the following definition of professional nursing:

> “Professional nursing” is the performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to: (a) Responsibility for the teaching of health care . . . (b) Assessment, nursing diagnosis, nursing care and counsel of persons who are ill, injured or experiencing alterations in normal health processes; (c) The administration of medications and treatments as prescribed by a person licensed in this state to prescribe such medications and treatments; (d) The coordination and assistance in the delivery of a plan of care . . . ; or (e) The teaching and supervision of other persons in the performance of any of the foregoing.

Following their loss in the lower court, the nurses appealed to the Missouri Supreme Court. They were supported by amicus curiae briefs “resembling a letter-writing campaign directed at a legislative body.” Summarizing the content of those briefs in the final report, the judges wrote: “It suffices to say that those briefs detailed the historical development of the nursing profession and the nurses’ expanding role in the delivery of health services, the reality of which both the Court and the public notice. Many expressed their opinions as to how we should construe our
Missouri statues, a matter which we are obligated to do in accordance with long established rules of statutory construction.”

Clearly irritated by the sheer volume of *amicus curiae* briefs, the Missouri Supreme Court judges went on to note a new procedure and rules for submitting them, then returned to a discussion of the issue at hand:

The facts are simple . . . the appellant nurses Solari and Burgess are duly licensed professional nurses in Missouri . . . both have had post-graduate training in the field of obstetrics and gynecology . . . Appellant physicians . . . are duly licensed. . . . The ultimate issues for determination [are]: (A) does the conduct of plaintiff nurses Solari and Burgess constitute Professional Nursing as defined in #335.016.8 [the nurse practice act] . . . and (B) If the court finds and concludes that any act of the plaintiffs does not constitute “professional nursing” . . . the Court must determine if #334.010 [the medical practice act] is unconstitutionally vague. . . .

The parties on both sides request that in construing these statutes we define and draw that thin and elusive line that separates the practice of medicine and the practice of nursing in modern day delivery of health services. . . . In our opinion [that] would result in an avalanche of both medicine and nursing malpractice suits alleging infringement of that line and would hinder . . . the delivery of health services to the public.20

In the end, the court decided in favor of the nurses, reasoning:

Fundamentally, we seek to ascertain the intent of the lawmakers and to give effect to that intent. . . . The legislature substantially revised the law affecting the nursing profession with enactment of the Nursing Practice Act of 1975. Perhaps the most significant feature of the Act was the redefinition of the term “professional nursing,” which appears in #335.016.8. Even a facile reading of that section reveals a manifest legislative desire to expand the scope of authorized nursing practices. Every witness at trial testified that the new definition of professional nursing is a broader definition than that in the former statute. . . . Most apparent is the elimination of the requirement that a physician directly supervise nursing functions. Equally significant is the legislature’s formulation of an open-ended definition of professional nursing. . . . The 1975 Act not only describes a much broader spectrum of nursing functions [than earlier legislation], it qualifies
this description with the phrase “including, but not limited to.” We believe this phrase evidences an intent to avoid statutory constraints on the evolution of new functions for nurses delivering health services. Under #335.016.8, a nurse may . . . assume responsibilities heretofore not considered to be within the field of professional nursing so long as those responsibilities are consistent with her or his “specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences.”

The Missouri Supreme Court decision would set precedent for nursing practice for the remainder of the century. New state nurse practice acts used very general wording to allow for expansion in nurses’ roles and functions over time. They also defined professional nursing to include the acts of diagnosis and treatment—a significant ruling for nurse practitioners.

“Nursing Diagnosis” and Nurse Practice Acts

The general wording and the expanded functions listed in the 1975 Missouri Nurse Practice Act were critical to the judges’ decision. One of the new terms, “nursing diagnosis,” was particularly important, although it would have been equally effective had the statute used the terms “diagnosis” or “medical diagnosis,” as other states would later do. Nevertheless, in 1975 the Missouri legislators drafting the nurse practice act used the term that was just being developed. In fact, the Missouri definition was one of the first to include it, as the Nursing Diagnosis movement was in its infancy. In 1973, nurse leaders Kristine Gebbie and Mary Ann Lavin had convened the First Task Force to Name and Classify Nursing Diagnoses and appointed Marjory Gordon, PhD, RN, as chairperson. In 1974, the First Conference Proceedings, edited by Gebbie and Lavin, were published.

Nursing was still trying to carve out its niche but differentiate its practice from the medical model, and many nurses were determined to draw that “thin and elusive line” (as it was described by the Missouri Supreme Court) between the professions. Differentiating nursing from medical diagnoses was one step toward drawing that line, and, although it would lead to controversy within the profession, in this case, the incorporation of the particular term had been critical to the nurses’ success.
State Nurse Practice Acts and NP Practice: 1980s

Although states soon incorporated the acts of diagnosis and treatment into their laws regulating nursing practice, a large majority continued to avoid granting nurses independent prescriptive authority. By 1983, only Oregon and Washington granted NPs statutory independent prescriptive authority. Other states granting prescriptive authority to nurse practitioners did so with the provision that the nurse practitioner be directly supervised by a licensed physician. Particularly in the 1980s, when federal funding for health care services decreased under the Reagan administration, it was—as Elizabeth Hadley noted—in the “economic best interest” of physicians to confine NPs to a “largely complementary role in the provision of health services.”

By 1984, approximately 20,000 NPs were employed, for the most part in outpatient clinics, health maintenance organizations (HMOs), health departments, community health centers, rural clinics, schools, occupational health clinics, and private offices. The problem was that many worked under various titles, including “nurse clinician,” “advanced clinical nurse,” and “nurse practitioner.” Moreover, all of these titles had different meanings, differing descriptions of educational requirements, and different performance expectations. The issue plagued the profession and was hotly debated in the nursing literature. As Yale law professor Barbara Safriet later noted, the “multiplicity of roles and titles for advanced practice nurses (APNs)” resembled “the rubble of the Tower of Babel.” According to Safriet, “Even the most sophisticated health care consumer or policymaker” could be “easily confused.” Nursing as a profession had to clarify its titles and its educational requirements for advanced practice before legislators could be expected to write meaningful laws regulating its practice.

Before Safriet’s commentary, nurses themselves realized the confusion that the plethora of new titles was causing. In 1984, Joy Calkin, associate professor at the University of Wisconsin–Madison, proposed a model for advanced nursing practice, specifically identifying clinical nurse specialists and nurse practitioners with master’s degrees as advanced practice nurses, or APNs. Other practitioners, including nurse anesthetists and nurse-midwives with graduate education, would soon share the title. By definition, advanced practice nurses were educated at the master’s level, worked in direct clinical practice, were expert coaches, provided consultation, used research to determine practice, provided clinical and professional leadership, collaborated with other professionals, and used ethical decision making. For those who would be certified as nurse practitioners, part of their education included classes in advanced health assessment and physical diagnosis, as well as advanced pharmacology. In addition, they had hundreds of hours of clinical application.
Opposition from the American Medical Association

While the nursing profession was striving for clarity in role definitions and titles, graduating nurse practitioners, nurse anesthetists, and nurse-midwives with master’s degrees and watching them become employed in various settings, the American Medical Association was planning to “combat” new legislation that authorized “medical acts by unlicensed individuals.” In fact, in 1984 the AMA House of Delegates passed a resolution to “oppose any attempt at empowering non-physicians to become unsupervised primary care providers and be directly reimbursed.” According to that resolution:

The AMA (1) opposes the enactment of new legislation which would authorize the independent practice of medicine by individuals who are not licensed to practice medicine and surgery in all of its branches; and (2) supports the enactment of amendments to restrict current statutes which authorize the independent practice of medicine by individuals who are not licensed to practice medicine and surgery in all of its branches.

To block new legislation to this effect, the AMA would have to lobby state legislators. By tradition, state governments controlled medical and nursing practice. Regulations varied according to each state. Some states allowed nurse practitioners to practice independently, whereas others restricted them to practice only under physician supervision. Constraints included “requirements for written agreements and written protocols, a limited selection of drugs listed in an official formulary” that was itself “limited to Schedule VI drugs and devices, and supervision by a physician.”

For the remaining years of the twentieth century, both individual physicians and medical associations did lobby against “any legislative efforts to acknowledge prescriptive authority as part of the advanced practice nurses’ scope of practice.” To make it easier to do so, in April 1992 the AMA adopted model legislation on the “Regulation of Prescription-Writing Authority of Nurse Practitioners,” defining prescribing as a medical act.

Nursing Publications and Cost-Effective Care

Members of the nursing profession decided to argue for the safety and efficacy of NP practice using scientifically based research data. Since the 1950s, as increasing numbers of nurse faculty were educated at the PhD
level, they had been emphasizing clinical research, conducting studies, and publishing their results. By the 1970s, among other things, they were conducting studies on NPs’ practice. By 1980, nurse researchers studying nurse practitioners’ effectiveness had documented that their care was comparable to that of physicians. Through the 1980s, nurses published about the unique aspects of NP practice that distinguished it from medical practice, particularly about the cost-effectiveness of care provided by the nurses.

Cost containment in health care characterized the 1980s, producing legislative and economic changes that affected the entire health care delivery system. Of particular significance was the establishment in 1983 of a prospective payment system using diagnosis-related groups (DRGs) for hospitalized Medicare recipients. In an effort to control rising hospital costs, this payment system shifted reimbursement from “payment for services provided” to “payment by case” (capitation). As a result, hospital administrators pressured nurses and physicians to decrease the length of time patients remained in the hospital. The hospital would be reimbursed for the “disease condition,” based on standardized estimates of what the treatment should cost, rather than for the amount of time it took for the patient to be ready for discharge. Each day the patient stayed in the hospital cut the hospital’s profit margin.

In the mid-1980s, the need to provide cost-effective, quality care to American citizens prompted the US Senate Committee on Appropriations to request a report from the Office of Technology and Assessment (OTA) on the contributions of nurse practitioners, certified nurse-midwives, and physician’s assistants in meeting the nation’s health care needs. The report, released in 1986 and entitled “Nurse Practitioners, Physician Assistants and Certified Nurse Midwives” (later referred to as the OTA Report), was based on an analysis of numerous studies that assessed quality of care, as well as patient satisfaction and physician acceptance. It concluded that “within their areas of competence NPs . . . and CNMs [certified nurse-midwives] provide care whose quality is equivalent to that of care provided by physicians.” Unfortunately, the OTA Report only compared nursing care to medical care and did not address the “value-added” components of advanced nursing practice—particularly the holistic perspective, health promotion, and patient education. The OTA Report also found that the cost of care provided by nurse practitioners (per care episode) was 20 percent less than traditional physician-provided care for the same patient population. The problem was that nurse practitioners could not be reimbursed by third-party payers. There was another problem: while the OTA was conducting its study, the American Medical Association was taking a stance against nonphysician care providers. Primary care was becoming a medical specialty.
Nurse Anesthetists, circa 1980s

While the profession as a whole focused on nurse practitioners, the specialty of nurse anesthesia continued to develop. By 1980 there were four master’s programs in nurse anesthesia in the United States. Despite this progress on the educational front, interprofessional conflicts with medicine continued. Although the earlier litigation, Frank et al. v. South and Chalmers-Frances v. Nelson, provided the critical legal basis of nurse anesthesia practice, tension between medicine and nurse anesthetists continued, particularly in relation to malpractice policies, antitrust, and restraint of trade issues. In 1986, Oltz v. St. Peter’s Community Hospital established that certified registered nurse anesthetists (CRNAs) could sue for anticompetitive damages when anesthesiologists conspired to restrict the CRNAs’ practice privileges. A second case, Bhan v. NME Hospitals, Inc., established the CRNAs’ right to be awarded damages when hospital administrators made exclusive contracts with physician anesthesiologists—contracts that barred CRNAs from practicing there. As evidenced in all these cases, nurse anesthetists were winning the legal battles and overcoming barriers to their practice.

Like nurse practitioners during the 1980s, nurse anesthetists also had to overcome barriers to be reimbursed for their services by third-party payers. The chief problem was that nurse anesthetists could not bill for their services, and hospital administrators had to consider them as a cost center rather than as a revenue-generating service, creating reimbursement disincentives for their employment.

1990s: The Challenges of Managed Care

The changing marketplace of the 1990s, with its focus on health care reform, created new challenges for nurse practitioners. Now they had to struggle not only with restrictive, outdated state laws on prescriptive authority, but also with “non-governmental, market-based impediments” to their practices. Writing in The Yale Journal on Regulation in 1992, Barbara J. Safriet urged immediate legislative reform to reduce the restrictions on advance practice nurses, particularly those constraining the work of nurse practitioners and certified nurse-midwives. According to Safriet:

> Although our ailing health care system presents an endless array of symptoms, the diagnosis is relatively straightforward: too few people can get good care when they need it and at a price they can afford. Any proposed cure should therefore include, at a minimum, steps to
eliminate . . . those things that impede the efficient and effective pro-
vision of health care. . . . Chief among these are conflicting and
restrictive state provisions governing the scope of practice and pre-
scriptive authority of Nurse Practitioners and Certified Nurse
Midwives (CNMs), as well as the fragmented and parsimonious state
and federal standards for their reimbursement. As a result of these
provisions, NPs and CNMs are severely hampered—or disabled alto-
gether—in their efforts to fulfill their fully proven potential to
enhance our nation’s health.50

One of those restrictions had to do with controlled substances.

The Controlled Substances Act, 1991–92

Federal legislation regulating narcotics in the Controlled Substances Act
(revised in 1991 and 1992), would play a major role in the nurse practi-
tioner’s attempt to obtain prescriptive authority during the 1990s. As nurse
practitioners began to gain prescriptive authority for controlled substances
in the different states, they required a parallel authority granted by the
Federal Drug Enforcement Agency (DEA). In 1991, the DEA first
responded to this situation by proposing registration for “affiliated practi-
tioners” (56FR 4181). This proposal called for those nurse practitioners
who had prescriptive authority pursuant to a practice protocol or collabor-
ative practice agreement to be assigned a registration number for con-
trolled substances tied to the numbers of physicians with whom they
worked. The proposal was criticized for restricting access to health care and
its implications for legal liability. Because of these problems, it was revoked
early in 1992. Later, in July of that year, the DEA amended its regulations
by adding a category of “mid-level providers” (MLP), to include advanced
practice nurses, who would be issued individual provider DEA numbers so
long as they were granted prescriptive authority by the state in which they
practiced. The mid-level provider’s number would begin with an “M.” The
provision took effect in 1993, significantly expanding the NPs’ ability to
prescribe.

By 1994, over 50,000 nurse practitioners were practicing as primary
care providers and had negotiated some form of prescriptive authority in
forty-six states. Twenty-five states had legislation authorizing private and
commercial insurers to reimburse them for their services, twenty-one states
and the District of Columbia permitted them to write prescriptions for
drugs, and fifteen of these gave independent prescribing authority for con-
trolled substances.51 Alaska and Oregon gave full prescriptive powers to
advanced practice nurses permitting them to practice independently of physician control. Most other states, including New York, limited their autonomy by requiring nurse practitioners to practice in collaboration with a licensed physician.\textsuperscript{52} According to the New York state practice act:

The practice of registered professional nursing by a nurse practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols. . . .\textsuperscript{53}

“Specialty areas of practice” would soon expand from primary care to include numerous specialties such as neurology, neurosurgery, cardiology, nephrology, and intensive care, as the idea of using nurse practitioners in tertiary care centers was on the horizon.

**Acute Care Nurse Practitioners**

As health care became increasingly based on technology, and as patients progressed rapidly from intensive care units to “step-down” units to home in an attempt to decrease their length of stay, hospital care lacked continuity and coordination. In fact, patients were cared for by numerous teams of doctors and nurses. One particular nurse did not follow the patient from admission to discharge in order to have a complete picture of what the patient had been through during hospitalization and what the plan was for care afterwards. Doctors were rushed and often busy in surgery or busy following other patients in clinics. Patient care was becoming increasingly fragmented as specialists came and went, seeing the patient for only one particular problem.

A few nurse educators responded quickly to the problem, creating a role that was to provide quality patient care and care coordination.\textsuperscript{54} Their solution was to put nurse practitioners inside hospitals. University of Pennsylvania Professor Anne Keane and Theresa Richmond, RN, MSN, were among the first to document the new “Tertiary Nurse Practitioner” (TNP) role, writing:

The TNP is an advanced practice nurse educated at the master’s level with both a theoretical and experiential focus on complex patients
with specialized health needs. . . . There is precedent for the NP in tertiary care. For example, neonatal nurse practitioners are central to the provision of care in many intensive care nurseries. . . . It is our belief that the TNP can provide clinically expert specialized care in a holistic manner in a system that is often typified by fragmentation, lack of communication among medical specialists and a loss of recognition of the patient and patient’s needs as central to the care delivered.55

It was a logical next step. Nurse practitioners were already working in the outpatient setting and in neonatal intensive care clinics with premature newborns, and their care had been proven to be effective.56 Now, nurse practitioners who wanted to work with adult patients inside the hospital could become “TNPs,” a title that was quickly changed to “Acute Care Nurse Practitioners,” or ACNPs. These nurses were usually experienced in caring for patients in various medical specialties, like cardiology, nephrology, neurology, and oncology. Some had been clinical nurse specialists for years and now wanted to have the skills and knowledge necessary to follow patients in specialty clinics. They needed to have the skills to take health histories and prescribe medications in addition to doing the patient education and counseling they were already doing. Those skills could be acquired in nurse-practitioner programs.

Nurse faculty responded by creating acute care nurse practitioner tracks within their master’s programs. Between 1992 and 1995, numerous ACNP programs opened. In 1995, the American Nurses Credentialing Center (ANCC) administered the first ACNP certification examination.57 By the late 1990s, acute care nurse practitioners were employed in multiple specialties, including, among others, cardiology, cardiovascular surgery, neurosurgery, emergency/trauma, oncology, internal medicine, and radiology services.58 Meanwhile, the idea of requisite master’s preparation for nurse anesthetists was also becoming a reality.

Nurse Anesthetists in the 1990s

As the decade opened, there were seventeen master’s programs in nurse anesthesia; by 1999, there were eighty-two.59 As of 1998, all accredited programs in nurse anesthesia were required to be at the master’s level; however, they were not uniformly located within schools of nursing. Rather, they were housed in a variety of disciplines, including schools of nursing, medicine, allied health, and basic science. As it had been throughout the century, nurse anesthetist programs continued to be
regarded by the profession as “on the fringe.” Toward the turn of the twenty-first century, however, CRNA programs were increasingly becoming incorporated into graduate nursing programs.

Conflict and Negotiations Continue

During the 1990s, conflict with the medical profession and negotiations with state legislatures continued. In 1994, Dr. Jerome Kassirer, writing in the *New England Journal of Medicine,* questioned the role of nurse practitioners in primary care. He particularly discredited the published data on the NPs’ competency and effectiveness, and he accused the OTA Report of “serious flaws, including a lack of appropriate controls, heterogeneity of practice settings, small sample of nurse practitioner subjects and patients, lack of random assignment of patients, failure to account for differences in the severity of illnesses and a paucity of outcome events.” Kassirer also noted that he was not “the first to point out these shortcomings,” as they were “described in the OTA report and by nurse researchers themselves” in their call for better-designed studies in the future. Kassirer did concede that NPs effectively managed “a large number of common problems” like sore throats, “with and without physician supervision.” Kassirer argued that he was not concerned with “considerations of turf”; rather, he was concerned with the fact that the nurse practitioners had considerably less training, and primary care was becoming more complicated. He argued that there were increasingly sophisticated diagnostic tests that needed a high level of education to interpret. Kassirer concluded with a statement of caution that the safety and efficacy of advanced practice nurse’s care needed to be established before “further expanding an independent role for nurse practitioners.”

Dr. Kassirer had a point. With the knowledge explosion in the fields, both medicine and nursing were becoming increasingly complex. New drugs were being added to the formularies on a daily basis, and many practitioners, overwhelmed with information, were turning to the use of handheld “Palm Pilots” or personal digital assistants (PDAs) to keep up with the new information. Furthermore, Kassirer was justified in his argument for careful analysis of nurse practitioner practice through randomized, controlled clinical trials (RCTs) with larger sample sizes and homogeneity of practice settings and patient populations. RCTs are, of course, the “gold standard” for research studies and nurse researchers would agree that studies should be ongoing.

What Dr. Kassirer did not mention was that nurse practitioners are professionals who can be trusted to know the limits of their areas of com-
petence and determine when they need physician consultation. As professionals, they could also be trusted to attend pharmacology seminars and continuing education conferences on new diagnostic tests and new therapies, and/or read the literature in their particular fields in order to ensure that they had the knowledge they needed to provide safe care—just as physicians are trusted to do. Enhancing that legitimacy, state boards of nursing, or in some cases joint boards of nursing and medicine, were establishing criteria for nurse-practitioner licensure, and certification boards were determining who could sit for examination.

Necessary Knowledge for Safe Care

Necessary knowledge for safe practice was indeed being mandated for the increasing numbers of NPs entering practice. By 1994, 384 NP tracks were incorporated in master’s programs throughout the United States. By 1998, that number was 769. Most used the National Organization of Nurse Practitioner Faculty (NONPF) guidelines in determining curriculum—guidelines that required nurse practitioners to have courses in advanced pathophysiology, physical assessment, and pharmacology and a minimum of five hundred hours of supervised clinical practice. As of the end of 1997, the ANA required that applicants who wanted to sit for advanced practice certification examinations have a minimum of master’s level preparation. The reality was that many had post-master’s educational preparation. Some had PhDs or other doctoral degrees (e.g., DNSc, ND). The nursing profession itself was cognizant of the fact that these practitioners would be expected to perform at an advanced level, and wanted that care to be safe.

Realities of Practice

Nurse practitioners wrote fifteen million prescriptions in 1998, an increase of 66 percent over 1997, according to the pharmaceutical consulting firm Scott-Levin. Although the public debate over prescriptive authority was framed in terms of quality of care, economics was the subtext. The market forces represented more significant barriers than regulatory ones. As law professor Barbara Safriet would note in 1998:

No longer is governmental prohibition or restriction the only—or even the principal problem. Now an increase in the competitive chaos of the marketplace has thrown APNs into unfamiliar territory in
which private contracting, market-share, and capital requirements may pose potentially serious obstacles. From closed panels to physician-dominated contracting arrangements with integrated delivery systems, APNs and other “non-physician providers” face new non-governmental, market-based impediments to their practices.68

Nurse practitioners had been slowly making progress in removing legal barriers to practice. At the turn of the twenty-first century, many states were recognizing nurse practitioner practice and expanding the scope of prescriptive authority for advanced practice nurses. The Commonwealth of Virginia provides one example of what was occurring nationwide.

The Virginia Experience

In the spring of 2000, the state legislature in Virginia passed a new law regulating the nurse practitioner’s prescriptive authority. According to Virginia Code 54.1–2957.01, “Prescription of Certain Controlled Substances and Devices by Licensed Nurse Practitioners”:

In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 of this title, a licensed nurse practitioner . . . shall have the authority to prescribe controlled substances . . . as follows: (i) Schedules V and VI . . . on July 1, 2000; (ii) Schedules IV through VI on and after January 1, 2002; and (iii) Schedules III through VI . . . on and after July 1, 2003.

Nurse practitioners shall have such prescriptive authority upon the provision to the Board of Medicine and the Board of Nursing of such evidence as they may jointly require that the Nurse Practitioner has entered into and is, at the time of writing a prescription, a party to a written agreement with a licensed physician which provides for the direction and supervision by such physicians of the prescriptive practices of the nurse practitioner. Such written agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the physician providing direction and supervision. . . .

This section shall not limit the functions and procedures of certified registered nurse anesthetists. . . .69
In Virginia, as in many states, nurse practitioners had acquired the legal authority to prescribe various schedules of medications. According to the law, the specifics would be left to negotiations between physicians and nursing practitioners working together at the grassroots level. The next hurdles would be to institute board of nursing rather than joint Board of Medicine and Board of Nursing oversight of nursing practice, and to convince the American Medical Association to collaborate in the recognition of an expanded scope of practice (including prescriptive authority) for advanced practice nurses and other nonphysician health care providers rather than oppose such changes. In both negotiations, at the individual practice level and at the organizational level, in Virginia and in other states, it would be a matter of trust.