

NURSE PRACTITIONERS IN ALABAMA
A SYNTHESIS OF PERCEPTIONS OF ROLE AND REGULATORY
ACCOUNTABILITY

A Collaborative Research Project

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Nurse Practitioners in Alabama

A Synthesis of Perceptions of Role and Regulatory Accountability

Purpose and Need for the Study

This study is concerned with issues of health care delivery by advanced nurse practitioners. The purpose is to determine (1) characteristics of currently licensed and certified nurse practitioners by the Alabama Board of Nursing, (2) functions performed in various practice sites, (3) nurse practitioners perceptions of their practice, and (4) political, economic and regulatory matters affecting their practice.

The need for the study evolved subsequent to a conflict over barriers to advanced nursing practice. Specific barriers include controls exerted over the nurse practitioners practice by other professions and groups with vested interest. Major controls include restrictions to prescriptive authority, direct reimbursement for services rendered, and autonomous practice (Pearson, 1994; Safriet, 1993). Although nurse practitioner leaders are promoting autonomy, one of the greatest barriers is the dearth of scientifically based data to clearly show what role a majority of nurse practitioners wish for their scope of practice to include, or even what their perceptions are regarding their current practice. Further, little research exists to show the relationship nurse practitioners wish to have with other health care providers. As of this writing, only two studies have been conducted by nursing regulatory agencies which address the aforementioned concerns (Idaho Board of Nursing, 1987; Department of Professional Regulation, Common Wealth of Virginia, 1990).

Background

Since the turn of the century, health care delivery has been in a perpetual state of reform.

Its effectiveness has consistently been evaluated from the perspective of: access to care; quality of care; and cost of care (Safriet, 1993). In earlier years physicians and registered nurses were the primary care givers in America. Both were controlled by licensing laws. Physicians dominated in the management of health care. Cost was focused primarily on physician fees and capitol improvements/additions to hospitals. Except for selected areas of health care promotion and delivery, cost of the care received until the mid-century, was born primarily by the private sector. Private health care insurance was limited to the institutional setting and physician fees. Near the mid-century, fiscal provisions for health care delivery began to shift to the public sector. Today, it is estimated that over 14% of the Gross National Product is devoted to health care delivery (Inglis & Kjervik, 1993). As Safriet (1993) summarized, efforts to control cost and provide equity in health care delivery have centered around the Social Security laws, the most recent have been seen since the introduction of the Tax Equity Fiscal Responsibility Act and the Omnibus Budget Reconciliation Act (1989) (Safriet, 1993).

Over the years the types of care givers and care giving agencies have increased but, medicine has retained full control of patient care management and reimbursement. This has been accomplished in part by legislatively restricting the practice of other qualified health care providers.

Even with the tremendous layout of capitol for current tax based funding for health delivery, costs for health care have continued to spiral so that access to care is being restricted or even denied when the consumer is no longer able to pay for his/her own care. A multiphase study funded by the Federal Office of Rural Health Policy and conducted under the auspices of the New York Rural Health Research Center at the University of Buffalo evidenced maldistribution of

nurse practitioners, especially in rural areas. Restrictiveness of practice was cited as a major cause (American Nurse, 1995). The concept of distributive justice is an elusive term rather than the pursued reality. The failure of efforts to effectively meet the health care needs of the public with both private and governmental endeavors has forced the leaders of the nation to examine these issues and propose drastic changes. Organized nursing has been among those disciplines assuming an aggressive leadership role by proposing an agenda for health care reform, which identifies ways to more effectively use nurses with advanced preparation for practice (Reifeneider, 1992). A major review of literature by Koch, Pazahi and Campbell (1992) evidenced growth of the practitioner movement from a passive to active involvement in decision making. Appendix A provides a summary of the findings of this review.

Nursing has, through professional and educational endeavors, developed the knowledge and practice base for advanced nursing practice for over a quarter of a century. Idaho, in 1971, broke the ground for validating advanced practice in nursing in the area of diagnosis and treatment with regulation under two agencies. From that first landmark step, most states have developed some type of regulations for "expanded roles" and/or "advanced practice." Limited prescriptive authority was first codified in North Carolina in 1975 for nurse practitioners and 1977 for Certified Nurse Midwives. As of January, 1993, 43 jurisdictions have addressed advanced nurse practitioners in statutes and regulations; 50 states have, through indirect statutes, allowed for some limited types of reimbursement, although federal laws have not promoted consistency. Nationwide, professional certification and regulatory systems have resulted largely from the efforts of organized groups of nurses seeking professional and economic recognition and clarification of the authority to practice. Today there is a lack of consistency in regulatory systems

and professional certification. There is confusion for the public, legislators, regulators, nurses and other health care providers regarding titling, credentialing, scope of practice and reimbursement related to advanced practice in nursing (Pearson, 1993; Pearson, 1994).

Chapter 610-X-9 of the Administrative Code of the State of Alabama provides regulations for three levels of specialty practitioners, Certified Nurse Anesthetists, Certified Nurse Midwives and Certified Nurse Practitioners. In the regular session of the 1993 Legislature, the Medical Association of the State of Alabama introduced a bill to place the regulation of nurse practitioners under the Board of Medical Examiners and to grant prescriptive authority in accordance with a set protocol which required a signature on each order. The bill gave the responsibility of licensure and certification to the Board of Nursing. The numbers of supervising physicians for whom a nurse practitioner could work would be limited as would the number of nurse practitioners who the physician could supervise. The proposed legislation was the most restrictive in the nation and considered to be an antithesis to the proposals for health care reform (S. Bill 570). While some nurse practitioners have been firm in their opposition to proposed legislation, others have stated they do not care to be involved politically, and do not care who regulates them. Although this bill died in the House, it is exemplary of barriers currently used to control health care delivery. Many of the factors described in this situation are consistent with those described from a national perspective by Birkholz & Walker (1994).

In Alabama, sixty goals have been set to promote an overall goal for health care intervention and prevention. Alabama falls far short of other states in preventing infant mortality, and adult morbidity, and intervention for effective treatment of numerous chronic disorders and communicable diseases (Healthy Alabama 2000, Department of Public Health, 1992). Achieving

the goals cannot be accomplished within the current health care delivery system. It is perceived that qualified health care personnel, other than physicians, can increase the potential of goal attainment. Although Idaho and Virginia's Boards of Nursing have formally studied the characteristics of individuals licensed as nurses and certified as practitioners in their states, data have not been formally organized for analysis.

Research Questions

The following research questions were constructed to address the purpose of the study.

1. What are the demographic characteristics of nurse practitioners with Alabama licenses and nurse practitioner certifications in Alabama?
2. What functions are performed by nurse practitioners in the various practice settings in Alabama?
3. What are the methods of reimbursement for services rendered by nurse practitioners in Alabama?
4. What perceptions are held by nurse practitioners regarding relations with other health care professionals?
5. What perceptions are held by nurse practitioners regarding their practice authority?
6. Do the sites in which nurse practitioners work restrict the performance of the practitioner?
7. Is the practitioner allowed to fully utilize the knowledge and skills for which they were prepared in their educational program?
8. What practice and/or regulatory changes are needed to facilitate the nurse practitioner role to provide the needed health care services for the citizens of Alabama?
9. What barriers are perceived by nurse practitioners in executing their practice?

Population

All registered and certified nurse practitioners in Alabama, as of June, 1994 (N=362), were included in the study. Of these, 258 responded to the invitation to participate by September 1, 1994. One of the 258 questionnaires was classified as "missing" based on insufficient data.

Study Method

Questionnaires designed by the Idaho and Virginia Boards of Nursing were utilized to help construct a basic demographic profile for the study. Questions were then constructed to address qualitative concerns and the remaining elements of the study. The questionnaire was piloted at the University of Alabama by nurse researchers to achieve instrument validity. Informed consent was implied in a cover letter to the nurse practitioners and assurances of confidentiality given. The instrument with the letter of invitation to participate was mailed in June, 1994 (Appendix B). An additional reminder was sent in August, 1994.

Analysis

Data were tabulated, organized, and subjected to a variety of statistical tests. Descriptive statistics were employed to organize demographic variables. Chi Square was applied to determine relationships of practice characteristics to demographic variables. Multiple regression analysis was applied to determine effect of demographic characteristics on practice characteristics and regulatory variables.

Findings

Certain demographic data were studied in order to describe the sample. The frequencies and percentages of the demographic data are presented in Table 1. A majority (52%) of the study population had worked less than ten years as nurse practitioners, were female (95.3%) with a family practice specialty (33.3%), and 50% had their practitioner preparation from a masters program.

The age range of 34-41 years had the highest representation (39%), followed by the 42-50 year range (26.7%), and the 51-58 range (14%). Only 5% of the sample were 59 and above.

Table 1. Demographic Characteristics of Nurse Practitioners (N=258)

<u>Demographic Characteristics</u>	<u>Frequency</u>	<u>Percent</u>
<u>Sex</u>		
Female	246	95.3
Male	11	4.3
Missing	1	.4
<u>Age</u>		
25-33 years	29	11.2
34-41 years	100	38.8
42-50 years	69	26.7
51-58 years	36	13.95
59-73 years	13	5
Missing	11	4.3
<u>Highest Level of Nursing Education</u>		
Diploma	37	14.3
A.D.N.	14	5.4
B.S.N.	39	15.1
M.S.N.	144	55.8
Doctorate	10	3.9
Other	11	4.3
Missing	3	1.2
<u>Type of NP Preparation</u>		
Certificate	115	44.6
M.S.N.	129	50
Other	10	3.9
Missing	4	1.6
<u>Nurse Practitioner Specialty</u>		
Adult	20	7.8
Family Practice	86	33.3
Maternal Child	1	.4
Neonatology	14	5.4
Pediatrics	30	11.6
Adolescent Health	1	.4
Women's Health	14	5.4
Geriatrics	5	1.9
Family Planning	7	2.7
School Health	1	.4
Obstetrics/Gynecology	61	23.6
Other	11	4.3

In terms of the highest level of nursing education achieved, 55.8% of the sample had a master's degree in nursing while only 4% held a doctoral degree, fifteen percent (15%) had a baccalaureate degree, 5% had the associate degree and 14% had the diploma in nursing. In addition, two nurse practitioners listed a Masters in Public Health as the highest level of nursing education while one listed a Bachelor of Science in Health Science. Of these, 44.6% indicated that nurse practitioner preparation was obtained through certification programs, and 50% through masters in nursing degree programs.

A majority (240 or 93.0%) of the nurse practitioners reported they had worked in Alabama. Currently, several who hold an Alabama license work in other states including North Carolina, Alaska, Mississippi, Florida, Tennessee and Georgia. One of these worked in Alabama as a certified nurse specialist (CNS) while she worked as a nurse practitioner in Florida. In addition to those working within the United States, one stated she works as a nurse practitioner in Japan. Further, seventy-five percent of the nurse practitioners were currently employed as nurse practitioners. In contrast, 5 percent were nurse faculty members or held other nursing positions including staff RN (2.3 percent), clinical specialist (.8 percent) and nursing administrator (1.2 percent).

The data in Table 2 show that the majority (43 or 16.7%) of the nurse practitioners work for a state or local health department and identified the geographic characteristics of their practice area as urban. An additional 38 (14.7%) indicated their practice setting as a community health center. Overall the practice site for a majority of nurse practitioners was identified as urban (165 or 64%). Seventy-five (29.1%) stated their practice site to be rural.

The fifty-five nurse practitioners who were not employed as nurse practitioners were last employed in that category from a low of less than one month (5 or 1.9%) to a high of over thirty-six months (22 or 8.5%). The lack of a collaborating physician was identified by only one practitioner as the reason for not working. While 16 nurse practitioners identified family and educational factors, only two practitioners cited insufficient earnings as a reason for not working. Six nurse practitioners were retired and two had been retired for more than three years.

Table 2. Practice Characteristics (N=258)

Practice Setting	Frequency	Percent
Community Health Center	38	14.7
Free Standing Clinic	25	9.7
Home Health Care	1	.4
Hospital	34	13.2
Nursing Home	1	.4
Private Physician in Single Practice	12	4.7
Private Physician in Group Practice	21	8.1
State or Local Health Department	43	16.7
Student Health	8	3.1
Health Maintenance Organization	0	0
University Faculty Practice Site	24	9.3
Other	33	12.8
Missing	18	7.0
Practice Site		
Rural	75	29.1
Urban	165	64
Missing	18	7

Table 3 provides data relative to productivity in practice. A majority (83.3%) do not make house calls, a similar number (73.6%) are not on call. While 155 (60.1%) stated they used all advanced practice knowledge and skills, 87 (33.7%) responded negatively. A qualitative

assessment of comments returned regarding the use of knowledge and skills demonstrated a variety of reasons including agency restrictions to type of clientele being served, i.e., family nurse practitioners being restricted to womens health or childrens health, restrictions on prescriptive authority including the prescribing of pharmacologic products and other treatments, limited resources, medical practice dominance, restrictions on interventions, i.e., suturing, insertion of IUD's, biopsies and other. Some added a rational or other comments. One stated she was restricted "depending on how many physicians are available." Another said, "I intend to relocate out of this state ASAP, permanently. It is virtually impossible for any qualified nurse practitioner to 'practice' in this archaic environment. Verbatim comments are provided in Appendix C. " The work places of these nurses were concentrated primarily from State department of health to free standing clinics and occupational health. Concern was expressed about not meeting patients' needs.

The data in Table 3 also indicate that: the majority (88.4%) of nurse practitioners receive an income derived from salary and work 40 hours per week. The salary for nurse practitioners ranged from a low of 16,000-20,000 dollars to greater than 50,000. Six or 2.3 percent of the nurse practitioners are in the 16,000-20,000 dollar salary range while the majority (62 or 24%) are in the 43,000-50,000 dollar range and 50 or 19.4 percent receive greater than 50,000. Income generally did not increase with age, number of years in practice and number of hours worked. There was no direct relationship between salary and educational preparation.

Table 3. Practice Characteristics (N=258)

Practice Information	Frequency	Percent
<u>Income derived by:</u>		
Salary	228	88.4
Fee for service	2	.8
% of practice income	1	.4
Other	9	3.5
Missing	18	7.0
<u>Charges for services</u>		
Same as Physician	94	36.4
Less than Physician	96	37.2
Other	40	15.5
Missing	28	10.9
<u>Patient Payment</u>		
"Out of Pocket"	30	11.6
Insurance reimbursement	31	12.0
Medicaid	80	31.0
Medicare	5	1.9
Other	50	19.4
Missing	62	24.0
<u>Hours worked each week</u>		
More than 40 hrs per week	44	17.1
40 hours per week	107	41.5
Between 30 and 35 hrs per week	12	4.7
Between 20 and 25 hrs per week	21	8.1
Less than 20 hrs per week	16	6.2
Missing	58	22.5
<u>Annual Salary Range</u>		
\$16,000-\$20,000	6	2.3
\$21,000-\$25,000	7	2.5
\$26,000-\$30,000	9	3.5
\$31,000-\$36,000	37	14.3
\$37,000-\$42,000	55	21.3
\$43,000-\$50,000	62	24.0
Greater than \$50,000	50	19.4
Other	13	5.0
Missing	19	7.4
<u>House Calls</u>		
Yes	25	9.7
No	215	83.3
Missing	18	7.0
<u>On Call</u>		
Yes	53	20.5
No	190	73.6
Missing	15	5.8
<u>Use of Advanced Practice Knowledge and Skills</u>		
Yes	155	60.1
No	87	33.7
Missing	16	6.2

A majority (72 or 27.9%) of the nurse practitioners did not perceive hospital privileges as an issue for their specialty. Similarly, 67 or 26.0% of the practitioners perceived hospital privileges as unimportant for their practitioner specialty. These figures are consistent with the number of practitioners who do not work in hospital practice settings. Most nurse practitioners (203 or 78.7%) stated they did not have hospital privileges and indicated they had not applied (175 or 67.8%) for privileges. Six (6) individuals stated they had applied for hospital privileges that had not been granted due to no staff category for nurse practitioners in hospital by-laws.

The data in Table 4 show that the majority of nurse practitioners (145 or 56.2%) were engaged in diagnosing and treating clients. In contrast only 10 or 3.9% of the nurse practitioners perceived administrative duties as their primary function. Similarly, only 11 nurse practitioners or 4.3% identified documentation and paperwork as a majority activity.

A majority (178 or 69.0%) of nurse practitioners perceived they function collaboratively with physicians. Further, a majority (181 or 70.2%) collaborated with more than one physician. The data in Table 5 show highest level of nursing education and nurse practitioner perceptions of how protocols are developed. Nurse practitioners who held the diploma as the highest level of nursing education perceived that protocols established for the evaluation and management of disease states are jointly developed and agreed upon by the physician and nurse practitioner. In contrast an almost equal number of master's prepared nurses held two different perspectives. Forty-three perceived that protocols are jointly developed while 41 believed protocols are nurse practitioner developed with physician concurrence. Although the relationship between highest level of educational preparation and how protocols are developed was not significant at the .05 level, p was less than .06.

Table 4. Practice Factors and Scope of Function (N=258)

Functions/Scope	Frequency	Percent
<u>Age Range of Patients Seen</u>		
Children	28	10.9
Adolescents	3	1.2
Young Adults	51	19.8
Middle/Older Adults	32	12.4
All age ranges	73	28.3
Missing	71	27.5
<u>Patient Conditions Seen</u>		
Minor, acute illness	* Y 179	69.4
	* N 68	26.4
	* M 11	4.3
Health Promotion/Screening	Y 171	66.3
	N 76	29.5
	M 11	4.3
Family Planning/Obstetrical Care	Y 154	59.7
	N 93	36.0
	M 11	4.3
Stable, chronic illness	Y 139	53.9
	N 108	41.9
	M 11	4.3
Emergency Care	Y 78	30.2
	N 169	65.5
	M 11	4.3
Other	Y 26	10.1
	N 221	85.7
	M 11	4.3
<u>Majority NP Activities</u>		
Diagnosing and treating	145	56.2
Patient teaching	37	14.3
Documentation and paperwork	11	4.3
Managing patient medications	2	.8
Providing coverage for MD	11	4.3
Administrative duties	10	3.9
Missing	42	16.3

* Y = Yes, N = No, M = Missing

Table 5. Highest Level of Nursing Education and How Protocols Established

Nursing Education	How Protocols Established			
Level of Nursing Education	Jointly Developed	Physician Developed	NP Developed	Other
Diploma	13		9	1
Associate Degree	6	1	2	
Bachelor of Science	11		9	3
Master of Science	43	5	41	16
Doctoral Degree			1	3
Other	4		4	
Chi Square ----- Pearson	Value of Significance			
	24.32324		15	.05980

An almost equal number of nurse practitioners characterized the attitude of physicians about the involvement of nurse practitioners in the provision of patient care as either very supportive (99 or 38.4%) or supportive (93 or 36.0%). Only 14 (5.4%) nurse practitioners characterized physician's attitude as very opposed to practitioner involvement in patient care. Similarly, an almost equal number of nurse practitioners characterized the attitude of hospital and/or clinic administrators regarding the same issue as either supportive (89 or 34.5%) or very supportive (86 or 33.3%). Only 9 (3.5%) nurse practitioners characterized administrator's attitude as very opposed to practitioner involvement in patient care.

A majority (192 or 74.4%) of the nurse practitioners had no difficulty in finding collaborating physicians; did not (163 or 63.2%) perceive that a physician had tried to limit the nature and scope of their practice; were unaware (217 or 84.1%) of instances where a physician refused to refer patients to them; and did not (201 or 77.9%) perceive that physicians refused to accept patient referrals from them.

A majority (139 or 53.9%) of nurse practitioners perceived the ability to directly bill third party payers for their services as very important. The data in Table 6 indicate that nurse practitioners held very strong perceptions ($p < .01$) regarding delays and lack of prescriptive authority as related to importance of billing third party payers.

Table 6. Prescriptive Authority and Third Party Billing

	Very Important	Important	Ambivalent	Unimportant	Very Important
No delays	14	10	4	13	
Brief delays	36	18	5	11	1
Moderate delays	51	15	5	4	2
Long delays, no significant impact	6	7	1	2	
Long delays, significant impact	22	7		1	1
Chi-Square	Value of Significance				
----- Pearson	32.58716			16	.00838

The data in Table 7 indicate nurse practitioner's perceptions regarding prescriptive authority. A majority (106 or 41.1%) of the NPs perceived prescriptive authority as very important if one worked for a state or local health department. A retrospective review of data evidenced that the 34.5% (See Table 7) who indicated that prescriptive authority did not apply worked primarily in settings other than a State or local health department (hospitals, university faculty positions, community health centers and free standing clinics). Only, 31 or 12.0 percent of NPs perceived that the lack of prescriptive authority resulted in long delays, with significant impact on the patient's health. However, a majority (159 or 61.6%) believed extension of prescriptive authority

would greatly enhance their ability to care for patients. The data in Table 8 show acceptable limitations on prescriptive authority. Limiting prescriptive authority to drugs in the NPs specialty was not an acceptable limitation to a majority (172 or 66.7%) of the nurse practitioners.

Prescriptive authority limited to drugs specifically agreed upon with the nurse practitioner's supervising physician in a written protocol was considered to be an acceptable limitation by a majority (158 or 61.2%) of the respondents. In contrast, limiting prescriptive authority by excluding drugs with high potential for abuse was not considered an acceptable limitation by a majority (136 or 52.7%) of the NPs.

Table 7. Nurse Practitioner Perceptions Related to Prescriptive Authority

Perceptions	Frequency	Percent
Important to prescribe medication		
Very important	106	41.1
Important	13	5.0
Ambivalent about issue	3	1.2
Very unimportant	1	.4
Not applicable	89	34.5
Missing	46	17.8
Total	<u>258</u>	<u>100.0</u>
Treatment delays due to lack of prescriptive authority		
No delays		
Brief delays	41	15.9
Moderate delays	71	27.5
Long delays, not significant	77	29.8
Long delays, significant	16	6.2
Missing	31	12.0
Total	<u>22</u>	<u>8.5</u>
	<u>258</u>	<u>100.0</u>
Effect of prescriptive authority on client care		
Greatly enhance	159	61.6
Moderately enhance	52	20.2
Slightly enhance	25	9.7
No effect	12	4.7
No opinion	1	.4
Missing	9	3.5
Total	<u>258</u>	<u>100.0</u>

Table 8. Acceptable Limitations on Prescriptive Authority

	Frequency	Percent
Limit to drugs in NPs specialty		
Yes	84	32.6
No	172	66.7
Missing	<u>2</u>	<u>.8</u>
Total	258	100.0
Limit to drugs by MD agreement in a written protocol		
Yes		
No	158	61.2
Missing	98	38.0
	<u>2</u>	<u>.8</u>
Total	258	100.0
Limit by excluding abusable drugs		
Yes	120	46.5
No	136	52.7
Missing	<u>2</u>	<u>.8</u>
Total	258	100.0

The data in Table 9 show legal and regulatory factors. The majority (228 or 88.4%) of NPs carry malpractice insurance, do not (189 or 73.3%) carry a personal policy, have not been named in a malpractice suit, and have not had a malpractice verdict entered against them. Likewise, only one malpractice verdict has been entered against a collaborating physician and only one NP has been subject to disciplinary proceedings.

Table 9. Legal and Regulatory Factors (N=258)

	Frequency	Percent
Ever named in a malpractice suit		
yes	3	1.2
no	253	98.8
missing	<u>2</u>	missing
Total	258	
Malpractice verdict against NP		
yes	1	.4
no	254	99.6
missing	<u>3</u>	missing
Total	258	
Malpractice verdict against collaborating physician		
yes	1	.4
no	253	99.6
missing	<u>4</u>	missing
Total	258	
Subject to disciplinary procedures		
yes	1	.4
no	254	99.6
missing	<u>3</u>	missing
Total	258	100.0
Carry malpractice insurance		
yes	228	89.1
no	28	10.9
missing	<u>2</u>	missing
Total	258	100.0
Carry personal policy		
yes	67	26.2
no	189	73.8
missing	<u>2</u>	missing
Total	258	100.0
Cost of malpractice insurance a barrier		
yes	38	15.0
no	215	85.0
missing	<u>5</u>	missing
Total	258	100.0

Conclusions, Implications and Discussion

In the beginning of the study, a four-fold purpose was established. This purpose was achieved in that a majority of Alabama licensed, certified registered nurse practitioners provided demographic data, and information on practice functions. Additionally, the participants gave their perceptions of nurse practitioner practice, and political, economic and regulatory matters affecting nurse practitioner practice in Alabama. These data are now considered relative to implications.

The overriding implication is that the information may, in some indirect way, provide for better and more accessible health care. The more immediate implications are that the data may provide a foundation for further research and findings may directly be applied to the development of educational programs and legislation or regulations for practice. Further, the data may assist in developing strategies for strengthening nurse practitioner practice in the political arena.

Within the context of demography and practice, it seems necessary to determine the implications for a relatively young specialty practice whose practitioners, by majority are women in the middle to older age range who were certified or approved in the passive era. Further, questions should be asked about how this demography will affect the potential to gain economic autonomy in the competitive market of health care delivery when the majority have and continue to work under the direction of physicians within a legally restricted scope of practice for not-too-generous salaries, but whose services have been assessed, for many, at the same rate as physicians.

Other demographic and practice data which should be considered in event that legislative reform is proposed, include the fact that a majority of nurse practitioners in Alabama practice in urban areas. These findings parallel national statistics. For a quarter of a century, their services

have been used, without prescriptive authority, to diagnose and treat patients of all ages. While the majority of conditions seen are predominantly in the primary care area, approximately a third of conditions diagnosed and treated were classified as "emergency." The recent rationale for legislative reform has projected nurse practitioners as primary care givers in rural areas. A careful analysis of populations in need and under served areas must be clarified and amplified. Legislation should not restrict practitioners geographically. Focus of legislation should be on providing health care delivery by qualified practitioners where the need is clearly documented. Restrictions of trade should be scorned by law makers.

In matters of regulation, the most significant findings show that the nurse practitioners with more education, support autonomy and collaboration in practice. They further have shown, by majority, they believe that patient care is adversely affected by having restrictions on prescriptive authority. In Alabama, this autonomy for practice was rejected, when aggressive political behaviors were demonstrated outside the regulatory agency. Boards of Nursing have an obligation to be leaders in collaborative legislative development between concerned parties.

Since this study began, the national political scenario has changed. In 1992 and 1993, the national trend was directed toward a centralized, federally directed health care plan. Nurse practitioners were presumed to have a central place in the plan. Today, the trend leans toward decentralization with the states as the determinants of need and distribution (NCSBN, September, 1994). Nursing, in general, is under threat in the workplace (Ketter, 1994; Mikulencak, 1994). The role that nurse practitioners may have on a national basis is uncertain. This shift in scenario again places a leadership challenge before the Boards of Nursing.

In Alabama, nurse practitioners continue their practice under the unrevised and conservative regulations of the Board of Nursing. The Board, however, has taken a proactive role

in developing legislation collaboratively with the medical regulatory agency, nurse practitioner and professional nursing groups. Schools of nursing which were gearing their educational programs toward anticipated health care reform are evaluating their curricula and the potential market for practitioners. It is critical for educational administrators and the Board of Nursing to work collaboratively to share data which benefit the purposes of both institutions to the end of improving public health. This is especially so since the legislature has passed regulations to allow physicians assistants prescriptive authority, and have supported funding for institutions of higher education to develop physician's assistants programs. Restructuring of health care systems and the use of unlicensed personnel is escalating.

With these events confronting nursing there is tremendous need to understand the population of care givers and conflicting roles within nursing and between other health caregiving occupations. There is also need to plan strategies for having a voice in the planning and development of the health care needs of a growing population lacking in quality health care. The information from this study provides a beginning data bank on one small but significant population of health care providers.

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Appendix A

TABLE

Summary of Findings in Nurse Practitioner Literature by Koch (1992)

Subjects of Categories	DATES AND BRIEFS			
	1965-1969	1970-1974	1975-1979	1980-1986
Nurse Practitioner Roles	Conceptualization: Physician Extender, Work as a member of the health care team.	Continued as past but concept of autonomy and collaborating roles was initiated: Demarcation of roles for nurse practitioners; Concern was expressed about using nurse practitioners to solve other health care groups' shortages.	Similar findings	Stress between physicians, nurses in general practice, and between nurse practitioners and other providers of health care.
Nurse Practitioner Education	Education was designed to meet rural and economically deprived population; Focus was also on increasing medical skills.	Integration of medical and nursing education. Focus on delivery of primary health care, teamwork and leadership.	Same plus more on autonomous practice.	
Health Care Crisis	Major crisis was physician shortage	Nurse practitioners were viewed as solution to physician shortage particularly for poor and rurally located.	Same focus regarding provision for poor; shift, however was beginning to focus on physician surplus.	Same trend noted; Added, however, to concerns about physicians surplus, were noted attempts to restrict nurse practitioner practice.
Evaluation	Not addressed	Nurse practitioners were found to provide services on the same level as physicians, more cost efficient.	Reaffirmed previous findings.	Increased concern over costs of health care.
Legal	Not addressed	physicians were warned of legal vulnerability to malpractice claims made by patients displeased with M.D. supervision of non-physician assistants. Institutional licensure recommended	Joint practice is an issue; discomfort found in evolving nurse practitioner autonomy; third party payment is okay with Federal agencies, not with state controlling agencies.	Nurse practitioners demanding third party payment.

Appendix B



ALABAMA BOARD OF NURSING
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MONTGOMERY, AL 36130-3900
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MAILING ADDRESS:
P.O. Box 303900
MONTGOMERY, AL 36130-3900

JUDI CRUME
EXECUTIVE OFFICER

June 27, 1994

Dear Alabama Nurse Practitioner:

As a nurse practitioner, we are inviting your participation in a study sponsored by the Alabama Board of Nursing. The purpose of this study is to examine nurse practitioners' perceptions and experiences regarding their nursing practice. This survey is being sent to all Alabama nurse practitioners and your response to each item is important and valued.

Your anonymity and confidentiality in participating in this study will be assured, since we are requesting that you do not include any specific identifying data (e.g., no name or return address is required). Approximately twenty (20) minutes will be required to complete the questionnaire. We are requesting that the questionnaire be returned (see enclosed self-addressed stamped envelope) by July 18, 1994. Your consent to participate in this project is implied by the completion and return of the questionnaire.

Your views as a nurse practitioner are extremely important to the Alabama Board of Nursing. The results of this survey will provide vital information for the Board of Nursing in making changes or revisions in current practice regulations and policies.

Thank you for your time and participation in this important survey. We appreciate your contribution to this effort and value your input.

Sincerely,

A handwritten signature in cursive script that reads "Jean B. Mann".

Jean B. Mann, EdD, RN
Education Consultant
Alabama Board of Nursing

A handwritten signature in cursive script that reads "Charlie Jones-Dickson".

Charlie Jones-Dickson, EdD, RN
Professor of Nursing
University of Alabama at Birmingham

Alabama Board of Nursing State of Alabama Nurse Practitioner Questionnaire

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

All questions refer to your practice as a nurse practitioner. For each question, put an "X" in the box next to the answer that is most **true** for you. Please check **only one answer** for each question unless the question itself asks you to do something else.

PART I

1. What is your gender?
 Female

 Male
2. What is your age?
_____ (list age in years)
3. Of the following speciality areas, which area best describes your nurse practitioner speciality?
Please check only one response.

<input type="checkbox"/> Adult	<input type="checkbox"/> Family Planning
<input type="checkbox"/> Family Practice	<input type="checkbox"/> School Health
<input type="checkbox"/> Maternal Child	<input type="checkbox"/> Obstetric/Gynecology
<input type="checkbox"/> Neonatology	<input type="checkbox"/> Midwifery
<input type="checkbox"/> Pediatrics (Child Health)	<input type="checkbox"/> Emergency - Adult
<input type="checkbox"/> Adolescent Health	<input type="checkbox"/> Emergency - Pediatrics
<input type="checkbox"/> Women's Health	<input type="checkbox"/> Emergency - General Practice
<input type="checkbox"/> Geriatric	<input type="checkbox"/> Other (please specify) _____
4. What is your highest level of nursing education?
 1. Diploma
 2. Associate Degree
 3. Bachelor of Science in Nursing
 4. Master of Science in Nursing
 5. Doctoral Degree
 6. Other (please specify) _____
5. What is your nurse practitioner preparation?
 1. Certificate
 2. Master of Science in Nursing
 3. Other (please specify) _____

6. Have you ever worked as a nurse practitioner in Alabama?
[] 1. Yes
[] 2. No
7. Are you currently employed as a nurse practitioner in Alabama?
[] 1. Yes [Answer question 8 and skip to question 13]
[] 2. No [Skip to question 9]
8. On average, how many hours do you work each week?
[] 1. More than 40 hours per week
[] 2. 40 hours per week
[] 3. Between 30 and 35 hours per week
[] 4. Between 20 and 25 hours per week
[] 5. Less than 20 hours per week
9. If you are currently employed, but **not** as a nurse practitioner, what is your position?
[] 1. Staff RN
[] 2. Clinical Nurse Specialist
[] 3. Nursing Administrator
[] 4. Nursing Faculty
[] 5. Other Nursing position (please specify) _____
[] 6. Non-nursing health related position _____
[] 7. Non-health care related position _____
10. Please indicate the length of time since you were last employed (including self-employed) as a nurse practitioner.
[] 1. Less than 1 month
[] 2. 1 - 6 months
[] 3. 7 - 12 months
[] 4. 13 - 24 months
[] 5. 25 - 36 months
[] 6. Over 36 months
11. If you are currently retired, please indicate the length of time since you were last employed (including self-employed) as a nurse practitioner.
[] 1. One month or less
[] 2. Between 1 month and 6 months
[] 3. Between 6 months and 1 year
[] 4. Between 1 year and 2 years
[] 5. Between 2 years and 3 years
[] 6. Over three years
12. If you are not working as a nurse practitioner, please indicate the primary reason.
[] 1. No longer interested in working as a nurse practitioner
[] 2. No nurse practitioner positions are available in my practice area
[] 3. No nurse practitioner positions are available in my geographic area
[] 4. Insufficient earnings
[] 5. Practice reimbursement barriers
[] 6. No collaborating physicians are available
[] 7. Family/educational/personal/health or other reasons not directly related to any nurse practitioner occupational issues
[] 8. Other (please specify) _____
-

PART II

13. What are the geographic characteristics of your nurse practitioner practice area?
- 1. Rural area
 - 2. Urban area
14. Which of the following categories best describes your main practice setting?
- 1. Community health center
 - 2. Free standing clinic
 - 3. Health maintenance organization
 - 4. Home health care
 - 5. Hospital
 - 6. Nursing center
 - 7. Nursing home
 - 8. Private physician in single practice
 - 9. Private physician in group practice
 - 10. State or Local health department
 - 11. Student health
 - 12. University faculty practice site
 - 13. Other (please specify) _____
-
15. How important are hospital privileges for you to appropriately practice your nurse practitioner specialty?
- 1. Very important
 - 2. Important
 - 3. Unimportant
 - 4. Very unimportant
 - 5. Not an issue for my specialty
16. Do you currently have hospital privileges?
- 1. Yes
 - 2. No
17. If you do not currently have hospital privileges, have you ever applied for hospital privileges in Alabama?
- 1. Yes
 - 2. No
18. If you have ever applied for hospital privileges and were denied privileges, what was the primary reason given?
- 1. No staff category for nurse practitioners in hospital by-laws
 - 2. Qualifications were inadequate
 - 3. No collaborating physician
 - 4. Other (please specify) _____
 - 5. Not applicable
19. If you work for a state or local department of health, how important would it be for you to have the ability to prescribe medication for patients?
- 1. Very important
 - 2. Important

3. Ambivalent about the issue (or no opinion)
 4. Very unimportant
 5. Not applicable
20. To what extent has the lack of prescriptive authority for nurse practitioners resulted in delays in treatment for your patients?
1. No delays due to lack of prescriptive authority
 2. Brief delays
 3. Moderate delays
 4. Long delays, but no significant impacts on patient health
 5. Long delays, with significant impacts on patient health
21. What effect would the extension of prescriptive authority to nurse practitioners have on your ability to care for patients?
1. Greatly enhance
 2. Moderately enhance
 3. Slightly enhance
 4. No effect
 5. No opinion
22. If nurse practitioners were to be granted the authority to prescribe drugs, which of the following conditions would you consider to be acceptable limitations on that authority? (please check all that apply)
1. Prescriptive authority limited to drugs used in the nurse practitioner's specialty area
 2. Prescriptive authority limited to drugs specifically agreed upon with the nurse practitioner's supervising physician in a written protocol
 3. Prescriptive authority which excludes drugs with high potential for abuse (for example Schedule II drugs and all narcotics and tranquilizers)
 4. Other acceptable restrictions (please specify) _____

23. How important would the ability to directly bill third party payers for nurse practitioner services be to your practice?
1. Very important
 2. Important
 3. Ambivalent about the issue (or no opinion)
 4. Unimportant
 5. Very unimportant
24. Have you ever been named in a malpractice suit which was associated with your role as a nurse practitioner?
1. Yes
 2. No
25. Has a malpractice verdict ever been entered against you based on any action(s) you may have undertaken in your role as a nurse practitioner?
1. Yes
 2. No

26. Has a malpractice verdict ever been entered against any physician with whom you have collaborated, based on any action(s) you may have undertaken in your role as a nurse practitioner?
 1. Yes
 2. No
27. Have you ever been subject to disciplinary procedures for quality of care issues by state, local or hospital authorities based on any action(s) you may have undertaken in your role as a nurse practitioner?
 1. Yes
 2. No
28. Do you currently carry professional liability (malpractice) insurance?
 1. Yes
 If "Yes", please indicate which type(s) of insurance coverage you have:
 a. Personal policy
 b. Employer policy
 2. No
29. Is the availability or cost of malpractice insurance currently a barrier to your practice as a nurse practitioner?
 1. Yes
 2. No
30. How would you characterize the attitude of physicians you know about the involvement of nurse practitioners in the provision of patient care?
 1. Very supportive
 2. Supportive
 3. Physicians are uninterested in the issue
 4. Mildly opposed
 5. Very opposed
 6. No opinion
31. In working with physicians how do you perceive your advanced nursing role?
 1. Function independently
 2. Function with supervision
 3. Function collaboratively
32. In your nurse practitioner practice, how many physicians do you collaborate with in the evaluation and management of your clients' health care needs?
 1. One physician
 2. More than one physician
33. If you collaborate primarily with one physician, how are the protocols established for the evaluation and management of disease states?
 1. Jointly developed and agreed upon by the physician and nurse practitioner
 2. Physician developed
 3. Nurse practitioner developed; physician concurrence
 4. Other (please specify) _____

34. How would you characterize the attitude of hospital and/or clinic administrators you know about the involvement of nurse practitioners in the provision of patient care?
- 1. Very supportive
 - 2. Supportive
 - 3. Administrators are uninterested in the issue
 - 4. Mildly opposed
 - 5. Very opposed
 - 6. No opinion
35. Have you had difficulty in finding physicians with whom to collaborate in practice?
- 1. Yes
 - 2. No
36. If you have had difficulty in finding collaborating physicians, what in your opinion has been the most significant reason?
- 1. Few or no physician(s) in your specialty in your local area
 - 2. Lack of physician interest in collaboration for primary care
 - 3. General lack of need for primary care in the area
 - 4. Lack of Third party reimbursement for nurse practitioners
 - 5. Responsibility and malpractice concerns
 - 6. Other (please specify) _____
-
7. Not applicable

**IF YOU HAVE NEVER WORKED AS A NURSE PRACTITIONER,
PLEASE STOP HERE.**

37. Has a physician ever tried to limit the nature and scope of your practice as a nurse practitioner?
- 1. Yes
 - 2. No
38. Has a physician ever refused to accept patient referrals from you?
- 1. Yes
 - 2. No
39. Are you aware of any instances where a physician has refused to refer patients to you?
- 1. Yes
 - 2. No
40. All of the following are nurse practitioner activities, which one do you spend the majority of your time in?
- 1. Diagnosing and treating
 - 2. Patient teaching
 - 3. Documentation and paper work
 - 4. Managing patient medications
 - 5. Providing coverage for a physician
 - 6. Administrative duties

41. What patient conditions are seen in your practice? (please check all that apply)

- 1. Minor, acute illness
- 2. Health promotion/screening
- 3. Family planning/Obstetrical care
- 4. Stable, chronic illness
- 5. Emergency care
- 6. Other (please specify) _____

42. What is the age range of the majority of patients seen in your practice?

- 1. Children
- 2. Adolescents
- 3. Young Adults
- 4. Middle/Older Adults
- 5. All age ranges

43. How do you derive your income?

- 1. Salary
- 2. Fee for service
- 3. Percent of practice income
- 4. Other (please specify) _____

44. What is your annual salary range?

- 1. \$16,000 - \$20,000
- 2. \$21,000 - \$25,000
- 3. \$26,000 - \$30,000
- 4. \$31,000 - \$36,000
- 5. \$37,000 - \$42,000
- 6. \$43,000 - \$50,000
- 7. greater than \$50,000
- 8. Other (please specify) _____

45. How do the majority of your patients pay for your services?

- 1. "Out of Pocket"
- 2. Insurance reimbursement
- 3. Medicaid
- 4. Medicare
- 5. Other (please specify) _____

46. Which of the following best describes charges for your services?

- 1. Same as physician
- 2. Less than physician
- 3. Other (please specify) _____

47. Do you make house calls?

- 1. Yes
- 2. No

48. Are you on-call for patient services?

1. Yes

2. No

49. Are you utilizing all of your advanced practice knowledge and skills?

1. Yes

2. No

If "No", please explain _____

50. In total, how many years have you worked as a nurse practitioner? _____

51. In what zip code area is your main practice setting located? _____

Thank you for your time and participation.

Please have a cup of tea on us!

APPENDIX C

Verbatim Comments From Nurse Practitioners Who Responded "NO" to the Question
"Are you utilizing all of your advanced practice knowledge and skills?"

- "Limited treatment - mostly diagnostic - referral"
- "I primarily do supervision and administration - very little patient care"
- "Limited by practice setting"
- "Limited by scope of physician protocol"
- "Unable to insert IUDS now - or endocervical biopsies"
- "Lack of ability to prescribe medications"
- "Typically NNP's function in an intensive care setting, I was in well-baby nursery"
- "Depended on how many physicians were available"
- "The agency I work for is poorly, if at all, organized and there seems to be little understanding of effective use of personnel - I do more clerical work than anything else."
- "Relocated here due to NHSC payback - none of my advanced skills utilized in setting. "[Used]" more as a general duty RN and to cover non existent M.D.s, and for community health center in Alabama to obtain Federal grant money, ie NHSC functioning requires main primary care givers be midlevels. The community health centers utilized me to have my name and license appear on paper. I intend to relocate out of this State ASAP permanently. It is virtually impossible for any qualified nurse practitioner to practice in this archaic environment."
- "Limited to students - no peds"
- "Limited to young adults"
- "I am very frustrated because of lack of job opportunities in my geographic area and lack of support for nurse practitioner practice."
- "I am certified as a FNP working predominantly as OB/GYN NP"
- "Would like to **R**"
- "I am qualified to do OB U/S, perinatal bereavement counseling and have other skills not utilized at this time."
- "No in-hospital utilization"
- "↓ health promotion, disease prevention; ↑ acute care visits/medicine!"
- "no longer inserting IUD's - unable to treat minor problems due to lack of medicine in clinic since NP do not have **R** writing authority. We NP in the Health Dept. need it very much for the health/well being of our patients."
- "Utilizing all knowledge and skills"
- "Major experience was acute care"
- "Occasionally fill in for NPS"
- "AI has not addressed suturing minor laceration or I&D of wound with FB(minor)"
- "Very little illness care or treatment"
- "Limited Health promotion"
- "Need prescriptive privileges and way to code basic labs and x-rays"
- "Due to working assigned area (Hospital/Adult)"
- "Used to practice mainly in OR's"
- "Mainly involved in teaching residents as medical students"
- "Physicians limiting my practice due to economic pressure from NP's they don't want any competition for health care dollars!"

- "Lack of opportunity to work with family practice physician"
- "Limited to VA"
- "Protocols limit treatment of a lot of minor problems (Gyn)"
- "I feel very limited ..."
- "I may utilize approximately 1/2-2/3 of my knowledge and skills"
- "Primary care skills not fully utilized"
- "I do no OB care at present"
- "Limited practice due to clientele also unable to suture, etc in setting-physicians do that"
- "Time factor prevents my utilization of certain skills"
- "Limited by clinic practice could do more with hospital privileges"
- "do not use fertility or general medical skills"
- "We have to turn patients away who have Blue Cross/Blue Shield and want to see me because they will not allow physician extenders to see their patients and bill"
- "I mainly do OB/Gyn and I am a FNP-also with checking patients in health department and finding a problem and not being able to treat because of non Rx authority"
- "Certified in OB/Gyn-utilize primarily OB skills"
- "Hold ACLS certification-have not needed to utilize"
- "I am limited in the use of my diagnostic and treatment skills. Because I can treat so few problems my clinic is geared to health promotion, family planning and screening. I enjoy health teaching and family support, but it is frustrating to have a patient with a problem, to diagnose, and then ask them (while they are suffering!) to go someplace else and wait for hours for a prescription for a simple antibiotic"
- "Clinic practice is limited to well women, gyn family planning. I do not provide any OB/prenatal care"
- "Limited by not having prescriptive privileges"
- "Limited practice 2 to lack of 3rd party payment"
- "My employer is working to utilize all of my varied skills as a 2nd career in nursing I came to the BSN program with a varied background. Since my BSN and MSN I have also gained much experience outside the realm of NP"
- "Resources are limited, equipment is limited in my clinic"
- "Procedures such as suturing, biopsy, etc. aren't used much"
- "Very frustrated. Trained as family nurse practitioner but limited to primary women's health"
- "Was trained as a FNP-I work only with adults/elders. However, I am using my adult health background and more. I am very concerned that NP programs are not preparing NPs enough. I believe we need to lengthen nurse practitioner preparation and require more in terms of clinical experience, management decision, pathophysiology, pharmacology, and clinical laboratory medicine"
- "Restricted by inability to prescribe and order various test"
- "Treatment of minor lacerations/suturing prescribing of drug treatment using MD signed prescriptions"
- "I do not give intrapartum care, just antepartum, Gyn and well child care"
- "Provide primary care on limited basis only"
- "Little"
- "Presently I am providing family planning services to women. My educational experience is in family practice"

- "presently not working on any research"
- "Certified as adult practitioner-practice limited to family planning"
- "Prescriptive authority, ability to order test, independent patient caseload"
- "Health department allows limited services"
- "Treatment of chronic illness's - managing usually see acutely ill"
- "Procedures such as IND insertion"
- "Need Rx authority in some form"
- "Could do more complete physical exams"