The Changing Role & Autonomy of Nurse Practitioners

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Abstract

The role of advanced practice registered nurses (APRNs), particularly nurse practitioners (NPs) is constantly changing in response to national healthcare needs. As with most change, the discussion surrounding scope of practice and autonomy of NPs is often met with resistance. An examination of the current healthcare environment and all of its involved players lends itself to some insight of this resistance. Yet, further examination of the research highlights the necessity of the type of care that NPs can bring to an increasingly needy population. This paper aims to explore the issue of expanding the scope of practice and autonomy of NPs, as well as ruminate on the potential future of healthcare in this country should NPs not be given the full autonomy as dictated by their education. Lastly, recommendations to promote change will be discussed based on the current research surrounding this issue.
The Changing Role & Autonomy of Nurse Practitioners

The constantly changing landscape of healthcare needs in the United States is often the catalyst to ignite larger, systemic changes in the way that healthcare is provided. Since its establishment in the 1950’s, the role of nurse practitioner has continued to evolve to answer the call of a national need. The first training program for nurse practitioners was developed in 1965, the same year that Medicare and Medicaid programs provided care coverage to low-income women, children, the elderly and the disabled (O’Brien, 2003). Since that time NPs have established organizational groups in an effort to advance the profession. Educational preparations of NPs used to resemble the apprenticeship model, where a nurse with clinical experience would be mentored by and collaborate with a physician to provide advanced care (O’Brien, 2003). According to the National Council of State Boards of Nursing (NCSBN), nearly all NPs receive advanced, graduate education in pathophysiology, pharmacology and health assessment, as well as broad clinical experiences (NCSBN, 2008, p. 6). Despite this level of advanced training, NPs are still being prohibited from practicing to the full extent of their scope of practice and, ultimately, preventing patients from accessing primary care services.

The Issue

Regulation & Scope of Practice

Currently, the regulation of nurse practitioners is highly fragmented and determined at the state level. The states are the final arbiters of requirements for licensure, accreditation, certification and education (NCSBN, 2008, p. 5). This fragmented regulatory model has resulted in convoluted requirements for scope of practice, role expectations, and certification examinations (NCSBN, 2008, p. 6). This lack of a regulation model lends itself to complications
for NPs who intend to move from state-to-state as well as patients who wish to receive primary care from an NP.

There are eighteen states that allow NPs to practice to the full scope of their educational preparation, meaning they can “evaluate, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribe medications, under the exclusive licensure authority of the state board of nursing” (American Association of Nurse Practitioners [AANP], 2013). Twenty states allow reduced practice of NPs, meaning that at least one of the aforementioned activities is regulated by a collaborative agreement with a physician. The twelve remaining states restrict practice of NPs by requiring a physician to supervise, delegate or otherwise manage the way in which the NP can provide patient care (AANP, 2013).

The Research: Cost, Safety & Patient Satisfaction

Nursing care, and medicine as a whole, focuses heavily on evidence-based care, so it should follow that state regulations regarding healthcare should also be based on evidence and research to protect the interests of patient populations. Since the 1970’s NPs have been participating in and producing research to help define and legitimize the profession in the face of vehement opposition (O’Brien, 2003). Overall, the research has been in the favor of NPs and their ability to provide safe, cost-effective care at the same level of quality, if not better, when compared to physicians.

Cost. The current climate of healthcare, with the enactment of the Affordable Care Act (ACA), is now focused on expanding availability of care, especially to patients who may have not previously had healthcare due to costs. Research has shown that NPs are a cost-effective solution to rising healthcare costs when compared to physicians. According to the American
Association of Colleges of Nursing (AACN) (2010), educational preparation of an NP costs approximately one-fifth of the cost for physician education.

Additionally, NPs are typically compensated less than physicians, from one-third to one-half that of a physician. According to the American Medical Group Association (2009), physicians in primary care make a median annual income of $208,658. Based on figures from the AANP (2010), NPs across all types of practice, primary care as well as specialty practice, make a median annual salary of $97,345. For every one physician hired, two NPs could be instead hired for roughly the same price, theoretically increasing the number of available providers.

Lastly, the type of care provided between NPs and physicians has been found to differ in costs. According to Spetz, Parente, Town and Bazarko (2013), NP managed facilities, such as retail care clinics, are meant to handle low-acuity health concerns at a fraction of the cost that might be incurred should these cases be handled by emergency departments. According to one study, approximately 27% of emergency department visits could have been handled by retail clinics and urgent care facilities, resulting in an estimated savings of $4.4 billion annually (Weinick, Burns & Mehrotra, 2010, p. 1634).

Safety. Opponents of expanding autonomy of NPs often argue that allowing NPs to practice independently will directly threaten patient safety because they lack the skills and education provided by medical schools (American Medical Association [AMA], 2010). Yet, the research to support such claims does not exist. Mundinger et al., in a 2000 randomized trial, illustrated that no differences were found in patient outcomes between patients receiving primary care from an NP versus a physician. Follow-up at six months did not offer any significant differences in the health status of patients. A two-year follow-up of the same patients was
published and again, health statuses of patients were not found to be significantly different. In fact, patients treated by physicians were found to average more primary care visits than NP patients (Lenz, Mundinger, Kane, Hopkins, Lin, 2004).

**Satisfaction.** The AMA also makes the claim that “a new study shows” patients expect to see a physician when receiving care (AMA, 2010). Yet, no further citation for the study is provided, and in fact, many appropriately referenced studies have shown that patient satisfaction is comparable if not higher for NPs. A survey from the University of Michigan showed that NPs scored higher in patient satisfaction among low-income patients compared to physicians. NP scores were statistically significant in fifteen out of the eighteen core questions, all in favor of NPs. 80% of patients treated by NPs felt they were listened to carefully, compared to 50% of physician treated patients (Creech, Filter, Bowman, 2011).

Wait times to receive care play a large role in patient satisfaction.Steiner et al. (2009) conducted a study to determine the effect of NPs on patient care provided in an emergency department in Canada. Results showed that although patient length of stay was not affected, the volume of patients seen per shift increased and patient wait times to be seen by a provider decreased (Steiner et al., 2009, p. 210). Additionally, the number of patients who left without receiving care decreased, and emergency department physicians saw less lower acuity patients (Steiner et al., 2009, p. 211).

The research presented here greatly favors the independent practice of NPs. Given that the research here is just a fraction of the body of evidence supporting NPs, one must consider what other factors are preventing the unrestricted practice of NPs in the United States. The current landscape of healthcare in the United States involves a number of players who could be greatly affected by a change such as expanded NP autonomy.
Theory Base

A theoretical framework is a way in which to view and understand a topic or issue. As they relate to this particular issue, theories may help to illustrate the current setting in which changes are trying to be enacted. Theories from a nursing and interdisciplinary viewpoint help to demonstrate the wide reaching effects of nurse practitioner autonomy.

Nursing Theory: Care, Cure, Core

The nursing theory of Care, Cure, Core was developed by Lydia E. Hall in the mid-1960’s and was created in an effort to delineate nursing specific domains of patient care (Nursing Library, 2010). This theory identifies three aspects of a person when they take on the role of “patient”. The core is the patient and their holistic needs, such as social, emotional, spiritual and intellectual. This aspect of care may be addressed by the interdisciplinary team, but is largely facilitated by the nurse. The care is the physical and emotional nurturing of the patient, a domain specific to nurses. This aspect of patient care is meant to promote closeness and communication between the patient and nurse. The cure is the pathological, medical aspect of care. The interdisciplinary team also shares this aspect of care, and is largely controlled by the physicians, with the nurse taking on the role of patient advocate at this time.

This particular theory focuses on the demarcation of nursing care versus interdisciplinary care. NPs come from a background of nursing care and have extended training in pathophysiology and pharmacology, essentially being able to meld the domains of care and cure. This theory fails to identify the needs of patients who may not be acutely ill, and instead are seeking primary care. NPs, with their knowledge of both nursing care as well as medical care, have the potential to address the holistic care needs of their patients outside of acute facilities, such as primary care.
**Sociology Theory: Professional Socialization**

Professional socialization is a theory with its foundation in role theory, which states that people’s everyday actions and interactions are based upon socially defined categories, such as mother, nurse, teacher, etc. (Biddle, 1986). Professional socialization has been defined as “the learning of social roles. A process or series of processes through which knowledge, skills, values, norms, and requisite behaviors are acquired to fully participate as a professional member” (Lai & Lim, 2012, p. 32). Research has shown that professional socialization positively influences “organizational stability and commitment, satisfaction, feelings of acceptance, involvement with work and internal motivation” (Lai & Lim, 2012, p. 34). When professional socialization was not achieved in newly graduated nursing students, many of them did not find jobs or were greatly dissatisfied with the work environment (Lai & Lim, 2012, p. 34).

The theory of professional socialization as it applies to NPs is unique in that NPs straddle two different professional domains with very different sets of role expectations. NPs are educated to fulfill a role that closely resembles that of a physician, but are met with great resistance from physicians in filling this role. The educational background of NPs focuses on holistic care, something that they share with registered nurses (RNs), yet they are no longer filling the same role as an RN. There is discordance between NP role expectations and NP role acceptance by peers and colleagues, posing great potential for problems in role performance. This clash between role expectations and role acceptance is evident when one considers the current fragmented regulatory standards and the strong opposition displayed by many physician-based groups.
Healthcare Environment

The healthcare setting in which change is meant to be enacted greatly impacts the success of the intended change. A mixture of current and approaching legislation, national need, agency support, and opposition has created the present circumstances faced by NPs.

Acceptance

As was previously mentioned, the current body of research is largely in favor of NP’s ability to provide safe, high-quality and cost-effective care. To date, there has not been any evidence provided by the opposition to show that NPs are unfit to practice independently. In part due to the body of research supporting NPs, many national agencies have released statements in support of expanding NPs scope of practice.

Institute of Medicine. The Institute of Medicine (IOM), in partnership with the Robert Wood Johnson Foundation, released a report in 2010 entitled The Future of Nursing: Leading Change, Advancing Health. In this report the IOM expressed the follow four recommendations:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

Affordable Care Act. The report from the IOM was in part a reaction to the development and passing of the Affordable Care Act (ACA) of 2010, often cited as the biggest overhaul to the healthcare system since the creation of Medicare and Medicaid in 1956 (IOM,
2010). Approximately 30 million people will now have health insurance thanks to the ACA, and that means 30 million more people now have the ability to pay for and seek primary care services (IOM, 2010). This poses a problem to our current healthcare system, which already has a shortage of primary care providers without the influx of newly covered ACA beneficiaries. Figures from the Health Resources and Services Administration (HRSA) (2013) showed a deficit of approximately 7,500 primary health care providers, with estimates of this deficit tripling by 2020.

Federal Trade Commission. In March of 2014 the Federal Trade Commission (FTC) released its own report also supporting the expansion of scope of practice for APRNs. According to the FTC, “based on our extensive knowledge of health care markets, economic principles, and competition theory, we reach the same conclusion [as the IOM report]: expanded APRN scope of practice is good for competition and American consumers” (2014, p. 38). Furthermore, the FTC raised concern over physicians having an active role in regulating the scope of practice of APRNs. APRNs, in their expanded role, have the potential to compete with physicians for patients and their ability to restrict practice of their competitors is a conflict of interest (FTC, 2014, p. 20).

Barriers

While the barriers to APRN, specifically NP, expanded scope of practice seem few, they are complex and involve the collaboration and cooperation from many to overcome.

State Legislation. As previously discussed, the current state of NP regulation is highly fragmented. To fully expand the practice of all NPs nationally, that would require either a federal change to the law, or many changes in the states that do not currently allow for independent NP practice. Although the Consensus Model for APRN Regulation has been
developed and even accepted by the IOM as an adequate model for national APRN regulation, few states have adopted the model in its entirety (NCSBN, 2008, IOM, 2010). Change, especially when legislature, lobbying and politics are involved, is often slow moving and requires advocate involvement.

**American Medical Association.** Physician advocacy groups, such as the AMA and the American Academy of Family Physicians, have come out against the IOM report and against the expansion of scope of practice for NPs, citing concerns of patient safety (AMA, 2010, AAFP, 2012). Concerns for patient safety have not been identified in the body of research comparing NP care to physician care. The AMA lobbying group wields a great deal of financial power, spending well over $18 million in 2013 alone, compared to $300,000 spent by the AANP (Open Secrets, 2014). Regardless of patient safety concerns being unsubstantiated, physician associations continue to oppose APRNs, particularly NPs, possibly over concerns for competition as cited by the FTC (2014, p. 20).

**Inferences, Implications & Consequences**

**Supply & Demand**

In the fall of 2013 HRSA published projections for the supply and demand of primary care physicians (PCPs) through 2020. As identified previously, as of 2010 the country saw a national deficit of approximately 7,500 PCPs (HRSA, 2013). Projections for 2020 estimate a projected increase in demand due to the passing of the ACA, as well as the aging of the “baby boomers” and population growth. The supply of PCPs will only increase by half of the projected demand, resulting in a shortage of approximately 20,400 PCPs by 2020 (HRSA, 2013). If NPs and physician assistants (PAs) are utilized as primary care providers, the projected deficit will decrease to approximately 6,000, less than the deficit experienced in 2010 (HRSA, 2013).
Medically Underserved Areas

The HRSA projections look at national numbers and assume the nation, on average, will require the projected number of PCPs (HRSA, 2013). What HRSA fails to address is the existence of medically underserved areas (MUAs). HRSA defines MUA designation by considering four variables: “ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 and over” (HRSA, 1995). A score from 1 - 100 is generated based upon these variables and scores under 62.0 qualify as an MUA (HRSA, 1995). A study by Odell, Kippenbrock, Buron & Narcisse (2013) found that APRNs, particularly NPs, are more likely to practice in rural and health professional shortage areas (HPSAs), yet only 24% of the surveyed APRNs worked in HPSAs (p. 662). The states involved in this study are identified as states with a reduced scope of practice, which hinders the independent practice of NPs. If NPs cannot practice independently then the ability to practice in areas of medical need may be hindered.

Practitioner Migration

With regulation in its current state, it is in the best interest of practicing and newly graduating NPs to practice in states with the least amount of regulations. An NP who graduates from Georgia, a state with a high distribution of MUAs and with a restricted scope of practice for NPs, may be drawn away from this area in need of primary care due to restrictive regulations (HRSA, 1995). MUAs, places that are already lacking medical personnel, are at increased risk of developing an even larger deficit due to the potential for practitioner migration. The IOM has identified practitioner migration from areas of restrictive practice to independent practice as a concern for adequate distribution of services (IOM, 2010).
Recommendations

Ultimately, the focus of healthcare is the patient. This issue of expanding NP autonomy is much larger than any individual or group, and as such, requires action from many different participants. The American Nurses Association (ANA) and Quality and Safety Education for Nurses (QSEN) have developed standards and competencies to be used as benchmarks for safe and proficient care (ANA, 2010, QSEN, 2012). Actions that are built atop a foundation of the ANA standards and QSEN competencies have the potential to cause the greatest positive impact. The ANA standards of Quality of Practice, Resource Utilization and Leadership, and the QSEN competencies of Collaboration, Patient-Centered Care and Evidence Based Practice will be honored should the following recommendations be put into action.

Collaboration & Resource Utilization

RNs, APRNs and physicians should work to collaborate in patient care with each other. RNs should support their nursing colleagues and also work to elevate the image of nurses of all educational levels in the eyes of non-nursing colleagues and patients. APRNs should also strive to elevate the image of nursing by retaining pride in their achievements as a nurse and always striving to learn and achieve more. APRNs possess a unique perspective in providing patient care, and should collaborate with the interdisciplinary team to showcase that perspective. Research conducted by Street & Cossman (2010) found that physicians who work in practice with NPs have “more positive generalized attitudes towards NPs (p. 434). Collaboration is a method to enhance teamwork and improve quality of care for patients by utilizing each member of the healthcare team. Although resources are typically thought of as tangible objects or financial wealth, healthcare providers are resources that may be misused or mismanaged.
Collaboration allows for the strengths of each “resource” to be identified and utilized to his or her fullest abilities.

**Quality of Practice & Leadership**

Nurses are very familiar with the role of patient advocate, but there is now a need to actively advocate for self and colleagues to enact change. Nurses of all educational levels should strive to engage in life long learning opportunities in an effort to foster professional development. The IOM (2010) recommends that nurses seek out opportunities for new responsibilities to develop and exercise leadership skills. Encouraging larger numbers of nurses to take on leadership roles enables the profession as a whole to act as a leader in changing healthcare (p. 5).

Nurses who are interested in pursuing an advanced practice degree should be encouraged and enabled to attend accredited and reputable schools of nursing. Receiving a degree from a reputable school of nursing ensures that educational standards and clinical competencies have been met and students are adequately prepared for independent practice (IOM, 2010).

**Patient-Centered Care & Evidence Based Practice**

Medicine, like all sciences, is fact and research based. Innovative treatments are rigorously tested and proven to be effective in patient care prior to implementation. Nursing must also prove itself to be a research based, scientific endeavor. As has been discussed throughout this paper, there is an extensive body of research in favor of the independent practice of NPs. If nurses continue to be involved in producing scientifically rigorous research, the ability of opponents to use arguments supported by evidence will disappear. Furthermore, nurses can target the specific arguments against independent NP practice and develop research that directly disproves these unsubstantiated opinions.
Conclusion

Despite the substantial body of evidence, NPs still face restrictive regulations in over half of the fifty states. These practices keep NPs from practicing independently and to the full scope of their educational preparations. The history of NPs has been to answer the call of a nation in need of primary care services. We see history repeating itself with the passing of the ACA, expanding coverage to millions but without a primary care workforce to welcome new patients. Research has shown that NPs are uniquely equipped to provide holistic care that has been proven to be safe, effective, and positively received by patients (IOM, 2010). The current state of healthcare legislation should be a call to arms for nurses of all levels of licensure to act. Nurses of all licensure levels represent the profession as a whole, and should therefore actively support all members of the profession.
References


Mundinger, M., Kane, R., Lenz, E., Totten, A., Tsai, W., Cleary, P., Friedewald, W., Siu, A. & Shelanski, M. (2000). Primary care outcomes in patients treated by nurse practitioners or


