

## **Restraint of Trade: Organized Medicine is Building Barriers Instead of Bridges**

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### **Abstract**

With the passage of the Affordable Care Act millions more Americans are seeking healthcare through marketplace insurance that they were able to purchase. We have seen that there are insufficient family practice physicians to meet this overwhelming need for care, yet organized medicine continues to create barriers to the one group of health care providers that can serve as a bridge to the future: the nurse practitioners (“NPs”). Many major organizations including the FTC, National Governors, Institute of Medicine, American Association of Nurse Practitioners, American Nurses Association, etc. have advocated on behalf of NPs to reexamine outdated legislation and, where possible, to change that legislation so that it is congruent with the technological, biological, and medical changes that have occurred in our healthcare system over the past 50 years.

The quality and safety issues have repeatedly been debunked. Patient outcomes for both NPs and family physicians have been shown to be equivalent and, in some cases, NPs fare better in terms of outcomes than our physician colleagues. Competency of NPs is initiated and maintained through certification exams, continuing education, and workshops similarly to our physician colleagues.

The quest for NP autonomy is simply a desire to practice according to the education and skills that our respective states’ “scope of practice” regulations allow. In point of fact, no healthcare provider truly works “independently” because we all rely on one another: NPs refer to specialists, MD’s refer to surgeons and surgeons refer back to internal medicine. -. Restraint of one profession by another simply leads to litigation. If we all are to make a difference in terms of the access to and quality of health care, then the path we should follow is clear: it is time to break down the barriers and begin building bridges, for only by working collaboratively will we be providing the best care for our patients.

## Introduction

Healthcare in America is at a crisis point.<sup>1</sup> Approximately 33 million Americans were without insurance coverage in 2014.<sup>2</sup> While cost is a contributing factor to this crisis, lack of access to primary care providers is equally important.<sup>3</sup> This dearth of providers has been exacerbated by the multiple year declines in the number of family practice residency slots that have remained unfilled.<sup>4</sup> For example in 2016, 3,238 positions were offered but only 3,085 were fulfilled.<sup>5</sup> Yet despite this lack of providers, organized medicine is unwilling to allow other healthcare providers, such as nurse practitioners, whose education, skills, competency, and patient outcomes are equivalent to that of family medicine physicians, to help alleviate this backlog of patients with primary care needs. Nurse Practitioners by virtue of their education and skills are competent to provide autonomous care without supervision or collaboration by another discipline. Typically there is a triad of excuses as to why nurse practitioners need to have either a supervisory relationship or a collaborative relationship with a physician, specifically: safety issues, threat to a physician's livelihood, and educational issues.<sup>6</sup> Yet each of these "concerns" fall into the category of a "red herring."

The issue of "safety" has been debunked by multiple authors who have shown in research studies that "...nurse practitioners provide high quality, accountable, safe and effective care at least as well as physician or physician assistant colleagues."<sup>7</sup> Contrary to

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<sup>1</sup> T. R. Reid (2010) *The Healing of America: A Global Quest for Better, Cheaper and Fairer Health Care*. Penguin Books, p. 2-3

<sup>2</sup> Smith, Jessica C. and Carla Medalia, U.S. Census Bureau, *Current Population Reports, P60-253, Health Insurance Coverage in the United States: 2014*, U.S. Government Printing Office, Washington, DC, 2015.

<sup>3</sup> ARTICLE: Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing, 9 *Yale J. on Reg.* 417, 3. p.419

<sup>4</sup> National Resident Matching Program, *Results and Data: 2016 Main Residency Match*, National Resident Matching Program, Washington, DC 2016. Available at: [www.nrmp.org/wp-content/uploads/2016/04/Main-Match-Results-and-Data-2016.pdf](http://www.nrmp.org/wp-content/uploads/2016/04/Main-Match-Results-and-Data-2016.pdf), p. 419

<sup>5</sup> Supra at note 4, 12.

<sup>6</sup> ARTICLE: NURSING THE PRIMARY CARE SHORTAGE BACK TO HEALTH: HOW EXPANDING NURSE PRACTITIONER AUTONOMY CAN SAFELY AND ECONOMICALLY MEET THE GROWING DEMAND FOR BASIC HEALTH CARE, 24 *J.L. & Health* 261, 261, 263

<sup>7</sup> Lowery, B., Scott, E. & Swanson, M. (2015) *Nurse practitioner perceptions of the impact of physician oversight on quality and safety of nurse practitioner practice*. Available at:

the belief that having nurse practitioners practice to their full scope and skills decreases the revenue that physicians make, is the fact that nurse practitioners can treat the more simple conditions, which allow the physician to take the more complex cases that generate a higher return on reimbursement.<sup>8</sup> Finally, organized medicine argues that nurse practitioners have four years of nursing school and two years of graduate education while physicians have four years of medical school and 3 years of residency education, and hence, are not educationally qualified to care for patients without supervision.<sup>9</sup> What this line of thinking ignores is that the majority of nurse practitioners now practicing have had an average of 8.5 years work as a registered nurse prior to entering their graduate nurse practitioner program and that experience helps develop their clinical skills and knowledge base.<sup>10</sup> Yet despite these empirical data supporting autonomy for nurse practitioners, organized medicine continues to oppose any change in scope of practice.<sup>11</sup> However, changes in workforce needs and shortages of primary care physicians are going to provide the impetus needed to allow nurse practitioners by virtue of their education and skills to provide competent, safe, autonomous care without supervision or collaboration by organized medicine.<sup>12</sup> That having been said, it is important to note that no healthcare provider truly works independently (autonomously). We all collaborate with one another and make appropriate referrals to ensure that we are practicing within the legal limits of our scope of practice.<sup>13</sup> Hence, the belief that if we are to stem the hemorrhaging of the healthcare crisis in the United States then we are all going to

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<http://onlinelibrary.wiley.com/doi/10.1002/2327-6924.12336/epdf>, p.1; Dierick-van Daele, A., Metsemakers, J., Derckx, E., Spreeuwenberg, C., & Vrijhoef, H. (2009). Nurse practitioners substituting for general practitioners: Randomized controlled trial. *Journal of Advanced Nursing*, 65(2), 391–401.; Herrick, T. (2000). JAMA reports patient outcomes comparable for NPs, MDs: Study may signal shift in physician attitudes. *Clinician News*, 1(1), 6. p.1

<sup>8</sup> Supra note 6, at 262. ; Christensen, C.M. et al. Will Disruptive Innovations Cure Health Care? *Harvard Bus. Rev.* Sept-Oct 2000

<sup>9</sup> Health Policy Brief: Nurse Practitioners and Primary Care. *Health Affairs*, updated May 15, 2013, 3.

<sup>10</sup> Rich ER, Jordan ME, Taylor CJ, Assessing successful entry into nurse practitioner practice: a literature review. *Journal of the New York State Nurses Association*, 00287644, 2001 Fall-Winter, Vol. 32, Issue 2. Available at:

[http://rw3kt2qh5l.search.serialssolutions.com/?sid=Entrez:PubMed&id=pmid:160529\\_03](http://rw3kt2qh5l.search.serialssolutions.com/?sid=Entrez:PubMed&id=pmid:160529_03)

<sup>11</sup> THE NURSE WILL SEE YOU NOW: EXPANDING THE SCOPE OF PRACTICE FOR ADVANCED PRACTICE REGISTERED NURSES, 40 *Seton Hall Legis. J.* 127 ; Selvam, A. (2013). Stiff Resistance. Docs Fight Encroachment in Turf War with Nurses. *Modern Healthcare* 43:(16) 10.

<sup>12</sup> Knowledge @ Wharton (2013) Nurse Practitioners are In- and Why You May Be Seeing More of Them. Available at: <http://knowledge.wharton.upenn.edu/article/nurse-practitioners-are-in-and-why-you-may-be-seeing-more-of-them/>, 2

<sup>13</sup> Federal Trade Commission. (2014). Competition and Regulation of Advanced Practice Nurses. Available at: <https://www.ftc.gov/system/files/documents/reports/policy-nurses/140307aprnolicypaper.pdf>, 4

have to work as a team and put aside the hierarchical structure that has driven the past and allow all healthcare providers to work to their full scope of practice without creating barriers that detract from providing safe, competent, timely, and quality care to all patients. The bulk of this manuscript will review the history of NPs and how removing the barriers and restraints to autonomous practice will help provide a potential solution to this health care crisis that is affecting millions of Americans who are entering the system through the efforts and legislation of the Affordable Care Act.

### **Historical Background of Nurse Practitioner Movement**

Like most “disruptive innovations” the nurse practitioner movement was borne out of a need to provide care in an era when the newly instituted Medicare and Medicaid programs increased the need for primary care services especially in rural areas where there was a dearth of physicians.<sup>14</sup> It was the vision of Loretta Ford, RN and Henry Silver, MD to develop a program that would prepare registered nurses at the master’s level to provide primary care to both well children as well as those with acute and chronic conditions in collaboration with a physician.<sup>15</sup> This new cohort of healthcare providers eventually became known as Pediatric Nurse Practitioners (PNPs). Once this pilot program was evaluated and the education shifted from a certificate to a Master’s degree, the Division of Nursing of the U.S. Public Health Service began to fund nurse practitioner programs to help alleviate the massive influx of new patients who entered the primary care arena in a time when there was a shortage of physicians.<sup>16</sup> From these humble beginnings other specialty programs began to evolve in such areas as: adult, family, women’s health and psychiatry.<sup>17</sup> In the beginning push back from the physicians was minimal because the focus was on the underserved; however, as that began to change and other socioeconomic classes were being seen by nurse practitioners, and these providers were beginning to be reimbursed through insurance venues, the opposition began to arise.<sup>18</sup> This opposition was seen as a loss of revenue by physicians as well as a loss of control over what was once the sole domain of physicians.

### **IOM Report**

For the past 50 years physicians had held a monopoly on providing primary care and these new non-physician providers represented a threat that could only be resolved through

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<sup>14</sup> Saver, C. (2015). 50 Years of NP Excellence. *The Nurse Practitioner* 40(5). 16.

It was in 1965 that both the Nurse Practitioner Movement and Medicaid program were created. The government was looking for a way to provide services to families below the poverty level and the Nurse Practitioner program was looking to provide services for those rural families who would otherwise have been ineligible or unable to afford the cost of providing healthcare for their families. At that time there were also few physicians serving the rural areas of our country. So the union of the two programs helped to partially solve this healthcare problem.

<sup>15</sup> Brush, B. & Capestuti, E. (1996) Revisiting “A Nurse for All Settings”: The Nurse Practitioner Movement, 1965-1995, *JAANP* 8(1): 6

<sup>16</sup> Supra note 14 at 16; Supra note 15 at 6.

<sup>17</sup> Supra note 15 at 6.

<sup>18</sup> Supra 14 at 16.

state and national legislative actions, by rules and regulations that would curb the advancement in scope of practice for these new “upstarts.”<sup>19</sup> Several national organizations including: the Institute of Medicine (IOM); the Federal Trade Commission (FTC); and the National Governor’s Association sought to provide insight and logic into this competitive battle that has been waging for so many years.<sup>20</sup> Relying on evaluative data these supporters were able to offer compelling evidence that no single profession would be able to handle primary care crisis alone.<sup>21</sup> This was going to take a team effort in which all providers were allowed to practice to their full scope of practice.<sup>22</sup>

The IOM report has been one of the primary documents that have advocated for allowing nurse practitioners to practice to their full scope of practice based on their education and skills, specifically: “Advanced Practice Registered Nurses (APRN) should be called upon to fill and expand their potential as primary care providers across practice settings based on their education and competency.”<sup>23</sup> This recommendation is based on evidence garnered over several years from multiple studies.<sup>24</sup> Based on these data one of the key messages in the IOM report is Key Message #3, which states: “Nurses should be full partners with physicians and other health professionals, in redesigning health care in the United States.”<sup>25</sup> One of the most salient points that this section of the IOM report makes is the fact that nurses need to be more actively involved in the health policy arena, such that they no longer view policy changes as events that happen to them, but rather they become actively engaged in formulating health care policies.<sup>26</sup> To achieve this goal nurse practitioners are going to have to challenge the *status quo* and advocate for their “place at the table” whether it includes sitting on policy making boards, achieving admission privileges at hospitals, or simply being allowed to set up their own practice without being subservient to the supervisory or collaborative relationship conditions legislated by their particular state.

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<sup>19</sup> The Health Care Industry and Its Medical Care Providers: Relationship of Trust or Antitrust?, 8 DePaul Bus. & Comm. L.J. 251, p.252

<sup>20</sup> National Academy Press (2010). *The Future of Nursing: Leading Change, Advancing Health*; Federal Trade Commission. (2014). *Competition and Regulation of Advanced Practice Nurses*. <https://www.ftc.gov/system/files/documents/reports/policy-nurses/140307aprn Policypaper.pdf>; National Governors Report (2012) *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care*. Available at: <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>

<sup>21</sup> Supra note 16 at 4.

<sup>22</sup> Archibald, M.M. & Fraser, K. (2013). *The Potential for Nurse Practitioners in Health Care Reform*. *Journal of Professional Nursing* 29(5):272

<sup>23</sup> Supra note 20 at 22.

<sup>24</sup> Bodenheimer, T., K. MacGregor, and N. Stothart. 2005. *Nurses as leaders in chronic care*. *BMJ* 330(7492):612-613; Rendell, E. G. 2007. *Prescription for Pennsylvania: Right state, right plan, right now*. Harrisburg, PA: Office of the Governor; Craven, G., and S. Ober. 2009. *Massachusetts nurse practitioners step up as one solution to the primary care access problem: A political success story*. *Policy, Politics, & Nursing Practice* 10(2):94-100.

<sup>25</sup> Supra note 20 at 32.

<sup>26</sup> Supra note 20 at 32

The window of opportunity has been opened by the passage of the Affordable Care Act, more commonly known as “Obamacare.”<sup>27</sup>

### **Federal Trade Commission Act**

The Federal Trade Commission (FTC) published its report in 2014 as another evidentiary document that supports the role of the nurse practitioner.<sup>28</sup> The primary purpose of the paper was to investigate whether barriers to practice experienced by nurse practitioners was the result of attempts by another discipline to decrease competition of one profession by another such that the result would deny “...health care consumers the benefits of greater competition.”<sup>29</sup> By reviewing research studies and securing comments, testimony and letters from advocates the FTC was trying to determine whether or not “...mandatory physician supervision may not be justified.”<sup>30</sup> The mandatory agreements in the forms of supervision or collaboration (which incidentally is a *de facto* form of supervision) with physician colleagues do nothing more than restrict what nurse practitioners have been educated to do. New Jersey for example requires joint protocols between the physician and the nurse practitioner as well as a stipulation that the nurse practitioner has immediate access to the collaborating physician.<sup>31</sup> Frequently many of these collaborative agreements have even more stringent criteria such as: the physician having to review a certain percentage of the nurse practitioners charts twice a month, having to be present in the nurse practitioners clinic for a specified number of hours each month, or having the nurse practitioner provide the physician a stipend each month for his “services.”<sup>32</sup> Yet the FTC report notes that “effective communication between APRNs and physicians does not necessarily require any physician supervision, much less any particular model of physician supervision.”<sup>33</sup> While the FTC report does not purport to define the scope of practice for nurse practitioners it does offer insight, based on extensive research, as to why policy makers should critically review legislation that limits the ability of nurse practitioners to practice to their full scope of education and skills.<sup>34</sup> The report places the burden of breaking down these barriers on legislators, regulators and providers. Change can only occur when all three participants come together with a mutual understanding of the provider’s education and skills and tailor their legislation and rules to those metrics.<sup>35</sup> In their concluding remarks the FTC notes: “...mandatory physician supervision and collaborative practice agreement requirements are likely to impede competition among health care providers and restrict APRNs ability to

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<sup>27</sup> Affordable Care Act. Available at: <http://www.hhs.gov/sites/default/files/ppacacon.pdf>  
p.523

<sup>28</sup> Supra note 13.

<sup>29</sup> Supra note 13 at 2.

<sup>30</sup> Supra note 13 at 2.

<sup>31</sup> Supra note 14 at 130.

<sup>32</sup> personal communication with psychiatric nurse practitioner in Delaware who wishes to remain anonymous to prevent any retribution

<sup>33</sup> Supra note 17 at 3.

<sup>34</sup> Supra note 17 at 19.

<sup>35</sup> Supra note 17 at 4.

practice independently, leading to decreased access to health care services, higher care costs, reduced quality of care and less innovation in health care delivery.”<sup>36</sup> And it is for these latter reasons that directly affect the health care of all of our patients that barriers to practice should be removed and all health care providers be allowed to practice to their full scope of education and skills.

### **National Governor’s Report**

The National Governor’s Report (NGA) provides additional support to nurse practitioners by encouraging states to carefully consider not only easing restrictions on nurse practitioners scope of practice but also rethinking the reimbursement policies for these providers.<sup>37</sup> While equitable reimbursement is a factor in incentivizing NPs it is not the “be all and end all” of generating interest in autonomy for NPs. Data from the Colorado Health Institute notes that NPs are second only to physicians in terms of providing primary care.<sup>38</sup> It is simply a matter of a lack of timeliness in terms of states being able to keep pace with the evolving nature of the NP role over the past 50 years.<sup>39</sup> Yet the reimbursement issue is one that organized medicine has tenaciously clung to in the belief that allowing NPs to practice autonomously would result in a loss of revenue for them and their practices. However, data from a study by Pittman and Williams (2012) refute this belief in that they found: “This preliminary analysis suggest that MD wages are not affected by changes in SOP (Scope of Practice) barriers and/or that the removal of SOP barriers has a more nuanced effect on MD wages than simple economic substitution.”<sup>40</sup> In this type of scenario, NPs would more than likely take on the less complex cases, while the physician would be able to generate more revenue from the complex cases. Hence, a wage substitution effect would occur in which the physician might lose some simple patient cases, but the MD would generate greater revenue by caring for more complex patients. In their concluding remarks the NGA paper suggested that NPs “...may be able to mitigate the projected shortages of primary care services.”<sup>41</sup> Furthermore they echoed the research of Newhouse (2012) that: “...a review of nearly two decades of research conclusively found that care delivered by APRNs and care delivered by physicians (alone or in teams without an APRN) produce equivalent patient outcomes.”<sup>42</sup> Despite the data gleaned from the aforementioned reports, organized medicine continues to construct barriers that limit NPs from practicing to the full scope of their education and skills.

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<sup>36</sup> Supra note 17 at 38.

<sup>37</sup> Supra note 27 at 1.

<sup>38</sup> Colorado Health Institute, *Collaborative Scopes of Care Advisory Committee: Final Report* (Denver, CO: Colorado Health Institute, Dec. 30, 2008). Available at: [http://www.coloradohealthinstitute.org/uploads/downloads/executive\\_summary.pdf](http://www.coloradohealthinstitute.org/uploads/downloads/executive_summary.pdf), 5

<sup>39</sup> Supra note 27 at 4.

<sup>40</sup> Pittman, P. & Williams, B. (2012) Physician Wages in States with Expanded APRN Scope of Practice. *Nursing Research and Practice* Vol (2012): 1-5, 5.

<sup>41</sup> Supra note 27 at 11.

<sup>42</sup> Robin P. Newhouse, et al., *Policy Implications for Optimizing Advanced Practice Registered Nurse Use Nationally*, 13(2) Policy, Politics and Nursing Practice, 81 (2012)

## Additional Barriers to NP Scope of Practice

While much has been written to justify physician oversight of NPs this effort has been spearheaded by organized medicine, specifically the American Medical Association (AMA) under the guise that patient safety is at stake.<sup>43</sup> The AMA is not the only organization that is targeting autonomous practice for advanced practice nurses. The American Academy of Family Physicians (AAFP) published a report in 2012 entitled: *Primary Care For the 21<sup>st</sup> Century*, in which they advocated for a “medical home” that was “physician led.”<sup>44</sup> This document, once again, circles back to the already debunked arguments of the disparity of length of education between advanced practice nurses and physicians, and, hence, a safety issue that places patient care in jeopardy if NPs are granted clinical autonomy.<sup>45</sup> The question that needs to be posed here is: how many medical students enter medical school with an average of 8.5 years of clinical practice?<sup>46</sup> This type of experience by registered nurses prior to their entering a program for advanced practice nurses helps to augment their knowledge in the areas most critical to practice by any healthcare provider, specifically: critical thinking, pharmacology, diagnosis, and plan of care. There have been no research studies to date that have identified nurse practitioners as less safe than their physician colleagues. However there have been multiple studies, such as the previously mentioned IOM, FTC, and NGF reports that have shown that the patient care outcomes by NPs and physicians are equivalent, and in some cases NPs have better outcomes than those of their physician colleagues.<sup>47</sup>

A recent example of organized medicine’s attempt to construct barriers to advanced practice nurses autonomy is seen in the American Society of Anesthesiologists (ASA) attempt to block a proposed rule by the Department of Veteran’s Affairs (DVA).<sup>48</sup> The DVA is proposing a rule (38 CFR Part 17) that would allow all advanced practice nurses namely nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse midwives who hold national certification to practice to the full scope of their “education, training and certification without the clinical supervision of physicians” at any VA facility.<sup>49</sup> The argument that the ASA is using for this proposal is neither new nor compelling, specifically “(it) would directly compromise patient safety and limit our ability

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<sup>43</sup> John K. Inglehart, *Expanding the Role of Advanced Nurse Practitioners—Risks and Rewards*, 368 (5): N Engl J Med. 1935 (2012)

<sup>44</sup> American Academy of Family Physicians, *Primary care for the 21<sup>st</sup> century* (2012) [http://www.aafp.org/dam/AAFP/documents/about\\_us/initiatives/AAFP-PCMWhitePaper.pdf](http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMWhitePaper.pdf), pp. 3-4

<sup>45</sup> Supra note 12 at 3.

<sup>46</sup> Supra note 13.

<sup>47</sup> Supra note 13.

<sup>48</sup> American Society of Anesthesiologists, *Protect our veterans* (May 2016), <https://www.asahq.org/advocacy/federal-activities/legislative-activity/vha-nursing-handbook#>

<sup>49</sup> Federal Register, *Advanced Practice Registered Nurses* (25 May 2016) <https://www.gpo.gov/fdsys/pkg/FR>



to provide quality care to Veterans.”<sup>50</sup> And, as noted earlier, there is no data to support these allegations. There is only an attempt to create confusion and fear whether it is with our Veterans or the general public. The IOM and NGA reports clearly show through their analysis of multiple research studies over the past several decades that quality and safety of NPs (as well as the other APRN roles) as autonomous providers represent a potential solution to the health care crisis that we are now facing in this country.<sup>51</sup> Given the redundancy of the arguments posed by organized medicine and the refutation thereof by the aforementioned research data might lead one to believe that the real issue confronting the health care crisis in the United States is related more to a “turf” war and fear of “loss of revenue” by the physician groups than any other substantive or logical reason and thus, their aggressiveness in building barriers rather than bridges. This then leads us to question whether or not these barriers are really impositions that pose illegal “restraint of trade” issues rather than legitimate concerns by a harried medical community.

### **Restraint of Trade**

Black’s Law Dictionary defines restraint of trade as: “a limitation on business dealings or professional or gainful occupations.”<sup>52</sup> It further defines *unreasonable restraint of trade* as: “A restraint of trade that produces a significant anticompetitive effect that violates antitrust laws.”<sup>53</sup> There are three laws that affect restraint of trade and monopoly issues, namely: Sherman Antitrust Act, and the FTC Acts, and the Clayton Antitrust Law.

### **Sherman Antitrust Law**

The Sherman Antitrust Act was enacted in 1890 with the purpose of promoting free competition in both trade and industry.<sup>54</sup> The philosophy at the time was that more competition would produce lower prices and higher quality of goods.<sup>55</sup> Section two also made it a criminal offense to “...monopolize, or attempt to monopolize any part of trade or commerce.”<sup>56</sup> However, rather than making monopolies *per se* amenable to prosecution, the courts limited the reach of the act only to those cases in which abuse or unfair power were the motivating factors.<sup>57</sup> So for example, one might deduce that physician organizations that develop barriers to NP practice by convincing legislators not to change outdated laws have the potential to be examined more closely in order to discover the real reason why they are so adamant that NPs not be granted autonomous practice.<sup>58</sup> This is more compelling when one

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<sup>50</sup> Supra note 55.

<sup>51</sup> Supra note 25; supra note 27.

<sup>52</sup> BRIAN A. GARNER, (ED), BLACK’S LAW DICTIONARY, EDITION 9, 2004, 1429

<sup>53</sup> Supra note 60 at 1429.

<sup>54</sup> Sherman Anti-Trust Act legal definition of Sherman Anti-Trust Act, (5 June 2016)  
<http://legal-dictionary.thefreedictionary.com/Sherman+Anti-Trust+Act>

<sup>55</sup> Supra note 62 at 1.

<sup>56</sup> Supra note 62 at 1.

<sup>57</sup> Supra note 62 at 4.

<sup>58</sup> Supra note 13 at 2,3.

looks at the fact that NPs in most states are reimbursed for the very same procedures that family practice physicians perform at 80-85% of the physician fee schedule.<sup>59</sup> If the procedure is the same, the treatment and plan of care are the same, then why is there such a discrepancy in the reimbursement from health care payers?

### **The Federal Trade Commission Act**

The Federal Trade Commission under authority granted to it by FTC Act Sec. 3, 15 U.S.C. Sec. 43 is authorized “... and may gather and compile information concerning, and to investigate from time to time the organization, business, conduct, practices, and management of any person, partnership, or corporation engaged in or whose business affects commerce.”<sup>60</sup> In the FTC 2014 report they noted that legislators should “...avoid unnecessary restrictions on APRN scope of practice” unless those restrictions were related to safety issues.<sup>61</sup> Since the safety of NP practice was not an issue based on prior research then it was possible that supervisory restrictions by physicians over NPs were not justified.<sup>62</sup> Another issue that the FTC raised was whether or not “one profession may regulate the conduct of another profession” and do so legally.<sup>63</sup> As evidence of their concern they quoted *Missouri Assn. of Nurse Anesthetists v. State Bd. of Registration for the Healing Arts*.<sup>64</sup> In this particular case the Circuit Court granted summary judgment to the Respondents but the case was appealed to the State Supreme Court that granted review.<sup>65</sup> In this particular case, the state supreme court reversed the opinion of the trial court and sent it back for further deliberation.<sup>66</sup> In short, the opinion asserted that the Board lacked the authority to regulate the practice of nursing.<sup>67</sup> It is these types of reviews by the courts that will strengthen the NPs profession in securing the autonomy that they have rightly earned through decades of providing safe, quality care to patients. The remainder of this manuscript will focus on the legal ramifications of those who attempt antitrust violations in their pursuit of building barriers to allowing healthcare providers, specifically nurse practitioners, to practice to the full scope of their education and skills.

### **Clayton Act**

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<sup>59</sup> Carolyn A. Buppert, *Most Payers Now Reimburse NPs, but the Details Differ*, 8(9) JNP 744 (2012) ; Cathy Wasum, *The Rural Health Clinic Services Act: A Sleeping Giant of Reimbursement*, 2(2) JAANP 86 (1990)

<sup>60</sup> Federal Trade Commission *A Brief Overview of the Federal Trade Commission's Investigative and Law Enforcement Authority*, <https://www.ftc.gov/about-ftc/what-we-do/enforcement-authority>

<sup>61</sup> Supra note 26 at 2.

<sup>62</sup> Supra note 26 at 2.

<sup>63</sup> Supra note 26 at 15.

<sup>64</sup> *Mo. Ass'n of Nurse Anesthetists, Inc. v. State Bd. of Registration for the Healing Arts*, 343 S.W.3d 348 (Mo. 2011), p. 350

<sup>65</sup> Supra note 64 at 143.

<sup>66</sup> Supra note 64 at 143.

<sup>67</sup> Supra note 64 at 143.

The Clayton Act is a federal statute that was enacted in 1914 as a supplement to the Sherman Act of 1890.<sup>68</sup> Its primary purpose was to prevent price fixing, tying arrangements, mergers, and other types of antitrust actions if the end product was to restrict competition or create a monopoly.<sup>69</sup> Any attempt to prevent nurse practitioners from competing with other healthcare providers clearly places them in the realm of antitrust liability.<sup>70</sup> For example in *Bhan v. National Medical Enterprises Hospitals, Inc.* a certified registered nurse anesthetist (CRNA) was denied hospital privileges solely on the basis of his being a CRNA and not an MD.<sup>71</sup> The lower court upheld summary judgment in favor of the defendant-appellees but on appeal the court reversed judgment in favor of the plaintiff-appellant.<sup>72</sup> While this case clearly falls under Sherman Antitrust Act sections 1 and 2, it has elements of the Clayton Act under section 4 in that it was an attempt by the hospital system to exclude other qualified health care providers from providing an equivalent service.<sup>73</sup>

### **Barriers v. Legal Relief**

One of the first principles every first year law student learns is that the purpose of the law is to right a wrong and make a person whole. When illegal barriers are promulgated through outdated regulatory processes or presumed authority by one profession over another, then courts will be called upon to adjudicate the wrong. A perfect example of this is the case of the *N.C. State Bd. Of Dental Exam'rs v. FTC.*<sup>74</sup> In this particular case the North Carolina Board of Dental Examiners took it upon themselves to send cease-and-desist letters to non-dentist teeth whiteners.<sup>75</sup> In fact, dental hygienists were actually providing this service in multiple shopping malls around the state. Upon receiving the cease-and-desist letters all these entrepreneurial hygienists closed their businesses. The Dental Board perceived that as a state Board they could plead *Parker Immunity*, which allowed them the cover of state antitrust immunity, despite the fact that they were active market participants in a disputed service (teeth whitening) that they felt was in their domain and belonged to no other health care provider.<sup>76</sup> However, to fall under the aegis of state antitrust immunity they had to meet the two requirements of the Supreme Court of the United States (SCOTUS) *Midcal*

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<sup>68</sup> <https://www.justice.gov/atr/antitrust-laws-and-you>

<sup>69</sup> Supra note 52 at 286. Specifically under section 4 of the Clayton Act, any person or business that has been harmed by an antitrust action may file suit for damages that are equivalent to triple the losses suffered by the person or business.

<sup>70</sup> Ann Scott Blouin & Nancy J. Brent, *Collide or Collaborate: Changing Reimbursement and Legal Challenges Facing Advanced Practice Nurses and Physicians*. JONA, 26(4), 10-12, 1996.

<sup>71</sup> *Bhan v. NME Hosps., Inc.*, 772 F.2d 1467 (9th Cir. 1985)

<sup>72</sup> Supra note 71 at 1468.

<sup>73</sup> Supra note 71 at 1469.

<sup>74</sup> *N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101 (2015)

<sup>75</sup> Supra note 65 at 2.

<sup>76</sup> *Parker v. Brown*, 317 U.S. 341, 63 S. Ct. 307 (1943)

decision.<sup>77</sup> This decision had two mandates: 1) there has to be a clearly articulated policy by the state in regard to regulation; and 2) there had to be direct supervision by the state over the conduct in question.<sup>78</sup> In the case of the Dental Examiners there was no state policy that regulated teeth whitening and there was no direct supervision by the state. SCOTUS in a 6-3 decision affirmed the judgment of the Court of Appeals for the Fourth Circuit, and noted: “If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.”<sup>79</sup> It is this type of review of court decisions, which is ultimately going to force states to review outdated legislation and allow all health care providers to practice to their full scope and skills without the intervention of another discipline. But part of this process, at least for APRNs, is trying to overcome the historical fact that for decades physicians have been the primary health care providers in this country, and nurses, including nurse practitioners were simply “handmaidens” to these health care deities.<sup>80</sup> But times have changed and it is difficult for a ruling discipline to see that a culture change is necessary if we as a country are going to be able to provide safe, quality health care to the millions of patients in need. Progress only comes with change.

Ohlhausen (2016) makes the case that this “Brother, may I?” phenomenon is inconsistent with free market principles.<sup>81</sup> Yet when one reviews the barriers to practice this is exactly what is happening. Some states with collaborative or supervisory relationships require that a physician be available for APRNs within a certain mile range, some require APRNs to pay for chart reviews, and some agreements require physicians to be in the office of the APRN as certain number of days each month and to review a specified number of charts. In all these examples APRNs are being restrained by rules and regulations that prohibit them from providing free market services.<sup>82</sup> Some of these barriers clearly fall under the aegis of antitrust violations and will be explicated in the subsequent pages of this

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<sup>77</sup> 3-49 Antitrust Laws and Trade Regulation, 2nd Edition § 49.02 (2015) ; [California Retail Liquor Dealers Ass’n v. \*\*Midcal\*\* Aluminum, Inc.](#), 445 U.S. 97, 100 S. Ct. 937, 63 L. Ed. 2d 233 (1980)

<sup>78</sup> Supra 68 at 1. For example, in the case of physician supervision over NPs, if the NPs decided to provide a clinic for school physicals and the medical board threatened action under *Parker Immunity* but there were no state rules or regulations that prohibited NPs from offering that service, nor was there any direct state supervision of such, then NPs could allege improper use of *Parker*. This could be perceived as another barrier to prevent NPs from practicing in that particular state or community.

<sup>79</sup> Supra note 65 at 143

<sup>80</sup> Supra note 13 at 11.

<sup>81</sup> [J Antitrust Enforcement \(2016\) 4\(1\): 111-133](#), [J Antitrust Enforcement \(2016\) 4\(1\): 111-133](#); This “Brother, May I” issue occurs when a new competitor (nurse practitioners) hope to enter a market (primary care) but the incumbent (physicians) in the market attempt to require the newcomer to obtain the incumbent’s permission to enter that market. This clearly represents an antitrust violation.

<sup>82</sup> <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment>

manuscript.

### **Antitrust Barriers**

Restrictive covenants of the non-compete type provide another venue for potential antitrust litigation. In order for the restrictive relationship between an employer and an employee be upheld by the court it must be reasonable in scope, time and territory.<sup>83</sup> In short, the test for validity of such a covenant must meet a tripartite challenge as follows: 1) on the employer's part it must be reasonable insofar as it is designed to protect a legitimate business interest; 2) on the employee's part the reasonableness of the covenant should not be so harsh or burdensome that it denies the employee the ability to earn a livelihood; and finally, 3) it has to be reasonable insofar as it addresses a sound public policy initiative.<sup>84</sup> In all three criteria the reasonableness is the determining factor as to whether the covenant will withstand the rigors of potential litigation. In *Patient First Richmond Med. Group, LLC v. Blanco*, an employer sued a defendant nurse practitioner to enforce an employment contract that had both a non-competition and a non-solicitation clause that prevented the NP from competing with her current employer as well as for soliciting other employees from that same organization to join her in a new employment venture.<sup>85</sup> Shortly after she began as an employee of Patient First the NP decided to strike out on her own and open a nurse managed clinic within a seven mile radius of her former employer (Patient First); additionally she sought to hire two of the physicians she had worked with at Patient First to come and join her practice.<sup>86</sup> It was at this point that Patient First decided to file suit for breach of her employment contract on both the non-compete clause as well as the non-solicitation clause.<sup>87</sup> In response to the plaintiff's suit, the defendant filed a motion to dismiss.

The first problem that the Patient First encountered was the overarching broadness of its non-compete clause, to wit: "for a period of two (2) years following termination of ...employment for any reason...[defendant] will not, directly or indirectly, for himself or as an agent, officer, director, member, partner, shareholder, independent contractor, owner or employee... perform medical services within a seven (7) mile radius of a Patient First Center."<sup>88</sup> In reviewing this clause the court determined that because the clause was so "inherently overbroad" in such areas as barring the defendant from even being a stockholder that the covenant was unenforceable.<sup>89</sup> In elucidating its reasoning the court said that any ambiguities in a covenant fall back on the employer, not the employee, and secondly, that the law was designed to prevent direct competition with specific services that are offered by the plaintiff, not a generic prohibition on any types of medical services.<sup>90</sup>

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<sup>83</sup> Supra note 52 at 420.

<sup>84</sup> Patient First Richmond Med. Grp., LLC v. Blanco, 83 Va. Cir. 3 (Cir. Ct. 2011)

<sup>85</sup> Supra note 84 at 3.

<sup>86</sup> Supra note 84 at 4.

<sup>87</sup> Supra note 84 at 4.

<sup>88</sup> Supra note 84 at 4.

<sup>89</sup> Supra note 84 at 5.

<sup>90</sup> Supra note 84 at 5.

## Non-Solicitation of Staff Covenant

The same type of reasoning was used when the court considered the non-solicitation of staff covenant.<sup>91</sup> In this particular clause the court found that the lack of specificity in terms of location and function, as well as the broadness of the language, was unreasonable both in terms of public policy, as well as being detrimental to the livelihood of the defendant. The court determined that the non-compete clause and non-solicitation covenant were unenforceable.<sup>92</sup>

Another example of an anti-trust action under the Clayton Act, as discussed previously, is the case of *Bhan v. National Medical Enterprises Hospitals, Inc.* Bhan was a certified nurse anesthetist (CRNA) who had been working at a local hospital in California.<sup>93</sup> When his contract expired in 1983 the hospital decided to employ only physician anesthesiologists (MDAs) hence, he lost 80% of his livelihood.<sup>94</sup> Bahn alleged that the hospital administrator and the newly hired MDA conspired with both the California Society of Anesthesiologists and the California League of Anesthesiologists to form a monopoly that would exclude CRNAs from providing anesthesia services at the hospital.<sup>95</sup> The defendants under FRCP 12 (b)(6) claimed that the plaintiff “failed to state a claim on which relief could be granted.”<sup>96</sup> The district court agreed based on the belief that CRNAs and MDAs did not compete against one another and dismissed the claim “without prejudice.”<sup>97</sup> Bahn appealed to the United States District Court of the Eastern District of California. The issue before the Appeals Court focused on whether CRNAs and MDAs share in a single market or have their own individual markets.<sup>98</sup> California law has a requirement that CRNAs must have a supervisory MD, however, that MD does not have to be an MDA it can be any attending MD, dentist, podiatrist, or clinical psychologist.<sup>99</sup> Basing its decision on prior precedent in other similar cases, the court determined that input from an additional source (in this case a supervisory entity) should not exclude one member from offering a service similar to that of another entity.<sup>100</sup> The Appeals Court concluded that since the only real distinction between CRNAs and MDAs was the supervisory restriction, and that alone, was not sufficient to restrain the marketing practices of the MDAs, as there was no real competition because both parties were participants in the same anesthesia market.<sup>101</sup> Thus the gavel came down on the side of the plaintiff where the decision of the district court was dismissed and the case was

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<sup>91</sup> Supra note 84 at 5.

<sup>92</sup> Supra note 84 at 5.

<sup>93</sup> *Bhan v. NME Hosps., Inc.*, 772 F.2d 1467 (9th Cir. 1985)

<sup>94</sup> Supra note 93 at 1469.

<sup>95</sup> Supra note 93 at 1469.

<sup>96</sup> <https://www.federalrulesofcivilprocedure.org/frcp/title-iii-pleadings-and-motions/rule-12-defenses-and-objections-when-and-how-presented-motion-for-judgment-on-the-pleadings-consolidating-motions-waiving-defenses-pretrial-hearing/>

<sup>97</sup> Supra note 93 at 1469.

<sup>98</sup> Supra note 93 at 1469.

<sup>99</sup> 1984 Cal. AG LEXIS 68, 67 Ops. Cal. Atty. Gen. 122, 67 Ops. Cal. Atty. Gen. 122

<sup>100</sup> Supra note 93 at 1471.

<sup>101</sup> Supra note 93 at 1471.

remanded for further proceedings.<sup>102</sup> In short, the CRNA was able to convince the Appeals Court that his job was identical, in terms of the provision of patient anesthesia, to that of the MDAs and, thus, there was no competition in the market place.

### **Other Barriers**

Other barriers to NPs practicing to their full scope are less obvious, but just as detrimental to patient outcomes and NP practice. These barriers are frequently the result of outdated legislation and supervisory requirements. For example, when Medicare came on the scene in 1965 the only primary care healthcare providers were the physicians and in 1969 Family Practice became a new specialty.<sup>103</sup> As a result, NPs who were new on the scene were not included as providers of primary care and the MDs controlled the practice of primary care.

### **Legislative Barriers**

Legislation has not kept pace with the advances in healthcare.<sup>104</sup> This lag has delayed changes that have resulted in some untoward events experienced by patients. A report by a nurse practitioner at a national conference told of an incident in which his collaborating physician was out of town and forgot to appoint a replacement. This NP visited one of his homebound patients and found that the patient was in need of supplemental oxygen. While the NP could write the order he could not submit it until his collaborating physician signed off on the order. With the collaborating physician gone, the NP was helpless to do anything else. He visited the patient the next day and had to call 911 to have the patient admitted to the hospital. The patient spent the next 5 days in an intensive care unit. This is a problem that could have been prevented in one of two ways: 1) if his collaborating physician has appointed another physician as an overseer during his absence; or 2) if federal legislation allowed NPs to order durable medical equipment (DME) (this law was changed in 2015 and the NP could now go ahead and order the DME without the preauthorization of the MD).<sup>105</sup> While this particular case ended up as a barrier to providing timely care, it did not rise to the level of an anti-trust violation, but the next example very likely could. Miller (2010) provides a compelling example of a scenario that could likely end up as an anti-trust violation.<sup>106</sup> For example, if an NP in a state with autonomous practice orders a lab test and the lab refuses to analyze it without a physician signature then they could be held liable for refusal to honor a lawful business order that the practitioner has, by virtue of her license in

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<sup>102</sup> Supra note 93 at 1471.

<sup>103</sup> <https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf>

<sup>104</sup> Supra note 13 at 3.

<sup>105</sup> Personal communication with a family nurse practitioner in a state that had a collaborating agreement in its nursing practice act.

<sup>106</sup> Kenneth P. Miller. *Restraint of Trade: Patient Advocacy or Simple Turf Guarding?* JNP 6(6): 700-702, 2010

that particular state.<sup>107</sup> Secondly, cost of the service is increased by having to get the additional signature.<sup>108</sup> And finally, by forcing the NP to get a physician signature, despite the fact that the NP is authorized to order labs by virtue of her license and certification, this could be construed as *controlling the market*, another potential anti-trust violation.<sup>109</sup>

### **Cost as a Barrier**

One of the major themes throughout this manuscript has been related to the issue of cost. Cost from maintaining restrictive legislative barriers; the cost to NPs for having services provided by supervisory or collaborative physicians (many of which offer very little value to the provider); and finally the fear of loss of revenue to physicians. Each of these issues will be addressed subsequently.<sup>110</sup>

Restrictive state laws that affect the ability of NPs to practice to their full scope impact the cost of healthcare for some of the most needy patients who live in rural areas of the country.<sup>111</sup> The Kaiser Foundation noted that many physicians are less likely to practice in rural areas or to participate in Medicaid because of the lower reimbursement rates.<sup>112</sup> The patients in these areas then fall under the aegis of care by NPs and Physician Assistants both providers who have some restrictions place on their practice as a result of legislative decisions.<sup>113</sup> Despite the fact that NPs are the largest providers of care to the rural community, Medicare only reimburses them at 85% of the physician fee schedule for performing the same services.<sup>114</sup> Thus, many practitioners are kept out of the free market either by being forced to close their nurse-owned clinics, or by having insufficient capital to open a clinic because of their inability to generate the revenue that is needed to keep their nurse-managed clinics operating at a breakeven or achieve a profitable level. Those commercial insurers who reimburse NPs are free to set their own rates as long as they abide by state laws, and typically, the rates are around the CMS rates at 85% of the physician fee schedule.<sup>115</sup> However, there is potential change afoot in that the IOM has recommended to Congress that it update the Medicare law to reflect equity in the NP reimbursement schedule so that it duplicates the physician fee schedule.<sup>116</sup> An associated problem with

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<sup>107</sup> Supra note 106 at 701.

<sup>108</sup> Supra note 106 at 701.

<sup>109</sup> Supra note 106 at 701.

<sup>110</sup> Supra note 13 at 20.

<sup>111</sup> Supra note 13 at 20.

<sup>112</sup> <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf> It is interesting to note that in addition to being the primary providers of primary care in rural areas NPs also care for large numbers of CMS patients as well as minority and patients who are underserved. It will be interesting to see if this trend increases with the adoption of the Affordable Care Act and the increased enrollment of uninsured into the marketplace.

<sup>113</sup> Supra note 112 at 3

<sup>114</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf>

<sup>115</sup> Supra note 59 at 743.

<sup>116</sup> [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=92](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=92)



reimbursement is the “incident to” billing practices of many physicians run clinics.<sup>117</sup> Under this billing model, an NP can bill, and is often required to do so, under the physician’s National Provider Identification number (NPI) because the service is then reimbursed at 100% versus the 85% that the NP would get if billed under his/her number.<sup>118</sup> The problem with this model is that it does not allow researchers to collect data on how many patients, the type of patients, as well as their diagnosis and treatment that have actually been reported by the NP, because it is all reported under the physician’s number. Reform of these federal and state barriers is but one step towards true collaboration.

## **Collaborative Agreements**

Another barrier that has impeded true collaboration among NPs and physicians are the costs associated with collaborative agreements, costs both in terms of revenue as well as in the stress of not knowing what specific services your supervisory or collaborative physician is going to provide.<sup>119</sup> Unless noted in statute as to the specifics of what services the physician is to provide in his supervisory capacity the physician is free to determine what the NP can and cannot do.<sup>120</sup> And for these unspecified services a fee could be charged as noted previously.<sup>121</sup> The FTC report notes that in rural areas where there are fewer physicians it may be harder to find a supervisory or collaborative physician and if the provider does find such an overseer, because of market forces, the cost for the agreement might be higher.<sup>122</sup> But an even greater risk exists if the physician in the area refuses to enter into an agreement, or a current agreement is severed if a physician moves, retires or dies.<sup>123</sup> Under the former scenario of refusal, that might well fall under an anti-trust case if the NP can show that there was an agreement among the physicians in that area to keep NPs from practicing on “their turf.” Under the second scenario, if the physician moves, retires or dies there is no recourse unless a new agreement can be contracted with another physician.<sup>124</sup> A case very similar to this happened approximately two years ago when a NP in El Paso, Texas, lost her collaborating physician to retirement and could not find a replacement. She closed her office in El Paso, moved across the border to Las Cruces, New Mexico and opened a new clinic in a state that had full scope practice with no supervisory or collaborative agreement required, and her patients followed her across the border from Texas to New Mexico.<sup>125</sup> This willingness to travel across the border from one state to another is a clear example of patient choice and satisfaction with the care they had been receiving.<sup>126</sup> Another facet related to the

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<sup>117</sup> <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/incident/incident-billing-clearing-confusion?page=full>

<sup>118</sup> Supra note 117 at 1.

<sup>119</sup> Supra note 13 at 30.

<sup>120</sup> Supra note 13 at 28.

<sup>121</sup> Supra note 32.

<sup>122</sup> Supra note 13 at 29.

<sup>123</sup> Supra note 13 at 29.

<sup>124</sup> Supra note 13 at 31.

<sup>125</sup> personal communication with anonymous Nurse Practitioner

<sup>126</sup> Supra note 13 at 2.

cost of primary healthcare is the belief that allowing NPs autonomous practice will decrease the revenue of practicing primary care physicians.

Changes in legislation that would allow full scope of practice for NPs is likely influenced by the belief that adding competition, in the form of autonomous practicing NPs, would likely diminish the revenue generated by family practice physicians.<sup>127</sup> Data clearly shows that when states with autonomous practice (currently there are 21 states and the District of Columbia that fall in this model) are compared with states that have collaborative or supervisory agreements, that there is no difference in the revenue generated across the two groups of states.<sup>128</sup> One of the potential reasons for this phenomenon is related to the fact that once there is cadre of NPs working in a specific geographical area these NPs provide a substitution effect in that they are able to handle the less complex patients while the physician workload increased with the more complex patients which generated higher billing rates, and thus, more revenue for the physician which balanced the loss of seeing greater numbers of less complex patients.<sup>129</sup> When cost becomes the determining factor as to whether a physician community will accept the autonomous role of the NP and works to prevent new providers from practicing to their full legislative authorized scope of practice, it is at that point that one has to ask whether this action to prevent new providers from practicing in the community is simple advocacy for patient quality of care or is it simple turf guarding, and if the latter, then it takes us back to potential anti-trust violations.<sup>130</sup> The FTC notes this clearly in its report when it notes that scope of practice restrictions that are designed to reduce competition, that are not based on quality and patient safety, are forerunners to anti-trust violations.<sup>131</sup>

## Misinformation

Misinformation is another tactic that is frequently used by organized medicine to prevent scope of practice changes, and typically this information is related to safety and quality of care.<sup>132</sup> The first point of attack is usually related to the length of the educational programs for NPs when compared with MDs.<sup>133</sup> Typically the proponents of restrictive practice tout that physicians have 8 years of basic education and then an addition three to seven years of postgraduate training, while NPs have a total of four years of undergraduate education followed by 2 years of graduate education.<sup>134</sup> What the opposition fails to address is the fact that our current supply of NPs have typically had an average of 8.5 years of clinical practice before applying to graduate school for a graduate degree.<sup>135</sup> To date there

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<sup>127</sup> Patricia Pittman & Benjamin Williams, *Physician Wages in States with Expanded APRN Scope of Practice*, Nursing Research and Practice, vol 2012, Article Id 671974, 5 pages, 2012, doi:10.1155/2012/671974

<sup>128</sup> Supra note 127 at 4.

<sup>129</sup> Supra note 127 at 2.

<sup>130</sup> Supra note 106 at 701.

<sup>131</sup> Supra note 13 at 15.

<sup>132</sup> Supra note 20 at 4.

<sup>133</sup> Supra note 19 at 252.

<sup>134</sup> Supra note 19 at 252.

<sup>135</sup> Supra note 82.

are no studies that have compared the clinical skills of a newly graduated NP with those of a newly completed physician family practice residency and until these data are available, the statements by the physician proponents for restricted practice, are purely speculative with no basis in fact.

The most recent example of misinformation came when the Department of Veterans Affairs published a proposed rule that would allow all Advanced Practice Nurses in the VA system to practice to their full practice authority.<sup>136</sup> As soon as the proposed rule was published the American Society of Anesthesiologists posted on its website, a plea to all Americans strongly opposing the proposed rule on the basis of a safety issue.<sup>137</sup> The issue was really to prevent all CRNAs from practicing to their full scope, despite the fact that they admitted in the letter that there was no data to show that the outcomes of the CRNAs would be any different than the outcomes achieved by MDAs.<sup>138</sup> It is these types of attacks that lead to confrontation rather than collaboration among healthcare providers.

## Quality of Care

Quality of care is another area that seems to be a focus for organized medicine to attack and build barriers. Fifty years of research studies have shown that the quality of care provided by NPs is equivalent to, and in some cases, better than that provided by family practice physicians.<sup>139</sup> To use quality issues as a means to obstruct scope of practice, using the example noted above in the VA issue, appears *prima facie* as an attempt to monopolize or control an industry by preventing other competent providers, who have proved their competency through certification exams and multiple research studies over several decades is clearly a violation of the Clayton Act.<sup>140</sup> The fact that the outcomes are essentially equivalent between NPs and general practitioners supports the fact that the barriers that currently exist need to be removed both at the state and federal legislative levels.<sup>141</sup>

## Credentialing & Privileging Barriers

Credentialing and medical staff privileging can also be quagmires for NPs.<sup>142</sup> Multiple players and a sundry of state and federal legislation are required to run the

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<sup>136</sup> Department of Veterans Affairs, *Advanced Practice Registered Nurses*, 81(101) FEDERAL REGISTER, 33155, (2016)

<sup>137</sup> ASA, *Physician Anesthesiologists Urge Americans to Oppose VA Policy Abandoning Team Based Care in Surgery*, 7/11/2016 <https://www.asahq.org/about-asa/newsroom/news-releases/2016/07/physician-anesthesiologists-urge-americans-to-oppose-va-policy-abandoning-team-based-anesthesia>

<sup>138</sup> Supra note 137.

<sup>139</sup> Supra note 13; Supra note 20; Supra note 70 at 10.

<sup>140</sup> Supra note 68.

<sup>141</sup> P. Venning, A. Durie, M. Roland, C. Roberts, & B. Leese *Randomised Controlled Trial Comparing Cost Effectiveness of General Practitioners and Nurse Practitioners in Primary Care*, 320, BMJ, 1052 (2000).

<sup>142</sup> Katherine Benesch, Duane Morris, & David J. Hyman, *Nonphysician Practitioners: A Bridge to Future in Healthcare*, 8(11) HEALTH LAWYERS WEEKLY, 2010. Both

credentialing gauntlet.<sup>143</sup> In addition to having to deal with the varied requirements of the aforementioned bodies, there are also institution specific policies that must be met in order to gain access to credentials that allow one to both admit and care for patients in an inpatient facility.<sup>144</sup> Credentialing is a long drawn out process that includes multiple steps, such as: 1) validation of the applicant's credentials; 2) evaluating competence, including currency of the applicant; 3) securing peer references as to applicant's competence; and 4) having multiple discussion both from the applicant as well as sundry committees that have been evaluating the applicant's credentials.<sup>145</sup> The timeline associated with this process can prove to be a real hurdle for an NP especially if it involves months of time when the NP is unable to work. For example, an NP in Washington, DC had applied for privileges at a local hospital where she intended work as an Acute Care NP, the time for approval of medical staff privileges and credentialing was so prolonged (more than 12 months) that she never received her credentialing approval before her husband was transferred to another military base and they both left the city.<sup>146</sup> It is this type of process that makes one wonder whether there was some type of exclusionary process that might appear to be an anti-trust violation.

## **Conclusion**

With the passage of the Affordable Care Act millions more Americans are seeking healthcare through marketplace insurance that they were able to purchase.<sup>147</sup> We have seen that there are insufficient family practice physicians to meet this overwhelming need for care, yet organized medicine continues to create barriers to the one group of health care providers that can serve as a bridge to the future: the nurse practitioners.<sup>148</sup> Many major organizations including the FTC, National Governors, Institute of Medicine, American Association of Nurse Practitioners, American Nurses Association, etc. have advocated on behalf of NPs to reexamine outdated legislation and, where possible, to change that legislation so that it is congruent with the technological, biological, and medical changes that have occurred in our healthcare system over the past 50 years.<sup>149</sup>

The quality and safety issues have repeatedly been debunked.<sup>150</sup> Patient outcomes for both NPs and family physicians have been shown to be equivalent and, in some cases, NPs fare better in terms of outcomes than our physician colleagues.<sup>151</sup> Competency of NPs is

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credentialing and medical staff privileging are key to allowing nurse practitioners to both admit and follow their patients in the hospital setting without having to secure physician authorization for these tasks. This allows the nurse practitioner to ensure that her patients receive timely care when needed.

<sup>143</sup> Supra note 142 at 1.

<sup>144</sup> Supra note 142 at 2.

<sup>145</sup> Supra note 142 at 5.

<sup>146</sup> personal communication with an Acute Care NP

<sup>147</sup> <http://www.hhs.gov/healthcare/about-the-law/read-the-law/>

<sup>148</sup> Supra note 142 at 5; Supra note 5.

<sup>149</sup> Supra note 13; Supra note 20.

<sup>150</sup> <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8167.pdf>

<sup>151</sup> Supra note 151 at 1052.

initiated and maintained through certification exams, continuing education, and workshops similarly to our physician colleagues.<sup>152</sup>

The quest for NP autonomy is simply a desire to practice according to the education and skills that our respective states' "scope of practice" regulations allow. In point of fact, no healthcare provider truly works "independently" because we all rely on one another: NPs refer to specialists, MD's refer to surgeons and surgeons refer back to internal medicine.. Restraint of one profession by another simply leads to litigation. If we all are to make a difference in terms of the access to and quality of health care, then the path we should follow is clear: it is time to break down the barriers and begin building bridges, for only by working collaboratively will we be providing the best care for our patients.

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<sup>152</sup> Supra note 13 at 7.