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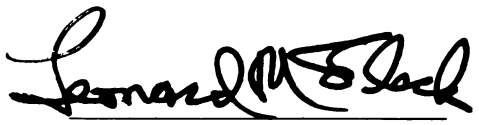

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ADVANCED PRACTICE NURSES

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ABSTRACT

ADVANCED PRACTICE NURSES

By

Elizabeth Tupper

This paper will examine how the use of advanced practice nurses, specifically nurse practitioners and clinical nurse specialists, could change the provision of primary care within our current health care system. Primary care is a keystone of this system, and the profession of nursing has a long and intimate relationship with both the intellectual concept and the shaping of a definition of primary care. Historically, there are three events that have contributed to the relative positions of nurses and physicians in the hierarchical ladder of power and authority in the delivery of health care. These three events all illuminate an aspect of contingency, that the system that has evolved was due to many forces, forces which were not rational or coordinated or planned. It is time to rethink the division of authority that currently exists within our health care system and look at ways that nurses can be used more effectively. There is ample evidence of ways in which nurses have responded even more effectively than physicians to the most crucial problems facing our health care system--cost containment, access, and care to underserved areas. Therefore, advanced practice nurses should be given the due authority and compensation for serving as providers of

primary care because they have a firm track record as being qualified to provide the care and they are a necessary component in our response to the problems we currently face in the delivery of primary care.

"What's emerging from the pattern of my own life is the belief that the crisis is being caused by the inadequacy of existing forms of thought to cope with the situation. It can't be solved by rational means because the rationality itself is the source of the problem...So I guess that what I'm trying to say is that the solution to the problem isn't that you abandon the rationality, but that you expand the nature of rationality so that it's capable of coming up with a solution."

Robert M. Pirsig

Zen and the Art of Motorcycle Maintenance

Daniel Callahan has made the observation that Americans, as a society and as a culture, have become enamored of medical progress and medical technology. I would like to add physicians to the list. America perceives physicians as being the only option in terms of the provision of health care. This is due in large part to the authority and power that the profession has developed over the last century. I will propose an alternative. I propose a redefinition of the "front line" in the provision of health care services--that is, the providers of primary care. I propose that we look to nurse practitioners and clinical nurse specialists, two groups of advanced practice nursing, for the provision of much of our primary care.[1] There are several models by which this could be accomplished, just as there are several models under which we obtain our health care from physicians. Most importantly, this proposal calls for the recognition, not only by society, but also by the legislatures, insurance companies, and physicians, of these advanced practice nurses as independent and autonomous agents.

I will make several substantiated claims within the confines of this proposal. First, that primary care is at least one of the most crucial aspects of health care, if not the most crucial aspect. Second, that primary care needs are very inadequately met in our society, especially for poor, urban populations and rural populations. Third, that physicians have not been adequately responsive to meeting these needs. Fourth, that nurses traditionally have been in the forefront of providing primary care and, in fact, have developed important specializations focused around primary care. Finally, that nurses are increasingly used in crisis situations to provide care and have certainly demonstrated that they are capable of providing such care in an effective, efficient, and quality manner.

I. PRIMARY CARE AND NURSING

The following discussion is based upon an assumption of the moral importance of primary care, an assumption that is important enough to bring out explicitly for the reader. This is an area that occasions much debate in and of itself. The debate revolves around issues of primary care as it relates to other, more intensive types of care, in terms of cost, health, and equality of opportunity. This debate also includes those arguments regarding social justice, funding priorities, and assignation of a price to specific lives and to populations of particular patients. I take as one very important assumption the position that investment in primary care and that increased access to primary care result in both

an increase in overall health and number of lives saved, and a decrease in the use of higher levels of care. This is a result of the fact that individuals, by virtue of this access, are enabled to attend to problems relating to health and disease when they may be relatively simple and easy to treat as opposed to waiting for the problems to progress to such an extent that their health is not only at greater risk, but hospitalization and other more intensive and expensive interventions and therapies are required.[2-6] The explorations of these arguments, however, is beyond the scope or the intention of this paper. I take then, as one foundation, the position of primacy of primary care. That is, that primary care is one of the keystones of our health care system, and possibly the most critical and important component.

There are a multitude of definitions of primary care.[2-9] However, within these definitions, one can find several characteristics in common that are considered essential. Primary care refers to what is often described as "first contact" care--that is, it is the individual's first contact with the health care system. It is from this point of contact that the individual is helped to access either other types of care or higher levels of care. This position within our health care system has garnered the label of the "gate keeping" position; often times, it is only through these primary care providers that an individual can access the rest of the health care system. This "gate keeper" ensures

appropriate use of health care resources, that referrals to other health care providers are made appropriately, and discourages overuse or misuse of the health care system.

In addition, almost all definitions of primary care contain the three C's: comprehensive, continuous, and coordinated. The primary health care provider must be able to function across all areas of specialty, must be able to function across time, and also serves to coordinate the health care "team" that is attending to the health needs of the individual. Some definitions also include two more important characteristics of primary care. First, that the provider treats the entire individual and not just the disease entity--that is, evinces a holistic approach to the patient. Second, that to adequately perform any of the aforementioned functions, primary care must be reasonably accessible.

Primary care is most often delivered at sites outside of what we consider to be the hub of the health care system. Delivery sites include, but are not limited to, the private office, public clinics, private clinics, health departments, health maintenance organizations, and the individual's home. These are often referred to as "ambulatory" care delivery sites, and some authors use the terms ambulatory care and primary care interchangeably.

The American Nurses Association definition is as follows:

> "Primary health care is a way of delivering health care. It is the care that the patient receives at the first point of contact with the health care

> system that leads to a decision of what must be done to help resolve the presenting health problem. It is also continuous and comprehensive care, including all the services necessary for health promotion, prevention of disease and disability, health maintenance, and in some cases rehabilitation. Primary health care includes identification, management, and/or referral of health problems, as well as promotion of health-maintaining behavior and prevention of illness. It is also holistic care, which takes into account the needs and strengths of the whole person. Since primary health care involves the delivery of health care from entry into the system and is also continuous and comprehensive, it necessitates collaboration among many health professionals."[7]

Both the federal government and the profession of medicine have tried to attend to this issue of access to primary care, most especially for the poor, for those who are geographically isolated, for urban populations, and for those with no health insurance. The federal government expressed its concern via its interest in and promotion of such programs as health maintenance organizations, the National Health Corps, and Rural Health Clinics. The medical profession expressed its concern and interest by establishing a new "specialty" in 1969, that of Family Practice. It was hoped that the increased prestige and economic incentives would lure more incoming physicians from other specialties into the specialty of family practice. But the fact of the matter is that our nation is experiencing a shortage of primary care providers even as the number of practicing physicians rises in relation to the population. A recent news items by Gannet News Service noted that, "The American College of Physicians estimates there will be almost 5,000 fewer internists than the nation will require in 1995 and a shortage of 26,800 by 2020."[11]

The connection between nursing and the provision of primary care is a strong one. Diane O. McGivern, R.N., Ph.D., F.A.A.N., wrote:

> "In its broadest sense, primary care is defined as the scope of nursing practice...The components of the nurse as generalist who is oriented to the psychosocial needs of clients and families, provides comprehensive care, and works collaboratively with clients were and are elements consistently defined as part of primary care as well as traditional nursing."[12]

She continues:

> "Nursing's recurrent themes and concerns are characterized by the unique perspective that focuses on the wholeness of the client, his or her quality of life, and general well-being beyond illness needs. In fact, and with irony, it must be noted that this very breadth of background is what makes nursing so clearly suited to the primary health provider role. It is a breadth not possessed by any other health care delivery group.[13]

The concepts of nurses as providers of primary care is certainly not a recent development. Traditionally, nurses functioned within the community as health care providers of first contact--for example, public health nurses. Within the profession of nursing itself, as early as 1943, one of the great leaders, Frances Reiter, began to address the idea of the "nurse-clinician". Her concept included the following three aspects: "1) clinical competence in the depth of understanding, range of function, and depth of services; 2) clinical expertise for coordination and responsibility for continuity of care; and 3) professional maturity in collaboration with the medical profession."[14] The 1950's heralded the first program specifically for advanced practice nurses at Rutgers University in psychiatric nursing. It was

during the physician shortage of the 1960's that the use of advanced practice nurses began to swell. The federal government began to take a special interest in using these providers as alternatives in areas that were inadequately served by physicians. The federal government also began to express its interest in these alternative providers by funding graduate education.

I have selected for concentration two areas of advanced practice nursing as they relate to primary care. These are the nurse practitioner and the clinical nurse specialist.

The American Nurses Association defines a nurse practitioner as:

> "...a registered nurse prepared through a formal, organized educational program that meets the guidelines established by the profession. This education prepares the nurse practitioner to provide a full range of primary health services. Practitioners engage in independent decision making about health care needs and provide health care to individuals, families, and groups across the life span."[15]

A clinical nurse specialist is defined by the same organization as:

> "...a registered nurse who, through study and supervised practice at the graduate level (master's or doctorate) has become expert in a defined area of knowledge and practice in nursing. Specialty practice is part of the discipline of nursing that is more focused than generalized practice; it is the diagnosis and treatment of human responses to actual and potential health problems within a specialized area of nursing."[16]

These two practice specialties, their similarities and differences, have been the source of much ambiguity not only outside the profession of nursing, but within it as well. It is a point, therefore, that deserves some attention.

Educational levels between these two areas of nursing of advanced practice are quite comparable. One survey noted that, "The nurse practitioner programs reportedly place more emphasis on pharmacology, primary care, physical assessment, health promotion, nutrition, and history taking."[17] The other difference noted in the survey was that of both clinical training and graduates' employment settings: Nurse practitioners were more focused on primary care settings while certified nurse specialists focused on secondary or tertiary settings.[17]

One author compared nurse practitioner and clinical nurse specialist roles in light of five parameters: range of knowledge and skills, practice domain, professional autonomy, interdisciplinary collaboration, and directness of service. While both practitioners approach patient care from a perspective of holistic care, the certified nurse specialist has what could be characterized as less breadth and more depth. The specialist focuses on a narrower population, such as pediatrics or geriatrics, and therefore, "...had a narrower range of advanced assessment skills and has intervened in greater depth with a narrower spectrum of problems within the defined population served."[18] It is, however, interesting and enlightening to note that the clinical nurse specialist defines her specialty in terms of a population of people, and not in terms of a disease entity or an organ system. The clinical nurse specialist role is also more closely associated with secondary and tertiary care settings. For example, a gerontological nurse specialist may

serve her clients totally within the confines of a nursing home.

A degree of difference was found in the histories of professional autonomy between the two practice areas. While the role of the nurse practitioner was developed as a "physician extender", and therefore required physician approval and supervision, the role of clinical nurse specialist was developed as a practice specifically within the nursing domain. In spite of this difference in origin and role development as regards professional autonomy, Harriet Kitzman notes, "...both the NP and CNS require professional autonomy and collegial relationships with physicians if the communication required to plan, implement, and evaluate clinical services is to be effective."[19]

Another difference is highlighted when one looks at the goals of the two practices. While nurse practitioners are more oriented to providing direct patient care, the clinical nurse specialist has several orientations. These include research, education, and consultation, what are referred to as indirect services. Kitzman observes:

> "Inherent in master's preparation, whether NP or CNS, is a specialization in clinical nursing, which forms the base for the expertise that is demonstrated through multiple direct and indirect care and leadership roles. These include practitioner, staff educator, patient advocate, and collaborative practitioner. The expertise in clinical nursing provides the content through which these activities are undertaken."[20]

It seems that despite all the ambiguity regarding these roles, the end result is unchanged. That is, both nurse

practitioners and certified nurse specialists are an untapped source of primary care providers. Kitzman, like many other experts in the field, calls for a conceptual meeting of these two roles. Both nurse practitioners and certified nurse specialists are oriented toward and capable of providing primary care. However, the CNS may be more narrowly oriented to providing primary care to a specific population of individuals.

II. HISTORICAL CONTEXT

Now that we have a grasp of primary care and how nursing, specifically those nurses in advanced practice, fits into this concept, we need to look at the profession of medicine itself. We do this to see if we can come to some understanding of how the health care system came to have the shape that it does today. It is a system that is overwhelmingly dominated by physicians who, in large part, determine what roles other health care professionals are allowed to play, who determine in large part what health care will cost, and also have great influence over who receives that care and in what form.

I am going to examine three main events to illuminate and aid in the understanding of how the monopoly of power over the health care system became so physician centered. Further, I will tease out the contingency of each of these events. The idea of contingency is an important one. The system evolved into the shape it has today due to the interaction of many forces, forces which were not rational or

coordinated or planned. Instead, the end result of a health care system that is so totally physician centered and dominated is a collateral or contingent outcome. For this reason, we need to look at the position of physicians within our health care system and ask ourselves, "Does our health care system, with this hierarchy of power, have to be this way? Is there some way in which it can be different and still be equally if not more effective and responsible to the health care needs of our country?"

The first area in which the aspect of contingency or incidentalism is illustrated is in the history of prescriptive authority. This history demonstrates that, with each move that the American Medical Association and the federal government made, the profession benefited from the incidental increase in power and authority. Note that for much of the legislative action taken, the intention was not the bestowal of prescriptive authority solely with the physician, but was to protect the public from false claims made by drug manufacturers. The control of drugs moved from the realm of the consumer to the realm of the physician. But an equally important effect of this transfer of control was economic power and the power of professional authority. The American Medical Association was deeply involved in lobbying for increased drug regulation. It is instructive to look at this history and its importance to a professional who provides primary care because, very simply, one must be able to prescribe medications if one is to treat patients.

"Prescription of drugs has become an act integral to the assessment, diagnosis, and treatment cycle in the provision of primary care," says Gene Harkless, R.N., M.S.N.[21]

In the early 1900's, the shift of power from the consumer to the medical professional began in earnest. According to Paul Starr, there were three factors involved in the genesis of this power shift. First, "muckraking" journalists began to do exposes on patent medicine companies, calling for increased regulation of these medicines and publicizing the companies' business practices as being deceptive. Second, the American Medical Association (AMA) had grown large enough, mostly in the financial sense of the word, to mount a campaign against what they called these "nostrum makers", calling for these companies to reveal their "secret formulas", and additionally, pressuring the companies to not market directly to the public. Third, with the drug companies' realization that the populace was increasingly relying on physician advice came the parallel realization that to market their product even more effectively, it would behoove them to market directly to physicians.[22]

In response to this combination of events, mainly the public exposure of the business practices of drug companies, the Food and Drug Act was enacted in 1906. The Act made it illegal to make claims about a product that were obviously false with regard to the contents of the product. The intention of this Act was to make consumer information more accurate, essentially so that people would know what they

were buying, and so that the consumer wasn't misled into buying a false product. Coinciding with this, the AMA established the Council on Pharmacy and Chemistry to, "...set standards for drugs, evaluate them, and head the battle against nostrums."[23] The Council wanted drug companies to apply to them for their Seal of Approval for their medicines. Further, they refused to approve any drug that was marketed to the public, no matter how honestly. This forced drug companies to make a crucial choice--either market to consumers or market to physicians. An additional benefit for physicians was the elimination of these drug companies as a source of free advice for the public. These events all interacted to ensure that physicians had increasing power over the world of pharmaceuticals.

The second decade brought further strength to the position of physicians with respect to the drug companies and the public. In 1912, the Act was enlarged to proscribe not only all fraudulent claims about composition, but about efficacy as well. The AMA Council, once again in concert with the federal government, enlarged their position of power by denying approval to specific drugs if <u>any</u> other drug made by a manufacturer was marketed to the public. Now companies had to choose not only how to market a single drug based on AMA approval, but their entire corporation!

> "The AMA's regulatory system did not merely augment the federal effort. The logic of the 1906 law was to improve the functioning of the market by making consumer information more accurate. The logic of the AMA's regulatory system was to withhold information from consumers and rechannel drug purchasing through

physicians."[24]

Throughout the next four decades, regulation of drugs increased. The legal right to prescribe pharmaceuticals came to rest solely within the profession of medicine. That power of prescriptive authority, as Harkless so eloquently pointed out earlier, is what enables health care providers to take care of patients.

Harkless makes some astute observations with regard to this history of prescriptive authority and the profession of nursing. Nurses, in the late 19th century and the early 20th century, made drug recommendations as part of their healing and caring function. This was especially true for those nurses who practiced within the domains of public health nursing and private duty nursing. Gradually, this aspect of nursing was eroded. In fact, in 1955, the American Nurses Association published a model nurse practice act that, "...explicitly excluded the acts of diagnosis and prescription as nursing functions."[25] It wasn't until as recently as 1970 that the model definition was amended. So nurses seemed to have, at least to some extent, participated in <u>giving</u> away some of that power. While the public's perception may be that physicians have always been in control of drugs, Harkless comes to the conclusion that, "...the authority for prescribing treatment 1) has not always rested with the M.D., 2) developed with little challenge and examination, and 3) may be competently carried out by others."[26] Further, Harkless states:

> "Patterns of authority tend to take on the status of objective social fact. Patterns of authority are perpetuated because people come to believe that this is how things always were, always will be, and always should be...The stability of the medical hierarchy, M.D.'s' perceived role as experts, the rise in technological development, and the support of government agencies have created a value-generating system that has served to strengthen the hierarchical structure of medicine."[27, 28]

In addition to the forces outlined above, there was another factor to be considered in the evaluation of this outcome of sole prescriptive authority residing with physicians. That is the rise of therapeutic efficacy, which are those pharmocologic and surgical interventions that were truly effective as treatments and cures and not merely the provision of symptomatic relief. Joseph A. Califano, Jr., former Secretary of Health, Education, and Welfare, states that physicians began to exercise control over pharmaceuticals even before the advent of therapeutic efficacy in the 1930's. The simple fact that the medications being prescribed actually worked just added to this position of and public perception of power. Once we entered the era of wonder drugs, most specifically, the antibiotics, this further bolstered the position of physicians. The events that occurred in the 1900's essentially made "...the doctor's prescription the indispensable key to patient access to most drugs. The doctors were perfectly positioned with the keys to the miracle drug kingdom, the exclusive power to prescribe."[29]

The public perception of the profession of medicine as the only competent prescribers of pharmaceuticals, the added

bonus of therapeutic efficacy, the lobbying efforts of the AMA, and regulation by the government had all interacted to yield sole prescriptive authority by physicians. Was this an intentional outcome of all these events? More importantly, was it a necessary outcome? Certainly, it was intentional on the part of the AMA, but I contend that a factor of contingency played a strong role in the development which added to the hierarchical power of medicine within the health care system. Although the AMA effectively exercised political power to protect and enlarge the scope of authority for the profession, the result is not a necessary component of the structure of the health care system.

The second area to be explored is that of the development of third party payers, specifically that of Blue Cross and Blue Shield. It is impossible to deliver health care services without the recognition by these third party payers of the legitimacy of the practice. That recognition is made concrete by reimbursement. As the health care industry began to grown in America, the AMA and the medical profession played an integral role in shaping it. However, other forces played just as strong a role, including the Depression, the federal government, corporations and labor unions, and even the second World War. The result of these many interacting forces was a system that recognized only physicians as reimbursable providers of health care. Institutions could be reimbursed, procedures could be reimbursed, but no other service offered by a provider was reimbursed.

Before the 1930's, about 90 percent of hospital and doctor bills were paid for out of pocket by most Americans.[30] During the Depression, hospitals were hit hard. "Between 1929 and 1930, average hospital revenues plummeted from more than $200 per patient to less than $60."[31]

This was only one of the reasons that the American Hospital Association began to look at pre-paid hospitalization plans. Another was purported to be a concern for increasing access for the middle class to the technology that the hospitals had to offer. "The primary political issue of hospital financing in the mid-1930's was affordability of care to the majority of those with low incomes, who were the backbone of growing productivity--that is, to working class white Americans."[32] A third and equally powerful reason was the fact that, if the hospitals actively stepped in and did something about increasing access for this middle class who couldn't afford to pay out of pocket and yet weren't quite poor enough to quality for charity care, they would stop the government from making a similar move and therefore retain control over these pre-paid plans. Most historians cite Baylor University Hospital in Texas as the site of the birth of the Blue Cross concept. The essence of these plans was that a specified number of days of hospitalization were provided in exchange for a yearly premium.

The AMA first was highly suspicious of these plans, thinking that they somehow reinforced the idea that hospitals

practice medicine instead of physicians. The AHA knew that they were highly dependent on physicians for patients to fill their beds and so were very careful not to alienate or antagonize them. So the AHA agreed to a distinct separation of hospital services from medical services. Another factor influencing physician acceptance of pre-paid hospitalization plans was the realization that, if the hospital bills were paid by the plan, then the patient would have that much more money available to pay the physician fees. However, just to make sure that there was no misunderstanding about the issue of who could legitimately practice medicine, in 1934, the AMA published ten principles regarding these pre-paid hospitalization plans. The principles addressed issues of control of medical practice, choice of physician, and patient confidentiality. These issues, in and of themselves, were not controversial. But the economic implications of these principles were. Paul Starr states, "The doctors took professional authority, patient confidentiality, and free choice to require a specific set of economic relations..." Principle 6 essentially "...meant that except for the poor, no form of health insurance was acceptable that paid doctor's bills as opposed to indemnifying patients...In other words, doctors would not accept any system of payment that confronted them with an organized payer." Principle 8 prevented "...a group of doctors from offering care to patients at any lower price than their colleagues. In the name of free choice, it effectively eliminated the possibility of competition and the right of patients to

choose among competing physician groups."[33] Starr sums up his analysis of these principles with the final observation that, "in short, the AMA insisted that all health insurance plans accept the private physicians' monopoly control of the medical market and complete authority over all aspects of medical institutions."[34]

Despite these admonitions, or more strongly, proscriptions, by the AMA to physicians so that they would remain aloof from pre-paid medical plans, they existed anyway. Corporations and employee associations often sought out contracts with physicians or with groups of physicians for the provision of medical care. Most historians cite the Ross-Loss Clinic of Los Angeles as the forerunner in pre-payment for medical care.

How did the profession respond to these challenges to the delivery of medical care? With force and anger. They lobbied, successfully, for many states to enact laws that specifically prohibited "consumer-controlled" plans. The AMA did not even approve of direct service pre-paid plans when they were controlled by physicians at this point in time. The medical society expelled the founders of the previously mentioned Ross-Loss Clinic. "If these physician-controlled plans were unacceptable to the AMA because they created 'unfair' competition, the medical cooperatives were doubly anathems because they subjected doctors' incomes and working conditions to direct control by their clients," says Starr.[35] It wasn't until 1942 that the AMA began to change its stance

toward service benefits, when it gave its approval only if the state medical society sponsored it. Starr says, "A plan that paid doctors directly was all right if the doctors ran the plan."[36] Once again, this response by physicians was prompted by the realization that, if the profession didn't take control of these plans, the federal government would. As with any other form of external control on the profession, control by the government was considered unacceptable. If physicians assumed the initiative, they could keep the government out and maintain control over these plans.

The end result of the interaction of all these forces is an insurance industry that, by and large, is controlled by the very profession that provides the service. Eli Ginzberg writes, "...The boards of directors of most of the Blue Cross and Blue Shield insuring organizations around the country are controlled by physicians and hospital administrators, who often hold the majority or set percentage of seats on the board by law."[37] Both of these programs, in addition, act as an intermediary for the federal and state government programs, Medicare and Medicaid. In the American Nurses Association's position statement on reimbursement for nursing services, the observation is made that:

> "In their fiscal intermediary role, the Blues have been subject to criticism that they not only negotiate the prices of their services with themselves, they have also been permitted to audit their own transactions! In no other industry have the providers of goods and services been accorded such favorable treatment as that given health care providers under the evolving reimbursement system."[38]

Ginzberg puts it another way:

> "In short, the nation's physicians and hospitals have had an advantage over most other providers of services. To a large extent, they or people close to them have sat in judgment on their own incomes, because the insurers decide which fees and rates to accept and to pay; in other words, they have been their own barriers."[39]

This impacts the system not only financially, but has some obvious implications for which of the practitioners and providers get reimbursed. Physicians have a long history of operating in a very anti-competitive mode, and control of the pocketbook of health care gives them an enormous amount of power over their competitors or any profession that they perceive as competitors.

The third event that illuminates the aspect of contingency in the development of the power of the medical profession can be found in the story of the Flexner report of 1910. Anne Stoline, M.D. and Jonathan Weiner, Ph.D. say, "Based on a study sponsored by the Rockefeller and Carnegie Foundations, the Flexner report has been called the single most important document in the history of American health care."[40] The Flexner report served several functions, but in terms of this discussion, the issues of power and control are most relevant. The most commonly cited impetus behind the Flexner report was the raising and standardization of medical education. However, another result was control by the physicians themselves of the number of both medical schools and physicians. Ginzberg comments, "What needs to be emphasized is that the AMA took the lead, through the establishment of the Council on Medical Education in 1903, to reduce the number of medical schools and the numbers of

physicians entering the profession."[41] In addition to this aspect of control of the profession, some other interesting aspects of control emerged as well. The increased educational and financial requirements mandated by the Flexner report:

> "...made it much harder for a relatively poor person to obtain a medical education and thus altered the social structure of the profession...In addition, from that point on, all medical schools took a common approach to the study of patients and disease: The AMA and allopathic medicine had emerged the victors of the competition among sects."[42]

Through this event, the medical profession was able to remain a relatively small and homogeneous group. The AMA skillfully lobbied state legislatures to enact these recommendations into law. L.S. Aaronson notes, "Medicine secured its power vis-a-vis society not on the basis of scientific knowledge, but rather through monopoly over the means of health care."[43]

Further restriction on the numbers of physicians entering the profession occurred during the 1930's. Ginzberg observes:

> "Although the thrust of the AMA's initial efforts to raise the quality of medical education in the early years of this century was not aimed at enhancing the economic position of its members through reductions in the supply of physicians, such a cartel-like objective was clearly manifest in its actions in the 1930's, a posture that carried over in the post World War II years."[44]

Many authors focus solely on the Flexner report. However, some note that this increasing control by physicians began as early as 1903. Through the efforts of the AMA's Council on Medical Education, the state medical licensing

boards began to raise their standards for licensure. Megali Larson states:

> "In 1906, the Council surveyed all the medical schools in the country, ranking them according to diverse criteria...The effects were immediate: Rather than face the publication of the rankings, many commercial schools closed, and others consolidated or sought university affiliation; homeopathic and eclectic schools were even more adversely affected than the regular commercial schools."[45]

But it was the changes in medical education, along with increasing therapeutic efficacy, that seemed to increase the public's confidence level in the medical profession. The Flexner report also played a large role in determining which of the medical schools that remained got the lion's share of money from foundations, further cementing the financial closed doors of the profession. Members of the profession itself, in large part, were leery of the "scientific" reforms sought by the Flexner report. But they did know that there were too many physicians, and they did know that competition for patients was fierce, and most cooperated with the reform measures with the end result being a bettering of their own economic position. Larson highlights two of the main motives for cooperative. "The 'qualitative' argument of the reform leaders--get better doctors--fused, therefore, with the 'quantitative' and practical concerns of the rank-and-file--permit fewer doctors and provide more secure incomes."[46]

Analogous to the Flexner report, for nursing was the Goldmark report of 1923. Aaronson says, "It attempted to do for nursing what the Flexner report did for medicine. Unfortunately, it did not challenge physicians' and hospital administrators' right to rule over the health sector."[47] Nursing, unlike medicine, was unsuccessful in its attempt to control its numbers, as was the attempt to increase the homogeneity of the membership as was done in medicine. Susan Reverby states:

> "As physicians had for medicine, nursing leaders sought to document the reasons for nursing's ills, to define professional nursing, and to gain from the foundations ideological and financial support for their goals. They hoped to create a unified, well-educated work force by severing nursing education from hospital nursing service demands. They wanted to develop collegiate programs for an elite, close the weaker schools, and define poorly trained nurses out of the profession."[48]

The Goldmark report received little support, not only from hospital administrators, superintendents, and physicians, but also from nurses themselves. The complaints of hospital administrators and physicians centered around the separation of nursing education from nursing service, around issues of "over-educating" the nurse. Nurses, especially those trained in the smaller schools, were fearful of being "defined out" of the profession and were also fearful of the report's call for the training of a "subsidiary nurse." Another major difference between the two reports of Flexner and Goldmark was the ranking and classifying of schools. Reverby says, "Goldmark's report, in contrast to Flexner's, had neither applauded the best programs nor sought to

discredit the worst by name."[49] Lauren Aaronson, who also analyzed the effects both reports had on these two professions, says:

> "Unlike medicine, however, nursing has never questioned the wisdom of 'grandfather' clauses. When the Flexner report was implemented, medical practice by those not educated in AMA-approved schools was immediately outlawed and over half of all medical schools in operation at that time were closed. In contrast, nursing's protracted struggle to establish a bachelor's degree requirement for beginning professional nursing practice grandfathers in all current registered nurses for practice as professional nurses. When will nursing learn?"[50]

Ginzberg's comments are:

> "Every occupational group or profession frequently faces a simple dilemma. On the one hard, to improve the economic circumstances of its members, it is sensible to control its numbers. The medical profession, surely through the 1930's and even later, followed such a policy. On the other hand, an inherent obligation of a responsible profession is to respond to the public's need for services, and that frequently means increasing the supply of practitioners. Yet the biggest barrier to improving the economic returns of its members is for a group to press for increases in the supply. The nursing profession has never faced this problem in these terms."[51]

The result of this missed opportunity was that the control of nursing was not in the hands of nurses themselves, but was placed, beginning in 1903, within the state regulatory boards.[52]

What these three events show is that the reason our health care system is set up, especially in terms of the roles within the system, is based on contingency--that is, an arbitrary historical evolution. None of the many events which led to this degree of physician control were mapped out ahead of time in a coordinated plan. Each separate step simply added on to the last, with an aggregate outcome of

substantial power. It is not the result of rational and thoughtful policy making or assignation of duties and responsibilities and power. The distribution of authority in health care may have made more sense in an older model of the health care system. It is becoming increasingly apparent, however, that it does not work optimally in today's context. The system does not have to be this way. There are not enough good reasons to support this current set-up within the system. It can be different. We need to rethink this distribution of authority and power using nursing, specifically advanced practice nurses, in a more central role. I will show what this difference would mean to the health care system and provide thoughtful and reasoned support for this plan.

III. "CAN NURSES DO THAT?"

As I demonstrated in the previous portion of this paper, there exists insufficient justification for maintaining the current balance of authority of our health care system. I am going to explore how this system could be different, arguing that advanced practice nurses can serve as the impetus for this difference--that is, increased access to and affordability of that very important piece of our health care system, primary care. First, I will look at how the federal government has turned to advanced practice nurses to assist with many of the problems that exist within our system today. This is important because the federal government has

a responsibility for the populace as a whole, and also because they have no vested interest in a battle for professional "turf". Although one may not regard these governmental decisions as entirely objective, one can certainly regard them as necessary because of this responsibility. Second, I will explore a moral argument with regard to the medical profession's response to the use of advanced practice nurses in these problem areas, and show that their current response, that of passivity, is either immoral from the point of view of the populace, or immoral from the point of view of advanced patient nurses.

Author Ellen Beer states:

> "The central issues blocking the widespread use of autonomous nursing to meet the primary health care needs are political and hidden behind protests of whether nursing is a true profession that is capable of safely caring for patients in an independent manner."[53]

She continues:

> "When nursing asserts its claim to occupy the primary health care role, which is more obviously occupied by medicine, it invites comparisons to medicine in the extent of its authority to act in that role. In that comparison...nursing is seen as having less authority. But that is a false issue. In comparison to medicine, every profession or group is seen as having less authority. The important question is, does nursing have appropriate authority to act in the primary health care role?"[54]

We have more than thirty years of studies that more than adequately document the efficacy and high quality care that can be provided by advanced practice nurses. The most extensive and politically powerful study of how nurse practitioners as providers can influence access to the health care system was conducted by the the Office of Technology

Assessment (OTA) in 1986 in response to a request by the Senate Committee on Appropriations. As was noted in my introductory comments regarding primary care, some analysts include ease of access as an integral part of primary care by definition. The case study used most extensively in this paper is Case Study #37: Nurse Practitioners, Physicians Assistants, and Certified Nurse Midwives: A Policy Analysis. Historically, the two populations of concern regarding access to health care were rural populations and the socioeconomically deprived populations of the inner city.

The OTA found that nurse practitioners have improved geographic distribution of care, due mainly to the fact that they are more willing than physicians to locate in rural and inner city areas. It was this very fact that led to the Rural Health Clinic Services Act of 1977, an act that waived the previous restriction for direct supervision of nurse practitioners by a physician in certified rural health clinics located in designated underserved areas.

The OTA also concluded that, "In addition to improving access to care in rural areas, N.P.'s...increase access to primary care in a variety of nongeographic settings and for populations not adequately served by physicians."[55] This was found to occur in several ways--by increasing access for underserved children in school settings, by increasing access for patients in nursing homes, by increasing access for socioeconomically deprived pregnant women and pregnant teens, by increasing access for the chronically ill and homebound, and by adding to the scope of primary health services

available to patients.[56]

Studies done by various researchers find that 60% to 80% of the tasks performed by physicians can be performed by nurse practitioners.[56-58] Even more powerful than this is a recent study that suggests that, "R.N.'s often perform CPT-coded services with little or no supervision by physicians..."[59] So not only <u>can</u> these services be provided by professionals other than physicians, these services <u>are</u> provided by professionals other than physicians. Yet, it is the physician who is reimbursed for these services. A study which looked at the savings that the Canadian Health Care System hypothetically could have incurred from the use of nurse practitioners in place of physicians for the provision of many types of primary care found that 10% to 15% of all medical costs or 16% to 24% of all ambulatory costs could have been saved by the widespread use of nurse practitioners.[60] Health Maintenance Organizations (HMO's) are one of the largest utilizers of advanced practice nurses. This is due, I believe, to two very important factors. HMO's are not set up as fee-for-service entities, but rather as pre-paid plans. Providers are salaried and are not reimbursed on a procedure or per-service basis. Nurse practitioners'' salaries are often less than physicians' salaries, and this makes them very effective providers from a financial point of view of the organization. Also, very few outside payers must be billed for the services provided within an HMO, so the issue of third party reimbursement

becomes less problematic in this arena. The second reason for the high rate of utilization of advanced practice nurses within this setting is that one of the first and best known clinical trials was conducted by the Kaiser Foundation in 1973 concerning the increase use of nurse practitioners in an HMO setting. The trial found that the use of N.P.'s increased the number of patients seen, saved the M.D. time, and generally decreased costs.[61, 62] Another study comparing a single nurse practitioner and a single physician found that the quality of care provided by these two professionals was comparable, but that the care provided by the nurse practitioner was less costly.[63] A study at Johns Hopkins University showed that an HMO staffed by a physician and a nurse practitioner could reduce costs in the provision of pediatric care.[64] The list goes on and on.

We, as a nation, are increasingly using advanced practice nurses to help us out of the trouble spots. These nurses can only gain reimbursement and authority in the midst of what is perceived to be a crisis, a crisis that the profession of medicine has chosen not to attend to or has not been able to attend to. This is analogous to the old saw that the greatest advances in medicine are a result of war. In these circumstances of crisis, and only in these circumstances, have we allowed advanced practice nurses to provide the care that they are trained to provide.

The first example of this crisis situation is access to health care for rural populations. This is an issue that President Johnson so strongly addressed in the 1960's.

Current legislation addresses this increasingly desperate problem of access to care for rural populations, as did the previously mentioned Rural Health Clinics Act of 1977.

> "Included in the Omnibus Reconciliation Act (OBRA) of 1990...signed into law in November of 1990, P.L. 101-508 is a Medicare provision to directly reimburse nurse practitioners and clinical nurse specialists working in collaboration with a physician for services provided in rural health areas. The nurse practitioners and clinical nurse specialists will be reimbursed for providing 'physician services' covered by Medicare that the nurses are legally authorized to deliver according the state law."[65]

American Nurses Association President Lucille Joel, Ed.D., R.N., F.A.A.N., was quoted in a recent issue of The American Nurse: "The passage of this bill is testimony to a new and long overdue trend in health care...improved access and acknowledgment of the high quality, cost effective care delivered by nonphysician providers." She continues, "Congress' willingness to commit to this bill illustrates its belief that the reimbursement and utilization of nurses is a good investment for the future of our nation's health."[66]

Another example of using advanced practice nurses to stave off a crisis situation can be found in the ongoing debate regarding reimbursement reform for physicians by Medicare. This discussion revolves around the innovation and implementation of one of the more interesting and important payment reform issues since the advent of Medicaid and Medicare in the 1960's. This payment reform follows on the heels of a similar system, called Diagnosis Related Groups, that was implemented in 1983 for hospitals. It is a system that is devised mainly for federal dollars, but most health

care analysts feel that private insurance companies will also begin to use such a system. This strategy for controlling health care costs through physician payment reform is known as the Resource Based Relative Value Scale (RBRVS). "The American Public Health Association reports that our nation's health tab will hit $661.2 billion this year. Payments to physicians have risen as much as 17% per year, compared with a 9% rise in hospital costs and a 4% rise in other aspects of our economy."[67]

The Resource Based Relative Value Scale is slated to begin in 1992. The reform is aimed at de-emphasizing the importance of procedures and re-emphasizing the importance of primary care. What the medical profession finds objectionable about these reforms is that there will be increasing limitations on what practitioners can charge their patients. Physicians are therefore leaving the Medicare programs, and/or refusing to accept Medicare patients. This is an opportunity for advanced practice nurses to step in. When physicians abdicate a position within the health care system, they lose any claim, historical or otherwise, that they arguably could have made.

Another reason that this reform system is so important to advanced practice nurses is that it is the <u>resource</u> that will be reimbursed, regardless of specialty. If advanced practice nurses are providing the same resource as a physician in the provision of primary care, then the reimbursement should be the same. Other factors are also

taken into account in this formula for reimbursement.

> "The ANA task force affirmed that payment to nonphysician providers (NPP's) be based on a resource-based relative value scale (RBRVS) and that the value of the service or work component of the RBRVS should be the same for the same service, regardless of whether it is delivered by physicians or nonphysician practitioners. The actual payment may differ, as it includes adjustments for practice costs and malpractice liability costs which may differ for nonphysician providers and physicians."[68]

Yet another example of increasing governmental reliance on advanced practice nurses within our health care system can be found in the Omnibus Reconciliation Act (OBRA) of 1989, section 6405. According to the Medical Assistance Program Bulletin issued May 1, 1991 by the State of Michigan, "The intent of Congress in enacting this legislation was to improve access to primary care for children and pregnant women by expanding the number of providers eligible to be reimbursed under Medicaid."[69] Initially, in February of 1991, the MSA noted that the Medicaid Program would directly reimburse certified pediatric and family nurse practitioners for services that they can legally provide under state law, "whether or not the certified nurse practitioner is under the supervision of, or associated with, a physician or other health care provider."[70] For those services not considered within the scope of practice, a Nurse Practitioner/Physician Agreement would have to be in place. (See P.A. 280 for consultation draft of the list of procedures that are reimbursed within the scope of practice for Certified Pediatric and Family Nurse practitioners pursuant to the Omnibus Budget Reconciliation Act of 1989.)

The point is this: If advanced practice nurses are good enough to deliver health care in governmentally defined rural areas, and if the federal government finds that the care delivered by advanced practice nurses merits reimbursement under a whole system designed to take care of the health needs of our elderly, and if the federal government finds that the services provided by advanced practice nurses are of high enough quality to merit direct reimbursement under the Federal Employment Health Benefit Plan (with no call for physician supervision), then who are we protecting by keeping these providers, in essence, unavailable to the rest of our populace? If these providers were in some way dangerous, or gave care that was in some measurable or noticeable way inferior to the care provided by physicians, would the federal government be making the use of them that they are today? Who actually is being protected here? I contend that the only thing being protected is the "turf" of the medical profession. Ellen Beer observes:

> "The incongruity of this reaction by medicine to nursing as nursing asserts its claim to occupy primary health care roles is that firstly, all that is really changing is the overtness of the nursing primary care activities, and, secondly, the physician practitioners being 'threatened' do not exist. Physicians are not providing primary care services in needy areas or in adequate numbers, but they do not want nursing to provide them either..."[71]

Given the fact that a health care system that has, as one of its major characteristics almost totalitarian physician dominance, is no longer rationally operative in today's context, and given that advanced practice nurses have a well documented, very solid track record of providing high quality, affordable and accessible primary care, and given that nurses have responded and can respond effectively to the aforementioned problems within the health care delivery system, I therefore propose that these advanced practice nurses be given the due authority and compensation for service as providers of primary care.

IV. THE RESPONSE OF THE MEDICAL PROFESSION

At this point, I want to focus on the response of the medical profession to the proposed and actual utilization of advanced practice nurses as providers of primary care. It seems to me that the profession of medicine could have responded in one of two ways. The first response could have been vociferous protest regarding the dangers of allowing advanced practice nurses to provide primary health services to underserved populations. However, had the profession responded in this way, the next logical step would have been that the onus of providing care to these people would have fallen on the shoulders of the medical profession. In some fashion, physicians would have to be directed to make themselves available to provide care for these populations. This concept flies in the face of a tenet of non-interference in determining where and how physicians practice medicine,

whether this interference comes from the government of from within the profession itself.

The alternative response would be one of passive acquiescence. By this, I mean that the profession voices no protest, but at the same time, does not openly acknowledge that the solution is acceptable. In fact, in large part, the medical profession chooses to ignore the situation.

Here's the problem. If, in fact, advanced practice nurses are somehow substandard providers of primary care, then it seems that the medical profession has a moral obligation to vociferously protest their use as primary care providers. This obligation arises out of their claim to the privilege and the responsibility to ensure that the health care that is provided is quality health care and meets their own internally defined standard of care. On the other hand, if advanced practice nurses <u>are</u>, at the very least, acceptable providers of primary care, then these nurses are being wronged by the position taken of passive acquiescence. Further, if the profession cannot deny that advanced practice nurses are able to provide primary care to underserved populations that is of acceptable quality and reasonable cost, then the profession has no moral basis from which to exclude these nurses from providing these same services to the non-rural and non-poor. The only reasons for these exclusions are political and self serving in nature. A recent item in <u>The American Nurse</u> ran as follows:

> "In an American Medical News commentary headlined 'Let's not hand over primary care to nurses', Susan Hirshberg Adelman, M.D., points to increasing instances in which government or private health insurers make direct payment to nurse practitioners or nurse midwives. Adelman predicts that nurses will argue successfully for equal pay for equal work. As the disparity between the nurse practitioner and physician income narrows, the public will use nurse practitioners more frequently, she says, resulting in a net increase in the cost of care. Adelman concludes, 'We cannot afford to be perceived by the public as unwilling to care for them at Medicaid rates, nor can we afford to have nurses seen as the only ones who will.'"[72]

Dr. Adelman's argument regarding increased costs of care due to increased health care liability issues seems weak at best. What strikes me most strongly about this stance is that the important factor here is the public's perception, not the actual delivery of care. If physicians were really intent on preserving their position as the only legitimate providers of primary care, then the most sensible thing for them to do would be to provide the care. Further, to provide the care at a reasonable cost to everyone--individuals, the government, and third party payers. This is what advanced practice nurses propose to do and have done in the past.

The response of the medical profession to the use of advanced practice nurses as providers of primary care can also be found within a discussion of collaboration. Nursing literature frequently and very comfortably discusses and acknowledges the aspect of collaboration in the provision of health care services. Barbara R. McClain, R.N., states:

> "An extensive literature published primary by nurses strongly advocates collaborative joint practice between nurses and physicians. Descriptors used to explore the nature of the collaborative relationship include such terms as co-equality, shared clients, interdependence, collegiality, shared accountability,

complementary, cooperative, mutual trust and respect, and joint decision making."[73]

These definitions of collaboration are much different when viewed from the other half of the relationship, the more powerful half, that of physicians. Joyce E. Roberts writes:

> "On the one hand, interdisciplinary collaboration has been considered a key variable in explaining and enhancing patient outcomes. On the other, collaboration between nurses and physicians has been characterized as co-optation because what nurses view as collaboration, physicians view as supervision."[74]

Ellen Beer expands on this point:

> "Despite some recent proposals and some model legislation, nursing has most commonly been defined legally as a dependent practice that delivers health care services under the supervision of a duly authorized physician or dentist. As the demand for primary health care services expanded, many institutions inaugurated solutions in which nurses, under such titles as nurse practitioner, are utilized in the primary care role, but operate in part under a system of protocols of practice or taxonomies of accepted nursing behaviors designed in advance by physicians. Such compromises may make everyone feel better, but in fact they serve to further cloud the issue, in that protocols are external restraints that suggest the inability of the nurse to correctly choose among 'alternative possibilities of action...in accordance with (appropriate) inner motives and ideals...' Protocols merely extend the distance between the nurse in practice and the physician in supervision. They act essentially as 'standing' or 'PRN' orders and implicitly reinforce the dependent model of practice for nursing."[75]

It is this issue of "collaboration" versus "supervision" that has become the core of the problem in implementing the legislation in the State of Michigan regarding reimbursement of pediatric and family nurse practitioners. The interpretation by the medical profession of collaboration put forth in this legislation is another invisible means of undermining the authority of advanced

practice nurses. The Michigan State Medical Society recently released a document entitled "Implications for Physicians of Medicaid Reimbursement to Certified Pediatric and Family Nurse Practitioners" which reinforces the idea that collaboration is supervision. In addressing issues of vicarious liability, the document states, "...the element of control may result in vicarious liability on the part of the physician, even though it might be assumed that the nurse practitioner is an independent contractor rather than an employee or agent of the physician."[76] The document further goes on to say, "One of the elements of collaboration is supervision."[77] If the profession of medicine can continue to maintain the perception that collaboration in this sense is supervision, then they are also able to keep nurses in a position where they are perceived as not having the competence and ability to function autonomously. It allows physicians to continue to occupy their position of dominance within the health care system as being the only appropriate providers of care. If one seeks care from an advanced practice nurse, one is vicariously seeking the care of a physician because the advanced practice nurse is really only a delegate of the physician. This is not only a falsehood, but an indefensible tool for the profession of medicine to use in its ongoing struggle to maintain its power over the health care system.

V. CONCLUSION

Finally, I want to conclude with an observation regarding reimbursement for advanced practice nurses, to ensure that my point is not misunderstood. This is not an argument that will aid nurses in getting rich from the provision of their services. It is not an argument that calls for the perpetuation of the current system, only with different providers. It is, however, an argument that supports the overt recognition of advanced practice nurses in the role of primary care provider. It is, additionally, an argument that supports equal pay for equal work.

First, when I speak of third party reimbursement, and the importance therein, I speak primarily from a position of the importance of the symbolism that this recognition imparts rather than from a position of moral support for a fee-for-service, supposedly "market driven", competitive system. It is my belief, or rather my hope, that this sort of procedure driven, wide-open system has seen its heyday and is now on the wane in lieu of a more rational and just system. Increasingly, providers will find themselves negotiating more reasonable fee schedules with payers. Advanced practice nurses can help themselves and help us, as patients and purchasers, by approaching payers and negotiating <u>fair</u> and <u>just</u> fee schedules for the provision of primary care.

Second, I have a strong inclination against arguing for the fact that nurses ought to be reimbursed at a lesser amount than physicians for the same services. Let's face it:

Culturally, we value things in relation to what we paid for them. If advanced practice nurses deliver the same kind and quality of care, but at a lower cost, then it will be perceived by the public as second rate care due only to the fact that it costs less. I guarantee it. On the other hand, I have strong reservations about how primary care is remunerated in our system today. Is it permissible for one provider, for example a Family Practice physician, to receive $30 for a well patient physical exam, while an Internist receives $60 and a Cardiologist receives $125 for this very same service? Don't we need to take a hard look at an issue of justice in this discrepancy? Can we afford to expend resources on such a disparate basis within an increasingly strident milieu of cost containment strategies? Is this a fair way to spend our dollars when this same system excludes a frightfully large number of individuals from receiving these services? These are the questions and observations that are beginning to be addressed in the concept of the Resource Based Relative Value Scale, and they are the characteristics that I find most exciting and sensible about it. Within this context, I would not support or expect advanced practice nurses to vary fees for the same service by specialty, but expect reimbursement of an equal nature based on resource or service.

By no means do I think that this proposal is a panacea for the ills of the health care system. What this proposal is, however, is a means by which primary care can be provided more equitably, more accessibly, most cost efficiently, and

still be provided in a consistently high quality manner. Advanced practice nurses have "done their time" or "paid their dues." They have proved over and over again that they, as professionals, have something valuable to offer. We, as members of society, as participants in the legislative process, and as purchasers and users of health care, would do ourselves a favor by accepting this offering.

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78. I do not want to leave the reader with the impression that I believe the response of the medical profession is the only reason our society has not made greater use of advanced practice nurses in the provision of primary care. There are also the powerful and persuasive issues of gender and class. The American culture does not have a history of women as healers that many other cultures have. As an overwhelming majority of nurses are women, this factor cannot be ignored. There is also the issue of divisiveness within the profession itself. Although this area was touched upon in the process of differentiating the nurse practitioner and the clinical nurse specialist, it is important to realize the lack of cohesiveness within the profession itself.