

CHAPTER 3

Advanced Practice and Prescriptive Authority

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Learning Objectives

At the completion of this chapter, you will be able to:

1. Identify formal and informal barriers that restrict scope of APN practice.
2. Outline the steps from bill to law.
3. Differentiate between statutes and regulations.
4. Strategize to identify allies and partners for nursing.
5. Examine the source and rationale for barriers to advanced practice.
6. Propose action plans to remove barriers to advanced practice nursing.

Background

Under the U.S. Constitution, the responsibility to safeguard public health is left to each state to regulate. And states, of course, differ in how they approach public safety. For instance, some states

require motorcyclists to wear helmets; others do not. State laws regarding prescriptive authority for advanced practice nurses (APNs) vary widely, as does the structure under which APNs may prescribe. In fact, there are tremendous differences among the states in how and what APNs may prescribe.

Whereas the education, certification, and skills required to practice as an APN do not differ markedly from state to state, the ability to practice fully depends absolutely on where an APN decides to practice. As you read this case, note the formal and informal barriers that prohibit full APN prescriptive authority and other practice.

The beginnings of advanced practice nursing can best be traced to the introduction of nurse midwifery in the United States in 1925, when Mary Breckinridge founded the Frontier Nursing Service in Kentucky (Frontier Nursing Service, n.d.). Over the ensuing decades, clinical nurse specialist and nurse practitioner roles developed. Today the concept of advanced practice nursing continues to evolve. As is true in other healthcare professions, prescribing is an important component of advanced nursing practice. However, achieving the right to prescribe has been challenging and is itself still in evolution.

Several factors underlie the uphill road to prescriptive authority for nursing: the primacy of physician practice, the public safety role of the states, policymakers' knowledge about advanced practice nursing, and nursing's ability to navigate political and legislative arenas. Each of these aspects, and their interplay, is key to understanding the current patchwork of prescriptive authority in the United States.

Prescription practice is relatively new. Prior to the twentieth century, pharmacists could dispense medications on consumer demand without consulting a physician. Over time, physicians gained dominance over prescriptive authority based on three factors: public safety regarding patent medicines, American Medical Association (AMA) ownership of "Ingredient Disclosure" and "Seal of Approval" designations, and pharmaceutical companies' realization that physicians could be used to market products (Harkless, 1989; Starr, 1982).

Physicians have had automatic prescriptive authority by virtue of their title and have not had to justify or prove competency to prescribe. Organized medicine via the AMA and state medical

societies, however, persistently insists that other provider groups demonstrate their qualification (Sutliff, 1996). A variety of rules and limitations has been enacted in different states to regulate nurse prescription. Some states allow truly independent prescribing by the APN. Most require some sort of oversight, either through supervision or collaborative agreement. The AMA continues to insist that physicians retain responsibility for all patient care regardless of the setting, although evidence is lacking to justify this ultimate supervisory role for physicians (American Medical Association, n.d.).

Physicians have traditionally dominated public policymaking in health care, largely because theirs was the first recognized health profession and thus they were able to define healthcare practice. Beginning in 1721, physicians first sought licensure in the United States as a method of excluding competition from so-called empiricks and quacks. Formal licensure, undertaken by the medical society, was granted by Massachusetts in 1781, and by other states soon thereafter (Rothstein, 1985). However, it was not until the mid-1800s that a statutory definition of healing came into play, which placed diagnosis, treatment, surgery, and prescribing firmly in medicine's arena; by 1901, every state had adopted this approach (Starr, 1982). Thus, other healthcare professions were required to justify their inclusion in the "healing arts" or like statute to avoid violating prohibitions against the practice of medicine by nonphysicians (Safriet, 1992). Physician predominance spills over even now to popular culture, which often depicts physicians as the only available prescribers: "Ask your doctor about our new drug."

The perceived need to protect the public has likewise played an important role in whether prescriptive authority was granted to nurses. State legislators and other policymakers often raise the safety issue when debating prescriptive authority and other scope-of-practice concerns, largely because they lack knowledge about advanced nursing practice and education. Nurse practitioners have been studied virtually from the inception of their profession to ensure that patients would not be harmed under their care, and such studies continue to abound (Beck, 1995; Munding et al., 2000; Office of Technology Assessment, 1986). Every such study confirms that advanced practice nurses are safe, effective, and well-liked providers.

A third component contributing to the state of prescriptive authority for advanced practice is nursing's increasing understanding and involvement in the political process and policymaking. Understanding the context in which laws and regulations are made is crucial to implementing change. This includes understanding of not only the formal process of rule and law making but also the impact of campaign contributions, lobbying efforts, and public opinion.

Crafting laws and regulations is at once both formal and informal. The formality resides in the technical process. A proposed bill is introduced, generally to a subcommittee of the legislature. Frequently, testimony is heard from supporters and opponents of the bill, and at the state level, such hearings are usually open to public view. Lawmakers in the subcommittee then vote on the proposed bill. If approved, the bill issues to the full legislature for a vote. If passed by whatever majority the state requires, the bill goes to the governor for signature. Once signed, it becomes law as of the effective date named in the bill. If not signed (vetoed), the legislature might revote and, with a substantial majority, override the veto, in which case the bill becomes law.

The informal part of this process involves the human element: the lobbying effort, the personal experiences of the legislators around the topic of the bill, the campaign contributions from supporters or opponents, and the public's opinion on the bill's content. Even if the bill is well reasoned and articulate, a legislator may choose to vote against it because she thinks her constituents will not be happy if she votes in favor of passage, or because her own experiences lead her to distrust the outcome if the bill passed, or because she feels she owes a "no" vote to a major campaign contributor who opposes the bill or to a fellow legislator whose support she desires for her own proposed legislation.

Rule-making is also generally open to public view, but less directly. When an agency, such as a board of nursing, proposes a rule, the proposal is published in some sort of state register and indicates a window of time for the public or interested parties to comment. Sometimes opportunity to present testimony in person is offered, but frequently comments are submitted in writing. The agency reads and weighs the comments, and then

either issues the rule or a revised rule or decides to withdraw the proposed rule.

As with legislation, rule-making also has its human element that influences the outcome. In addition, rule-making is in many ways less directly visible, and this can make it hard for nurses and other lay persons to access the rule-making process.

After nearly 4 decades of debate, prescriptive authority for advanced practice nurses exists almost universally in the United States. As of 2013, all states except Georgia recognize direct prescriptive authority for nurse practitioners (von Gizycki, 2013). In 2004, Georgia allowed APNs to phone in a prescription as a delegated medical act, but APNs are not still allowed to write prescriptions (Georgia Code Annotated, 2004). New Mexico, on the other hand, allows APNs fully independent practice, including full prescriptive rights (Nursing Practice Act, 1978). Only six states limit nurse prescription to legend (noncontrolled) drugs: Alabama, Florida, Georgia, Kentucky, Missouri, and Hawaii (Drug Enforcement Administration, 2005). All other states allow at least Schedule III–V prescribing by nurses (Towers, 2005).

DISCUSSION QUESTIONS

1. What does the restriction to Schedules III to V imply for practice? Consider that Ritalin (methylphenidate), fentanyl, and Demerol (meperidine) are categorized as Schedule II controlled substances.
2. What other concerns besides public safety might be at play in restricting nurse practitioner prescriptive authority?

Supervision, Collaboration, and Independent Practice

As mentioned earlier, many APNs practice under supervision or a collaborative agreement. How does supervision differ from collaboration? In general terms, supervision seems to indicate more direct control of the nurse's practice by a physician, whereas a collaborative arrangement indicates less oversight by the physician. Legally, however, the definitions of these terms are specific to each state, and there is no consistent usage among states.

Collaboration, especially, has many definitions and can look very similar to supervision. In Illinois, for example, APNs practice “in collaboration” with physicians under a written agreement that “shall authorize the categories of care, treatment, or procedures to be performed by the advanced practice nurse” (Nursing and Advanced Practice Act, 1999, Sec. 15-15). In Ohio, *collaboration* is defined as a “standard care arrangement” between a physician and a nurse, under which the physician is “continuously available to communicate with the nurse” (Nurse Practice Act, 2002, Sec. B). Connecticut defines *collaboration* as “a mutually agreed upon relationship” between a physician and an APN that “shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient” (Nursing, General Statutes of Connecticut, 2004, Sec. (b)). Some states, such as New York and Texas, define collaboration as practice under mandated written protocols devised by the physician (New York State Nurse Practice Act, 2005; Texas Statutes, 2005).

Another twist to nurse prescriptive authority is whether the nurse is limited to prescribing from some type of formulary. This may be in addition to the nurse’s authority to prescribe only certain schedules of drugs. The formulary may consist of a list of the drug categories (or in some cases the actual medication names) the nurse is allowed to prescribe. Or it may simply list the categories or medications that are disallowed. Either way, it adds another layer of regulation. For example, in the state of New Hampshire APNs have independent practice but may prescribe only according to an exclusionary formulary that is established and reviewed by the Joint Health Council, which consists of members of the Board of Medicine (three members), Board of Pharmacy (two members), and Board of Nursing (three members).

Other limitations on the nurse’s ability to prescribe may exist. In Texas, for instance, prescriptive authority is granted only to particular practice sites, such as community health centers, certain private physician practices, and rural practice sites (Texas Statutes, 2005). A nurse practitioner in California “does not have an additional scope of practice beyond the usual RN

scope and must rely on standardized procedures for authorization to perform overlapping medical functions” (Terry, 2002). Nurse practitioners in Illinois, like those in several other states, are granted prescriptive authority as a delegation of medical care by a physician. The Illinois statute, however, specifically notes that the physician “may, but is not required to, delegate limited prescriptive authority to an advanced practice nurse” (Nursing and Advanced Practice Act, 1999, Sec. 15-20(a)).

DISCUSSION QUESTIONS

1. Explore the difference between supervision and collaboration, including the terms’ legal definitions.
2. Why might legislators restrict advanced practice to a particular site or setting? What are the advantages and disadvantages of this arrangement?

CASE STUDIES

Why do APNs continue to practice under these restrictive arrangements? Consider the following three cases.

CASE 1: CONNECTICUT

Advanced practice nursing has been present in Connecticut since the late 1940s, both in training programs and practice. Clinical nurse specialists and nurse practitioners are governed as APNs under the same section of the Nurse Practice Act (Nursing, General Statutes of Connecticut, 2004). Certified nurse–midwives are governed by another statute and achieved prescriptive authority before APNs did.

In the mid-1980s, APNs functioned under the following practice act:

Sec. 20-871. Definition of nursing and practical nursing.

(a) The practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral,

collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

A health maintenance organization (HMO) from another state wished to start business in Connecticut. This HMO relied on nurse practitioners with adequate prescriptive authority; otherwise, the HMO physicians would have to prescribe for their own and the nurse practitioners' patients, an inefficient and costly practice.

Early inquiries by the HMO established that nurse practitioners at a major hospital in Connecticut did prescribe directly. When the HMO raised APN prescriptive authority with the Department of Consumer Protection (DPC), however, it discovered that this prescribing arrangement was under informal and unwritten approval that had been granted by the DPC years earlier as part of its regulation of pharmacies. DPC now realized that APNs were practicing in many settings and that prescriptive authority was unclear.

When the state legislature addressed the issue the next year at the request of the DPC, it referred the issue to the state Department of Health (DOH), the licensure authority governing APNs and other clinicians, as a matter of regulating who can prescribe rather than prescribing per se. DOH formed a task force consisting of several physicians and APNs. Many meetings were held to explore the variety of advanced practice settings and activities; whether prescribing was an innate professional act or a delegated medical one; the virtues and deficits of formularies; the wisdom of limited prescriptive authority; whether APNs could or should dispense; what other models were used around the United States; whether different settings necessitated site-specific "guidance and control"; and whether APNs could have blanket authority to prescribe. In short, the coalition considered every convolution of the intersections of pharmacy, medicine, and nursing. Legislation eventually emerged in 1990 and a new license for advanced practice nursing was created. Advance practice nursing was addressed as

[T]he performance of advanced level nursing practice activities which, by virtue of post-basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status... [and may] under the direction of a physician licensed to practice in this state and in accordance

with written protocols, and if practicing in... a hospital, home for the aged, health care facility for the handicapped, nursing home, rest home, mental health facility, substance abuse treatment facility, infirmary operated by an educational institution for the care of students enrolled in, and faculty and staff of, such institution, or facility operated and maintained by any state agency and providing services for the prevention, diagnosis and treatment or care of human health conditions, or an industrial health facility... which serves at least two thousand employees, or a clinic operated by a state agency, municipality, or private nonprofit corporation, or a clinic operated by any educational institution prescribed by regulations adopted pursuant to said section, prescribe, dispense, and administer medical therapeutics and corrective measures, except that an APRN licensed pursuant to Section 3 of this Act and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administering medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic, or other prescribed setting where such surgery is being performed.

APN prescriptive authority, though obtained from a separate license, was dependent on an approved site, under physician direction, with site-specific protocols listing the “medical therapeutics, corrective measures, laboratory tests, or other diagnostic procedures” that might be “prescribed, dispense or administered” by an APN in “various circumstances.” Only Schedule IV and V medications (nonsteroidal anti-inflammatory drugs, mild steroid creams, and the like) could be prescribed.

As often happens, the reality of prescribing overwhelmed the legal framework under which APNs could prescribe. APNs continued to work in a variety of settings, increasing their scope of practice and prescribing appropriate to patient care. By the 1990s, virtually no physicians or APNs were following the mandated restrictions. And then, in 1997, another outside force caused the prescriptive authority to be reexamined.

Congress passed the 1997 Balanced Budget Act (BBA), including, for the first time ever, direct reimbursement to APNs under Medicare. The statute required, however, that a collaborative relationship exist between the APN and at least one physician. This raised concerns in states where

APNs practiced independently (10 at that time) and where APNs were still under direction or supervision—Connecticut being one.

The leadership of the state's APN group, to the surprise and consternation of other nursing leaders, arranged a loose coalition with the nurse psychotherapists, nurse anesthetists, and clinical nurse specialists to open the practice act for independent practice. The coalition at best was ill defined and ticklish, as was the strategy. Communication between the coalition parties was scant, and the Medical Society was never considered as a potential member. The entire episode ended with bitter and very acrimonious testimony from the Medical Society and the APN coalition's rejoinder, to the embarrassment of legislative sponsors. Just prior to a legislative decision to send the issue back to committee for more study, the bill was withdrawn. This effectively kept the issue under control of the APNs and the sponsors, providing anyone *would* sponsor a bill in a future session. (Otherwise, the issue would be sent immediately to committee, session after session, until someone felt like taking it to the floor.)

Despite the instincts of most nursing leaders to keep their heads down for future sessions, the BBA language virtually demanded another try. Therefore, the coalition gathered again, hardly more cohesive than before, but this time with a major strength. A well-known senator, herself a registered nurse (RN) and a savvy legislator with power over healthcare issues, agreed to make it a priority. The legislative arena was rife with healthcare issues regarding patient rights and the rights of physicians to organize, issues falling to the senator's committee. All told, the Medical Society watched 27 bills closely; only one of them concerned APNs, but all of them were in the senator's committee. The senator made it a condition of sponsorship that the coalition hammer out the details of the new prescriptive authority with the Medical Society before she would introduce it.

The coalition drafted a bill for consideration, reflecting independent practice based on national certification procedures (already required for APN licensure in Connecticut). Heavy emphasis was placed on the 1997 BBA language, which clearly recognized APN practice as legitimate and not needful of supervision. However, the federal language did invoke collaboration, not independence, and the Medical Society made much of this. Medicine did not push for an elaborate definition, however, and the APNs came to agree that collaboration would be acceptable for now.

The Medical Society wanted collaborative agreements to be in writing, but only for prescriptive authority, and still at the total discretion of all parties regarding the authority. No objection was raised to allowing APNs to prescribe Schedule II and Schedule III medications. The APNs agreed to the requirement for written collaboration for prescriptive practice.

The legislation issued to committee and to the full legislature with very little disturbance and with glowing statements of consensus from the Society and the various nursing groups. Regulations for APNs were eliminated (having merely echoed the now defunct law), which meant protocols were no longer needed. The direction clause in the nurse practice act was replaced with this language:

The advanced practice nurse may, in collaboration with a physician licensed to practice in this state, prescribe, dispense, and administer medical therapeutics and corrective measures.... For purposes of this subsection, “collaboration” means a mutually agreed upon relationship between an advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such APRN. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the APRN, a method to review patient outcomes, and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between an APRN and a physician shall be in writing and shall address the level of schedule II and III controlled substances that the APRN may prescribe, including but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that the APRN may prescribe, dispense and administer.

DISCUSSION QUESTIONS:

1. Discuss the difference between state statute and regulation.
2. What is the difference between prescribing as a “delegated medical act” and prescribing as an “innate quality of professional practice”?
3. Identify what “homework” APRNs should do prior to open discussions to change the state practice act.

4. Review how a bill becomes law and compare it to the process that occurred in Connecticut.

CASE 2: MISSOURI

Missouri was the site of a case infamous in the early history of the nurse practitioner movement: *Sermchief v. Gonzales* (1983). This landmark case upheld the very existence of nurse practitioners, who had been sued by the state Medical Society for the illegal practice of medicine. The court upheld the legality of advanced practice, including prescriptive authority, noting the practice act required adequate education for nurses in such roles.

In 1987, Missouri passed a law under which physicians would be punished for “providing medication to a patient without first establishing a patient-physician relationship” (Sullivan, 1998, p. 328). The law was intended to prevent prescriptions for oneself, friends, or family. The Missouri Board of Healing Arts, however, interpreted the new law to mean that nurse practitioners could not prescribe medication for any patients without a physician first examining the patient.

The board investigated pharmacies and physicians who allowed nurse practitioners to prescribe without the requisite a priori physician examination for possible disciplinary action. Not surprisingly, physicians and pharmacies immediately stopped working with nurse practitioners. With this interpretation, the board unilaterally amended the nurse practice act.

Despite many attempts by a multidisciplinary coalition to remedy this situation, the practice environment was not changed until 1993, when the Missouri legislature passed a law establishing collaborative nurse–physician relationships. It left interpretation of the definition of collaboration with the Board of Healing Arts, and subsequent administrative interpretation was contentious. The law stated that the physician delegated medical authority in the collaborative agreement, including the right to prescribe. However, nurse practitioners were able to prescribe without first having the patient seen by a physician (Sullivan, 1998).

In 1996, 3 years after the collaborative law, regulations governing collaboration were issued. The collaborative agreement was required to be written and contain “disease specific protocols with clear criteria for making the diagnosis” (Rathbun & Richards, 1997). APNs were not allowed prescribe controlled substances.

An article written by a physician and a lawyer to educate physicians and nurses about the new regulations advised that the agreement contain a formulary with specific drugs listed. “Deciding what is the ‘appropriate hypertensive’ is a pharmacology course, not a standing order” (Rathbun & Richards, 1997, p. 4). The article estimated that a family nurse practitioner would need “50 to 100 protocols to work from” (Rathbun & Richards, 1997, p. 4). It is not known how influential this advice was.

In 2004, the APNs in Missouri proposed a bill to grant them the right to prescribe controlled substances if permitted under a collaborative agreement (Crouse, 2005). The bill failed, and the issue was raised again in 2005. It did not pass.

DISCUSSION QUESTIONS:

1. How did prescriptive authority originally undergo revision in Missouri?
2. Identify future APN issues similar to that of prescriptive authority that may arise and how you would begin to address those issues.
3. Discuss the arguments for and against APN prescriptive authority for controlled substances.

CASE 3: GEORGIA

Georgia is the only state that does not allow APNs to write prescriptions. APNs may, under physician approval, phone in a prescription. However, not all pharmacies allow nonwritten prescriptions; the VA, for instance, requires written prescriptions. Some private medical facilities recognize that telephonic prescriptions lead to errors and require written prescriptions to be issued.

This is the case at the large group practice at Memorial Health University Medical in Savannah, Georgia. APNs there work under a policy that patients must leave with a written prescription in hand. This means APNs must track down a doctor with time to write a prescription before patients can leave the clinic. “This definitely increases patient wait time and ultimately decreases the number of patients I can see due to lost time,” said an APN working there (Hart, personal communication, February 28, 2005). Neither patients nor APNs are happy with the situation (Hart, personal communication, February 28, 2005). In other settings, patients often have

to wait while an APN finds time between patients to make the call. Otherwise, the patient has to wait until the physician can write out and sign the prescription. This can cause a great delay, sometimes days from the actual visit (Hart, personal communication, February 23, 2008).

It is not for lack of trying that the APNs find themselves excluded from a basic piece of practice. Over the last 11 years, they have proposed legislation each year to change the law, and each time the powerful Medical Association of Georgia (MAG) manages to keep the bill in committee or to actually defeat it if issued to the general legislature. Even MAG recognizes the absurdity of allowing APNs to “recommend” a medication but not to actually prescribe it. The executive director of MAG has said the practice is “illogical.” However, MAG continues to adhere to the belief that physicians must be involved in any prescribing (Jones, personal communication, February 28, 2005).

The issue of nurse prescribing has a long history in Georgia, and several twists may explain the current dilemma. In 1979, the state’s attorney general issued an opinion that it was legal under the nurse practice act for nurses to “prescribe” under written protocols from a physician. The practice, developed nearly 20 years earlier, was essential to 245 rural public health clinics and numerous public health, homeless, and other clinics across the state that had trouble hiring sufficient numbers of physicians (A. Hill, personal communication, February 4, 1989). In fact, most physicians were usually contracted not to be on site, but to be available for nurse consultation as needed (McCarthy, personal communication, June 15, 1988). The attorney general’s opinion clarified that public health nurses were legally capable of prescribing birth control pills and antibiotics under written protocols for the impoverished patients whose only medical care occurs in a public health clinic.

In 1988, for reasons unknown now, the issue rose again. The director of the Drugs and Narcotics Agency in Georgia, which regulates prescribing practices, asked the attorney general to reexamine the practice of nurse prescription under protocol. This time, the attorney general found that the practice was illegal. “Nurses may not write or telephone in prescriptions by referring to a written protocol” (McCarthy, personal communication, August 2, 1988). The rural public health clinics were, however, still dependent on this model because too few physicians were willing to practice in those areas. The fallout from the sudden finding that nurses could not, in fact, prescribe under protocol was immediate and urgent.

The directors of the 19 public health districts sought and gained a meeting with the commissioner of Public Health to assess what options might be available so patient care would not be compromised. There did not seem to be many: either the physicians' fees for overseeing prescribing were too steep, or there simply were no physicians in a particular health district who could be contracted to "prescribe." The commissioner wrote to the attorney general asking for further clarification of the opinion, pointing out the circumstances and history of the protocol system, and summarizing the literature on the safety of such arrangements. Meanwhile, the public health nurses were forced to call the backup physicians "for every single thing" covered by protocol to comply with the new opinion. One nurse observed, "It makes more work and it's time consuming, but we're doing it so we won't be in violation of the law. We're really trying to avoid sending people to the emergency room for their medications" (McCarthy, personal communication, August 2, 1988).

Two months later, the attorney general wrote back to the commissioner of Public Health and affirmed that his opinion forbade nurses from prescribing in any manner. "Under Georgia law, the medication decision must be made by a physician," he found, and "that is as clear as a bell" (McCarthy, personal communication, October 5, 1988). The commissioner responded that his office would seek legislative remedy in the next session, and in the meantime he would work to alleviate the burden on the poor who frequent the public health clinics (McCarthy, personal communication, October 5, 1988).

The commissioner was successful in his legislative approach, and the governor signed a new law that explicitly allowed nurses to prescribe. The commissioner was joined in his efforts by the Georgia Nurses' Association and a state senator who recognized the gist of the problem as "a turf struggle" (Hill, personal communication, February 4, 1989). Although the physician and pharmacy lobbies raised strong objections, the legislature recognized the tremendous burden on patients and the fact that the "system came to a very, very slow crawl," as observed by the nurses' attorney (Hill, personal communication, February 4, 1989).

In 1994, the nurses proposed legislation to allow nurses with advanced training to prescribe medications directly. This effort, as well as the one in the following year, failed to create a bill. In 1996, however, the nurses got both a bill and a lot of good publicity. The failure of the 1996 effort did not deter the APNs from trying again the next year. As before, the papers followed the debate and endorsed the nurses. MAG raised the

usual arguments of insufficient training and physician supremacy. MAG also noted its fear that the health maintenance organizations (HMOs) designed to cut costs would hire nurse practitioners over physicians if nurse practitioners could prescribe. The 1997 effort failed to produce legislation.

By 2005, MAG admitted that the main concern was the issue of collaboration, which to MAG “implies nurses are equal to physicians,” causing safety problems for patients (Hart, personal communication, February 23, 2005). The nurses have stated that they are willing to accept prescribing under supervision (Hart, personal communication, February 23, 2005). Nonetheless, in 2005 the MAG website (<http://www.mag.org>) urges physicians to call legislators and ask for a negative vote because of public safety issues. Once again, APNs were denied prescriptive authority.

DISCUSSION QUESTIONS:

1. Discuss the merits of the various arguments used against APN prescriptive authority in Georgia.
2. The Georgia APN community has excelled at public news coverage for their cause. What other options exist?
3. Discuss whether advanced practice nurses are undertrained, or whether physicians in certain settings are overtrained.

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