Nurse Practitioners: Here Today . . . Gone Tomorrow?

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Abstract

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Today's nurse practitioners are fair game for malpractice lawsuits. These specialized nurses provide primary care services such as diagnosis, prescription and treatment for lower fees than physicians.¹ During the past decade, the dramatic increase in the number of nurse practitioners has been accompanied by a growing recognition of the legal ramifications of their practice. The number of nurse practitioners is certain to increase dramatically in the next few years.²

In 1965, training programs were initiated for nurse practitioners.³ Later, governmental interest focused on this new health care provider as a promising answer to the shortage of physicians providing primary care to rural or poor urban areas. Federal action included the Nurse Training Act of 1971⁴ and the Comprehensive Health Manpower Act of 1971,⁵ which directed funds toward training nurse practitioners.⁶ The Nurse Training Act of 1975⁷ continued federal support for training. In 1978, although the nurse training amendments failed, funding for nurse practitioner training programs was extended another year


3. The first educational program for nurse practitioners was started in 1965 at the University of Colorado Medical Center by Loretta Ford and Dr. Henry Silver to train pediatric nurse practitioners. Feinstein, Physician Extenders in Florida, 68 J. FLA. MED. A. 371 (May 1981).


under a continuing appropriations resolution. Even after the Nurse Training Amendments of 1979 also met with failure, the nurse practitioner movement continued to gain strength.

State legislatures responded by enacting laws that recognized nurse practitioners and permitted their practice. At present nurse practitioners are practicing in roughly 35 states.

A flurry of legislative activity has evolved over the last few years as state legislatures, aware of the exigency for clarification of the role of nurse practitioners, have revised or developed their nurse practice acts to provide both a legal basis for the nurse practitioners' functions and a definitive framework for regulating the scope of their practice. Although the ostensible and intended purpose of these statutes is to promote expanded delegation of powers to nurse practitioners, as applied most statutes tend to unduly restrict, or to leave unresolved, the scope of authorized delegations.

In 1979 Florida's Legislature added a new section to the Nurse Practice Act. This statute recognized such categories of advanced

    (1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he holds a current license to practice professional nursing and that he meets one or more of the following requirements as determined by the board:
      (a) Satisfactory completion of a formal postbasic educational program of at least 1 academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.
      (b) Certification by an appropriate specialty board.
      (c) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.
    (2) The board shall provide by rule the appropriate requirements for the following categories:
      (a) Nurse anesthetist.
      (b) Nurse midwife.
      (c) Family nurse practitioner.
registered nurse practitioners as anesthetist, midwife, family, family

(d) Family planning nurse practitioner.
(e) Geriatric nurse practitioner.
(f) Pediatric nurse practitioner.
(g) Adult primary care nurse practitioner.
(h) Clinical specialist in psychiatric mental health nursing.
(i) Other categories as may be determined by rule of the board.

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Monitor and alter drug therapies.
(b) Initiate appropriate therapies for certain conditions.
(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(3)(c).

(4) In addition to the general functions specified in subsection (3), an advanced registered nurse practitioner may perform the following acts within his specialty:

(a) The nurse anesthetist may, to the extent authorized by established protocol approved by the medical staff of the facility in which the anesthetic service is performed, perform any or all of the following:

1. Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the patient through the performance of the general functions.
2. Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.
3. Order under the protocol preanesthetic medication.
4. Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. This shall include ordering and administering regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.
5. Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.
6. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.
7. Recognize and take appropriate corrective action for abnormal pa-
planning, geriatric, pediatric, adult primary care, clinical specialist in

patient responses to anesthesia, adjunctive medication, or other forms of therapy.

8. Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.

9. Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs.

10. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(b) The nurse midwife may, to the extent authorized by established protocol approved by the medical staff of the health care facility in which midwifery services are performed, perform any or all of the following:

1. Perform superficial minor surgical procedures.

2. Manage patient during labor and delivery to include amniotomy, episiotomy, and repair.

3. Order, initiate, and perform appropriate anesthetic procedures.

4. Perform postpartum examination.

5. Order appropriate medications.

6. Provide family-planning services.

7. Manage the medical care of the normal obstetrical patient.

(c) The family nurse practitioner may perform any or all of the following acts:

1. Manage selected medical problems.

2. Order physical therapy.

(d) The family-planning nurse practitioner may provide family-planning services.

(e) The geriatric nurse practitioner may perform any or all of the following:

1. Manage selected medical problems.

2. Order physical therapy.

(f) The pediatric nurse practitioner may perform any or all of the following:

1. Initiate, monitor, or alter therapies for certain uncomplicated, acute illnesses within the framework of the standing protocol.

2. Initiate childhood immunizations.

(g) The adult primary care nurse practitioner may perform any or all of the following:

1. Initiate appropriate medications by defined protocol.

2. Initiate immunizations.

3. Monitor and manage patients with stable chronic diseases.

4. Initiate treatments and medications and alter dosage within the established protocol.
psychiatric mental health and others. The statute allows registered nurses with additional education, training and special licenses to perform expanded duties as authorized by professional licensing boards.

These so-called "physician extenders" or "representatives of expanded nursing" have consistently sought more independence in function and decision-making. Although Florida Statute Section 464.012 opened the way for expanded delegation of medical functions, it leaves uncertainty as to the permissible limits of delegation. There has been

(h) The clinical nurse specialist in psychiatric mental health nursing may perform the following:

1. Establish behavioral problems diagnosis and make treatment recommendations.

2. Monitor and adjust dosages of prescribed psychotropic medications as indicated within the framework of the established protocol.

5. The board shall certify, and the department shall issue a certificate to any nurse meeting the qualifications in this section. The board shall establish an application fee not to exceed $100 and a biennial renewal fee not to exceed $50. The board is authorized to adopt such other rules as may be necessary to implement the provisions of this section.

12. See also, State of Fla. Dep't of Prof. Reg., Bd. of Nursing, ch. 210-11, Administrative Policies Pertaining to Certification of Advanced Registered Nurse Practitioners.

210-11.21 (1) In addition to these categories of Advanced Registered Nurse Practitioners specified in Sec. 464.012 (2), F.S., the following categories are created by the Board: Emergency Nurse Practitioner, OB/GYN Nurse Practitioner, Maternal Child Health/FP Nurse Practitioner, College Health Nurse Practitioner, and Diabetic Nurse Practitioner.

210-11.20 (9) Established Protocol: Written guidelines or documentation outlining the therapeutic approach which should be considered. Such protocol shall be mutually agreed upon by the ARNP and the practitioner.

210-11.20 (16) Supervision: General supervision whereby a practitioner authorizes procedures being carried out but need not be present when such procedures are performed. The ARNP must be able to contact the practitioner when needed for consultation and advice either in person or by communication devices.

13. Nurse practitioner education programs in Florida are approximately one academic year in length and include:

a) University of Miami: midwifery, adult primary care, geriatrics and family practice;
b) University of South Florida: adult primary care;
c) University of Florida: adult health, child health, family health, pediatrics, and obstetrics-gynecology;
d) Shands Hospital (Gainesville): nurse anesthetist; and
e) Bay Memorial Medical Center (Panama City): nurse anesthetist.
no case construing this statute, indeed, no case in any state in which a nurse practitioner has been independently sued for malpractice. In light of the fierce legislative activity in the states during the past few months, this article evaluates the statutory controls over this emerging practice and suggests methods to impede a nurse practitioner malpractice suit. The Florida statute will be the focus of the discussion.

Nurse Practitioners In Florida

The role of the nurse practitioner embraces many functions not within the traditional scope of nursing practice such as testing, diagnosis, prescription and treatment. The last three are traditionally medical functions, and are the center of the controversy. These functions were the exclusive domain of the physician and, therefore, beyond the periphery of lawful practice for a nurse. Now a nationwide movement has emerged to establish legal authority for nurse practitioners to perform such "medical" functions free from repercussion.

Florida statutes allow registered nurses who meet the requirements for a nurse practitioner category to perform expanded duties as authorized by professional licensing boards; i.e., in accordance with rules and regulations issued by an administrative agency such as the board of nursing and/or medicine. The statute is, therefore, an administrative-type statute, as compared to other regulatory and traditional stat-

utes. Florida's statute, compared to other nurse practitioner statutes, appears to be one of the most comprehensive and detailed, enumerating the permissible duties for each of the eight types of nurse practitioners. However, the statute employs vague terminology which has the ultimate effect of restricting rather than expanding nurse duties.

Florida Statute Section 464.003(3)(c) defines "advanced or specialized nursing practice." The advanced registered nurse practitioner may perform:

... acts of medical diagnosis and treatment, prescription, and operation which are identified and approved by a joint committee ... such acts shall be performed under the general supervision of a practitioner ... within the framework of standing protocols which identify the medical acts to be performed and the conditions for their performance.

This restrictive phraseology inhibits and even prohibits independent


17. See note 11 supra.
judgment and decision-making by nurse practitioners. Florida thus ensures the dependency of nurse practitioners upon physicians.

This same statute, incorporating “nursing diagnosis and nursing treatment” within the scope of advanced or specialized nursing practice, defines the terms:

d) “Nursing diagnosis” means the observation and evaluation of physical or mental conditions, behaviors, signs, and symptoms of illness, and reactions to treatment and the determination as to whether such conditions, signs, symptoms, and reactions represent a deviation from normal.

e) “Nursing treatment” means the establishment and implementation of a nursing regimen for the care and comfort of individuals, the prevention of illness, and the education, restoration, and maintenance of health.18

The obvious purpose of the statute is to distinguish “nursing” diagnosis and treatment from “medical” diagnosis and treatment. Articulating satisfactory criteria to accommodate the conflicting factions is a recurrent challenge.19

Legislation and regulations vary among the states, but almost all states require physicians to supervise, become involved with and be legally responsible for the activities of nurse practitioners. Only two states20 provide independent prescriptive authority for nurse practitioners. It appears that the majority of nurse practitioner statutes intend to permit prescription or treatment only in a subordinate capacity. The physician’s control is manifested in: (1) the determination and promulgation of rules and regulations by joint boards of medicine and nursing; (2) the requirement that certain practices be performed within the scope of protocols, policies and procedures, standing orders and standardized procedures written in accord with the supervisory physician,

18. FLA. STAT. §§ 464.003(3)d and e (1979).
and (3) the necessity of a written agreement between the physician(s) and the nurse, submitted to the Board of Nursing, regarding the details of the supervision of the nurse.\textsuperscript{21} Whereas Florida requires that the acts be performed “under the general supervision” of a physician and “within the framework of standing protocols,” several states\textsuperscript{22} permit nurse practitioners to work “in collaboration” with physicians. These states have effected a valiant attempt to situate nurse practitioners in parity with physicians.\textsuperscript{23}

**Legislative Unrest: New Controls Proposed**

Presently, individual physicians establish standing orders or protocols with their respective nurse practitioners. This is a joint effort by two professionals, allowing each to contribute accordingly. Nurse practitioners perform the initial assessment, diagnosis and treatment of patients with uncomplicated illnesses; i.e., those necessary techniques with the least risk of malpractice.\textsuperscript{24} Physicians perform the diagnosis and treatment of complicated illnesses or give further treatments to patients initially examined and treated by the nurse practitioner who have not responded to treatment or who have developed complications beyond the area of nurse practitioner expertise. This sequence frees the overworked physician from routine procedures, permitting him to concentrate on more complicated cases and to attend to a greater number of patients.\textsuperscript{25}

In Florida, this cooperative ideal is colored by the physicians’ and nurse practitioners’ battle for economic supremacy. This legislative battle bears the semblance of protecting the public from nurses who would practice medicine without a physician’s supervision and assistance; but it is also an economic war as to who will reap the rewards of patient


\textsuperscript{23} See 81 Am. J. of Nursing 910 (May 1981).

\textsuperscript{24} Miami Herald, May 20, 1981, § E at 1, col. 1; Kissam, *supra* note 2, at 198.

\textsuperscript{25} See Kissam, *supra* note 1, at 7-9; Scheffler et al., *supra* note 2, at 198.
health care. Senate Bill 889 and House Bill 903 were drafted and introduced by the Florida Medical Association at the 1981 Florida Legislative Session. Although debated, both bills were defeated in committee hearings in late May of 1981. These bills would have instituted the following control measures for physicians working with nurse practitioners:

1) A physician could not enter into a supervisory agreement with a nurse practitioner until the Board of Medical Examiners approved each of the medical acts the nurse would perform and how closely each would be monitored.

2) A nurse practitioner would have to practice in the same community as the supervisory doctor.

3) A doctor could supervise no more than two nurse practitioners.

These bills were reintroduced at the 1982 legislative session as House Bill 239 and Senate Bill 500. The 1982 proposals would not apply to nurse midwives or nurse anesthetists. If passed, the first requirement may result in delay, chaos and possible abuse of discretion. Since there has been no documentation to date of any major problems with the protocol system as it presently exists, such a provision cannot be justified.

The second requirement, that nurse practitioners practice in the same community as the physicians with whom they work, may also reduce the level of service. Presently, the majority of nurse practitioners

26. See note 25 supra; Kissam, supra note 1, at 17, 51.
27. Fla. S.B. 889 (1981) and its companion, Fla. H.B. 903 (1981), died in committee without being heard. The bills were drafted by the medical association and proposed in the Senate by Senator Mattox Hair and in the House by Representatives Thomas Danson and James Ward.
28. See note 24 supra.
practice in physical proximity or in the same community as their respective participating physicians. Those nurse practitioners serving the health needs of patients in rural or poor urban areas have established telephone communications with their physicians; the absence of physicians in these areas leaves no other alternative. Florida's physicians could justify this new proposal since it would prevent nurse practitioners from capitalizing on the physician's absence by performing medical acts outside their permissible scope of practice. However, such abuse is rare, and has been successfully dealt with under existing statutes. In *Hernicz v. State of Florida, Department of Professional Regulation*, an appellate court affirmed the nursing board's decision to suspend a nurse practitioner's license for treatment of two patients without specific authorization for the treatment from a licensed physician.

A third requirement of these bills limits a physician to supervising a maximum of two nurse practitioners. This provision would appear to enable physicians to more closely supervise the acts of nurse practitioners, thus protecting the patient from any abuse of practice. Three factors dispel the need for this legislation. First, other controls have proved successful, as noted above. Second, there are approximately 1,437 nurse practitioners in Florida and approximately 18,500 physicians; overstaffing is unlikely to be a real threat. Third, no literature exists which describes this problem, even though these programs have existed for several years.

Other states in which physicians have launched legislative attacks against nurse practitioners include Oregon and Arkansas. Oregon, one of the forerunners of the nurse practitioner movement, gives nurse practitioners the most independence, permitting them to practice in "collaboration with" rather than "under the direct supervision of" physi-

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**Huard**, *The Nurse Practitioner as a Physician Substitute in a Remote Rural Community-A Case Study*, 94 PUB. HEALTH REP. 571 (Nov./Dec. 1979); Kissam, *supra* note 1, at 64.


32. See note 24 *supra*. See also Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476 (Tenn. 1981).

33. 390 So. 2d 194 (Fla. 1st Dist. Ct. App. 1980).
In addition, Oregon allows nurse practitioners to individually prescribe many medications without any specific protocols with physicians. However, the Oregon Medical Association is presently sponsoring a bill that would limit these privileges, narrowing the scope of practice for nurse practitioners on the ground that “it is not in the public interest for nurse practitioners to work independently of a physician.” The Oregon bill is analogous to the Florida bill in that the state medical board would have the ultimate authority to define the nurse practitioners’ relationship with physicians and to determine the protocol for practice. The Oregon bill, however, is even more restrictive, giving the state medical board the ultimate authority to establish the formulary from which practitioners prescribe, to set all the educational requirements for prescription-writing privileges and to control directly the screening and approval of applicants.

In Arkansas, the State Nurses Association recently instituted suit against the State Medical Board and the Arkansas Medical Society alleging that both boards had violated antitrust laws and pursued a conspiracy to restrain trade in the provision of health care services and to fix, control and raise the price of such services. This litigation resulted from the passage of regulations limiting a physician to supervising or employing no more than two nurse practitioners at any one time. This provision is analogous to the proposed Florida bills. Like the Florida bills, the Arkansas regulations require the physician to explain to the medical board how the nurse practitioner will be utilized and to describe her credentials.

35. Id. §§ 678.375, -385, -390.
37. Id.
38. Id.
39. 81 Am. J. of Nursing 934 (May 1981). In addition to the above allegations, the Arkansas State Nurses Association alleged that the actions of the medical boards violate constitutional and contractual rights “by restricting the nurse practitioners’ liberty and property rights, their right to practice their chosen profession [and their] right to be free from interference with their contractual relationships.” Id.
40. See text accompanying note 29 supra.
Obstacles to Independence

Although their training, experience and licensure prepares them for primary care techniques, nurse practitioners are confronted with several major obstacles: physician reluctance, inadequate malpractice insurance coverage, physician’s assistant competition, and potential malpractice litigation. These obstacles must be overcome or nurse practitioners, recently considered “here today,” will be “gone tomorrow.” Therefore, an analysis of each of these obstacles is requisite.

Physicians fear that in employing and supervising nurse practitioners, they risk increased exposure to lawsuits. Their fear may be well-founded. The physician’s liability increases with his level of control over the nurse or nurse practitioner. If “a nurse’s services are simply ministerial in character, she is not regarded as the doctor’s borrowed servant, but rather as the servant of the hospital, so that the latter may be vicariously liable.” With the appearance of nurse anesthetists, who had special training and greater responsibility, the issue of control in the hospital setting became less clear. One view is that a nurse anesthetist who obeyed a doctor’s order by following a standard hospital procedure was still not a borrowed servant. Since the doctor “did not actually supervise or control the acts of” the nurse anesthetist, he was not responsible for the outcome. Another approach is the “right of control” theory, illustrated in a case where the doctor was held responsible for the act of an anesthetist over whom “he had the authority to cancel

43. See Kissam, supra note 1 at 57.
44. See id. at 45.
47. Id. at 450.
and thereby control procedures at any time." Several states require nurse anesthetists to work only in the physical presence of their supervising physician. Florida restricts the nurse anesthetist to performing only "to the extent authorized by established protocol." Control is important in the hospital setting where the doctor may have relatively close actual control and yet may escape liability because the nurse anesthetist is the servant of the hospital. The work of the nurse practitioner in the community or office removes this safety net of hospital responsibility. This creates a dilemma for the physician. If he exerts more control over the nurse practitioner, his liability is more firmly fixed. If he promotes independent action for the nurse practitioner, his state-imposed responsibility may still make him liable for acts he does not actually control. The problem requires an analysis of the true increase in risk to the physician and the alternate methods of compensation.

The "nurse practitioner as a malpractice-aggravator" concept may be outweighed by a "nurse practitioner as a malpractice-alleviator" concept. Medical studies show that nurse practitioners tend to provide more personal attention to patients than do physicians in comparable situations, fostering improved patient/primary care provider relationships and fewer malpractice suits. One leading reason for the malpractice crisis is the short time physicians spend with patients, which promotes strained feelings in the patients and results in their increased propensity to consider litigation. The nurse practitioner as a malpractice alleviator would probably be a welcome relief to the burdensome workload of the physicians, and improve the level of patient care.

Another obstacle to the nurse practitioner movement for indepen-

51. Robyn & Hadley, supra note 41, at 447; Kissam, supra note 1, at 18. The high cost of physician's services relative to the cost of nonphysician's services suggests that much-expanded delegation may be economically feasible. Recent economic evaluations of nurse practitioners indicate that gains in physician productivity from effective use of full-time nurse practitioners are likely to be far in excess of thirty-three percent. Id. at 7. See also A. Holder, Medical Malpractice Law 401 (2d ed. 1978).
52. See Scheffler, supra note 2, at 219. See also A. Holder, supra note 51.
dence from physician supervision revolves around the inadequacy of malpractice insurance coverage. We enter this line of analysis with the assumption that there will be patients injured by nurse practitioners just as by any health care providers, and that these negligently injured patients deserve compensation. Physicians usually have professional liability insurance and nurses are generally insured through the hospital's malpractice insurance policy as long as they are acting within the scope of their employment. However, nurse practitioners, whose independent medical judgment and functions may result in legal claims similar to those against physicians, may not have adequate means of compensating an injured patient. Currently, there are only a limited number of policies made available to nurse practitioners.\textsuperscript{5} Even these policies are ambiguous regarding the extent of coverage and tend to leave nurse practitioners in a legal limbo. One inherent weakness of these policies is that they are traditional nursing policies that only cover the nurse practitioner for "nursing" acts of negligence, not for "medical" acts.\textsuperscript{6} But, as nurse practitioners are, in essence, performing "medical" acts of primary care, their policies ought to explicitly cover "medical" acts of negligence as well.\textsuperscript{5\textsuperscript{5}}

Only recently has there been a breakthrough in third party reimbursement to nurse practitioners by insurers.\textsuperscript{6\textsuperscript{6}} Florida has joined this movement by establishing some reimbursement under the Medicaid program.\textsuperscript{6\textsuperscript{7}} Previously, physicians reimbursed nurse practitioners for their services from the fees and insurance reimbursements they personally received. Independent payment may be regarded as a step to independent practice.

Physicians have been reluctant to relinquish their traditional diagnostic, treatment and prescriptive authority.\textsuperscript{6\textsuperscript{8}} This reluctance is manifested by the restrictive regulations established by medical boards. In Florida, the Department of Health was given the power to "make such rules and regulations as it may deem necessary for regulating the prac-
It drafted an application for licensure form which required more detailed information about past nursing practice than was required by the statute. The court found that if the information did not bear a direct relationship to the "skill, competence and fitness of an applicant" the specific requirements of the statute limited the inquiry. Interprofessional role conflicts, as between medical boards and practitioners, appear to be increasing. Professional opposition may be the inevitable reaction to the fear of competition from the nurse practitioner movement.

Gender discrimination is another obstacle which nurse practitioners will have to surmount. Some physicians may view the present women's liberation movement as a threat to their status quo. The past, however, does evince a gradual adaptation to the changing role of women. Therefore, time may conquer this handicap.

Withstanding competition from physicians' assistants is another obstacle. Physicians' assistants are another type of physician extender, analogous to nurse practitioners in development and responsibilities. Their function is to assist physicians. The first program for physicians' assistants began in 1965. However, this category of health care worker was and is predominantly male, made up primarily of medical corpsmen returned to civilian life. In Florida, only one educational training program exists. Physicians are required to supervise physicians' assistants and are generally held legally responsible for physicians' assistants' acts pursuant to the Medical Practice Act. Physicians' assistants may neither sign prescriptions nor utilize prescriptions presigned by a physician. Yet no restrictive measures similar to the

61. See Johnson, I Don't Want to Be a Test Case, 5 NURSE PRACTITIONER 7 (May/June 1980).
62. See Edmunds, Gender and the Nurse Practitioner Role, 5 NURSE PRACTITIONER 42 (Nov./Dec. 1980).
63. Nurse practitioners question why recent proposed restrictions have not been aimed at physicians' assistants. See also Feinstein, supra note 3.
64. See id.; Scheffler, supra note 2, at 216.
65. Scheffler, supra note 2, at 216.
66. Id.
68. Id. See also Kissam, supra note 1, at 18, 21, 50; Scheffler, supra note 2, at...
proposed regulations for nurse practitioners have been proposed for physicians’ assistants. As the two physician extenders are similar in many ways, it appears that Florida physicians seek to eliminate nurse practitioners, while retaining physicians’ assistants.

One final obstacle to nurse practitioners’ independence is medical malpractice litigation. Case law concerning nurse practitioners other than nurse anesthetists is scant. The problem in suits against nurse practitioners is determining the standard of care for a newly created profession. While the general standard of care for professionals in Florida is “that level of care, skill and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances;” the actual standard for nurse practitioners is difficult to define given the diversity of practice and the small number of practitioners. In the case of nurse anesthetists it has been defined in terms of their greater training and responsibility. “They have expertise in an area which is akin to the practice of medicine.” But comparison with the practice of medicine is also incorrect. Speaking of the California nurse practitioner statute and its consequences in tort suits against these professionals, the court said “In amending this section . . . the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. . . . It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses. . . .” The Legislature, however, did not expand the role to include the practice of medicine or surgery. Thus the jury instruction that the standard of care for a nurse practitioner is that of a physician was improper.

216.


70. See Scheffler, supra note 2, at 218.


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Solution: Minimize the Risks

Nurse practitioners have so far successfully eluded the malpractice specter. The present legal climate is favorable, but certainly subject to change.

One method to minimize the dangers of malpractice claims is to promote an increase in the number of nurse practitioners in order to provide proper insurance coverage for "nursing" and "medical" acts at reasonable rates.75

Another means of minimizing the risks is to provide for well-established and documented protocols outlining the therapeutic approach to be considered. These should be clearly written and mutually agreed upon by the nurse practitioner and the physician. A parallel approach would include instituting well-defined and documented job descriptions for all nurse practitioners at the inception of each particular position.76 These protocols and job descriptions would attempt to eliminate any subsequent questions about the scope of practice of nurse practitioners and would promote the proper degree of independent practice. But since the physician would have to authorize the established protocols and job descriptions, he may expose himself to potential liability. This would tend to make his protocols conservative, which would protect the nurse practitioner, but would be self-defeating of the long range goal. A balance must be worked out.

Conclusion

The concept of nurse practitioners is relatively new, and has been recognized only recently in statutes. The medical-legal community and state legislatures are faced with an enormous task, one that involves the hurdling of traditional concepts and views of nursing which have weathered decades of litigation. All states will soon be charged with a duty to appraise or reappraise their nurse practitioner acts, since the

75. F. Keeton, Insurance Law § 2.8(a) (1971). "In the marketing of any product or service, economy can be achieved through high-volume dealings. . . . By adjusting premiums to the average level of risk among the large number of participants, the insurer can maintain a financially sound plan." Id.
76. See also M. Edmunds, The Position Description, 4 Nurse Practitioner 45 (July/Aug. 1979).
general welfare is not served by relegating these health care providers to an inferior status. Legislators should look behind the proffered rationales for proposed amendments and examine the underlying motivations. Broad restrictions should not be enacted where unnecessary.

Indeed, expansion of the powers of nurse practitioners may be the better course of action. Under a cooperative effort between doctors and nurse practitioners, the field could flourish. With increased numbers the nurse practitioners could provide needed services protected by reasonably priced insurance geared to the scope of the practice. This would benefit the patients, the practitioners and the physicians. 77

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77. During publication of this note, House Bill 239 was passed, approved by the Senate, and signed by the governor. The bill becomes effective July 1, 1982.