Ethical *and* Legal Issues *for* Doctoral Nursing Students

A Textbook for Students and Reference for Nurse Leaders

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To our husbands,
Nathaniel W. Peirce, EdD
and
Daniel H. Smith, MD
for their constant support and encouragement.

Contents

Preface

Advanced practice nurses and researchers prepared at the doctoral level must be equipped with specialized knowledge and skills in all aspects of medical, research, legal and business ethics relevant to evidence-based practice and research in underserved and other populations. The editors of this text realized the need for such content after completing an article together in 2008 for the *Journal of Professional Nursing,* "The ethics curriculum for doctor of nursing practice programs" (24(5): September–October, 270–274).

Traditional bioethics content often does not address these issues and therefore there is need for an expanded view of required ethics content in the curriculum of Doctor of Nursing Practice (DNP) and PhD programs nationwide. Thus, we have edited this new textbook, *Ethical and Legal Issues for Doctoral Nursing Students: A Textbook for Students and Reference for Nurse Leaders.* In today's healthcare workplace, whether in practice, academia or in research settings, doctoral nursing students and faculty may face the following ethical dilemmas:

- Determining that a bodega (Spanish market) owner was selling unprescribed antibiotics over the counter
- Voting, as part of a committee, on whether a noncompliant patient deserved a second liver transplant
- Being asked by a collaborating physician to collect clinical information before IRB and HIPAA forms were completed
- Having to care for a child who was declared dead but whose parents refused to allow the ventilator to be shut down
- Deciding how to handle a suspected case of billing irregularity

These examples demonstrate that the rapidly expanding scope of advanced practice requires doctorally prepared-advanced practice nurses and nurse researchers to make more complex ethical decisions, often without the necessary background to do so competently and comfort-

ably. This curricular gap can have serious consequences in access, quality and patient safety and can also mean that nurses may not be able to fully contribute to the ethical decision-making process. DNP and PhD graduates must understand how the legal definition of death, assisted suicide and euthanasia may affect medication prescription and decisions about site of care. DNPs and PhDs must fully comply with HIPAA regulations and understand how the Stark Acts and the False Claims Act affect their practices. Medicare, Medicaid and private insurer reimbursement also requires a deep understanding of how coding irregularities might be considered fraud. As is true with clinical knowledge, traditional APN or undergraduate nursing ethics curricula do not reflect the expanded vision needed to practice in the twenty-first century. Nursing education at the doctoral level necessitates stronger ethical knowledge and application in clinical practice.

By the year 2015, nurse practitioner education will transition from the master's level to the doctorate. This represents a fundamental change that will require a curriculum that reflects the advanced level of a doctoral degree program. PhD nursing programs also require an advanced level of ethical education. This text will utilize a definition of nursing ethics which includes elements of medical, legal, research and business ethics. The expanded content is taught within one major core course and provides a foundation for all major courses.

The rationale for expanded expertise is based on five premises that directly influence health care quality:

- As the scope and independence of practice of DNPs have expanded, so too have ethical dilemmas that directly influence such practice. There are major, unaddressed ethical dilemmas that influence DNPs' ability to provide quality care to all. Consider that as part of a transplant team, DNP-prepared nurses may directly influence who is placed on organ transplant lists.
- Knowledge of bioethics, with its focus on patient care and research, is important but not sufficient for DNP practice. Nurses who practice at an advanced level must also understand other ethical frameworks, including legal and business arenas. Coding practices may influence reimbursement as well as patient costs. A nurse prepared at the DNP level must understand the ramifications of under- and over-coding.
- As health care becomes more interdisciplinary, DNPs must understand how different ethical frameworks impact the workplace. Having an expanded foundational base for ethical decision-making

will increase the DNP's ability to participate at the highest level with multiple professions.
- There are tremendous issues of access and disparity in care provided to the underserved. These problems are directly influenced by ethical reasoning and in turn lead to further ethical discourse. Knowledge of funding mechanisms and cultural differences are necessary but not sufficient to solve these problems. These issues will not be solved by health professionals who do not have a firm grounding in ethics.

We believe that *Ethical and Legal Issues for Doctoral Nursing Students: A Textbook for Students and Reference for Nurse Leaders* will help guide faculty and students in the complex healthcare arena faced by both.

Throughout this text, the LACE (Licensure, Accreditation, Certification and Education) 2008 APRN Consensus Model definition of advanced practice nursing is used. The model was developed by the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee with input from the stakeholder communities. There are four roles defined in this model: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner. When the title APRN is used in the text, it represents all four of these roles.

The contents of the book reflect current knowledge and legislation. We would like to thank all the authors for their thoughtful and wise contributions to this volume.

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CHAPTER 1

Ethics: What it is, What it is Not and What the Future May Bring

ANNE G. PEIRCE

1.1. OVERVIEW

It must be asked who in the health care system will protect the vulnerable and what knowledge and resources are needed for that protection. If not nurses, than whom?

The ethics of care has been a strong thread in the fabric of nursing. We have advised patients, negotiated with families, and argued for and against treatment, all in the name of nursing care. These singular efforts have not been in vain, but are not enough for the changing role of advanced practice nurses. Nurses at the forefront of advanced practice (APRNs) must have an in-depth knowledge of the foundations of ethics in order to understand the future of ethics and how to best apply current ethics knowledge in the health care arena. With in-depth knowledge of ethics comes the voice to assist patients when needed and to speak for them when they cannot, as well as to ensure fiduciary and legal compliance (Peirce and Smith, 2008). APRNs today cannot, and should not, only be employees who carry out bioethical decisions made by others. Doctorally prepared nurses, either in practice or research, must be the leaders to their colleagues, students, and other members of the healthcare team. This chapter will discuss the earliest writings on ethics as well as the newest work on neuroethics. This background can then be used as foundation for the chapters to come, where specific patient populations and situations are explored by experts in those areas.

Ethics, bioethics, morals, morality and even the law have overlapping definitions and in fact may sometimes be used interchangeably. The following are brief definitions of some of the major terms used in this chapter:

ETHICS: A theory or system surrounding moral practices and beliefs. Ethics is also called the philosophy of morality or moral philosophy.

MORALITY: A specific judgment about actions or character. It is sometimes used to define right and wrong actions.

MORALS: A standard of behavior used to define a good act or action.

BIOETHICS: Applied ethical inquiry and moral responses specific to health care.

NORMATIVE ETHICS: The study of the norms that make an act right or wrong.

VIRTUE ETHICS: The aspects of the human character that makes actions right or wrong.

UTILITARIANISM: The doctrine that an act is right if it produces happiness or benefits. It describes ethical acts that produce the greatest good for the greatest number of people.

DEONTOLOGY: The ethical approach regarding adherence to rules and obligations regardless of consequences.

PRAGMATIC ETHICS: This approach is situation dependent. In pragmatic ethics, all ethical dilemmas and their solutions are modifiable if the situation warrants.

NEUROETHICS: The view that some ethical decisions are intuitive and may be automatic, deriving in part from our genetic backgrounds and neural processing.

1.2. HISTORICAL VIEW

1.2.1. Greeks

The earliest Greek philosophers, including Plato, Socrates and Aristotle, explored the questions that we ask today: what is a good life and what is needed to live such a life? A significant part of that early discussion focused on virtue. Aristotle (384–322 BC), in the Nicomachean Ethics, wrote that a good life is living a life of virtue (Aristotle, 1980). To Aristotle, the virtues of a life well lived were somewhat dependent upon role. Whereas a soldier might need the virtue of courage, a nurse might need the virtue of compassion. He did, however, acknowledge the importance of core virtues needed by all, such as justice and wisdom (Pellegrino and Thomasma, 1993). Today, nurses continue to be influenced by Aristotle; just consider that undergraduate fundamentals and professionalism books often contain a list or description of the implied virtues of nursing, including but not limited to caring, honesty, and integrity (Chitty and Black, 2011).

Aristotle distinguished between moral and intellectual virtues (Aris-

totle, 1980). The former is knowledge based and the latter is character or habit based. To have a good life, it was important to both know what was good and act in ways that affirmed that good. But this thought of goodness, or what Aristotle called eudaimonia, is a term that is not fully captured in translation. In part, Artistotle referred to the need for balance, or the Doctrine of the Mean (Armstrong, 2007; Kuczewski and Polansky, 2000). The Doctrine of the Mean is evocative of the Eastern philosophies in which balance, evidenced by the concepts of yin and yang, underlie health and wellness. Aristotle considered that there is a necessary balance, and someone who is too virtuous can be as problematic as someone who is not at all.

Aristotle believed that there is a difference between being virtuous and acting virtuously. If one's character is virtuous, then one's action will be the same—it is part of the whole. However, a non-virtuous person can be taught to act in a virtuous way through education, and in time achieve the habits of virtue. To do what is right for the right reasons, to the right extent, to the right person and at the right time is goodness (Armstrong, 2007).

1.2.2. Romans

Similar to the Greeks, Roman Stoics considered virtues critical to a well-lived life. They perceived these virtues as so embedded in human life that they became a form of natural law. The notion that there are laws of nature that provide a guiding force is something we consider today as well (Baltzly, 2010). The human abhorrence of murder could be considered a reflection of natural law, as could the instinctive reaction to incest. These forms of natural law virtues are seen by biologists, most notably Wilson (2007), as critical to genetic survival. Sociobiologists see the value of cooperation and altruism in increasing fitness for survival. They point to the presence of cooperation and altruism in both animal and human behavior as evidence of its deep-rooted presence in nature (Houchmandzadeh and Vallade, 2012; Roughgarden, 2012).

Natural law has at least two important ethical doctrines that were defined by later thinkers. One is the Doctrine of Double Effect, which is credited to Thomas Aquinas (Moore, 2011). This doctrine proposes that if an act has two expected results, then both should be considered in making the decision (McIntyre, 2011). The use of morphine to reduce pain (primary effect), with its known effect of respiratory suppression (secondary effect), is a classic example.

The second doctrine of natural law is the Principle of Totality (Moore, 2011). Stoics, and later religious philosophers, believed that when we

are whole, we are perfect. Cicero wrote that "The primary duty is that the creature should maintain itself in its natural constitution; next, that it should cleave to all that is in harmony with nature and spurn all that is not . . ." (Cicero, 1914).

This principle of totality would indicate that health care should only occur in instances when that wholeness is threatened. For example, surgery for illness or trauma would be considered permissible under the Principle of Totality. Surgery to alter the body for cosmetic reasons would not meet the strictest standard of natural law. The Principle of Totality may become even more important in the future as medical research allows us to consider the possibility of genetic enhancement. The debate as to whether it is good for humankind is bound to echo the early work of the Stoics.

1.2.3. Hippocrates, Galen and Maimonides: Physicians as Philosophers

"As to diseases, make a habit of two things—to help, or at least to do no harm. The art (sic) of medicine has three factors: the disease, the patient, and the physician. The physician is the servant of the art. The patient must co-operate with the physician in combating the disease." (Hippocrates quoted in Bartz, 2000, p. 14).

The time of Hippocrates (460–370 BC) was one of magic as well as medicine. Hippocrates sought to codify the acts of medicine in order to prevent harm by charlatans. Early physicians were compelled to write about basic behaviors of physicians in order to create a moral or ethical bottom line. Many of these writings are attributed to Hippocrates, a contemporary of Socrates, who lived around 460 BC. His approach to medicine was one of vigilant watchfulness, allowing healing to occur naturally, but if it did not, to wait to intervene until it was clear that healing would not occur without intervention (Bartz, 2000).

Galen (131–200 AD) is considered one of the greatest physicians of all time. His influence on medicine remained strong up to the time of the Enlightenment. Of all his contributions, his work on the circulatory system was the most important. In addition to his work as an anatomist, Galen was also a philosopher. In fact, he wrote a treatise entitled *The Best Physician is also a Philosopher* (Drizis, 2008). His ethical focus, derived from the works of Hippocrates, was on the duties of the physician and not the patient-physician relationship.

At a later time, Maimonides (1138–1204) wrote similarly about the virtues of medicine (Nuland, 2006). A disciple of Galen and Hippocrates, he sought to solidify his religious life with his practice of

medicine (Collins, 2007). The duty of medicine was important to Maimonides because a healthy body was important to God. He did not think that prayer alone was enough to restore health. He also wrote of the importance of knowledge to the patient. While knowledge is important to autonomy, Maimonides did not see patients as fully autonomous but rather as somewhat dependent upon the knowledge of the physician and the will of God (Collins, 2007; Gesundheit, 2011).

1.2.4. Western Philosophy and Ethics

To the early European philosophers, moral goodness was less about education and character and more about faith. Important contributions to the thinking about ethics reemerged in medieval times with the writings of St. Thomas Aquinas and St. Augustine. Aquinas sought to reconcile the virtue ethics of Aristotle with the theological virtues of the Christian church. To Augustine and Aquinas, the duty to God as manifested in faith, hope, charity and obedience, were more important than the reasoned life advocated by Aristotle (Pellegrino and Thomasma, 1993).

The 17th century was a time of great philosophical debate. Labeled the Enlightenment or the Age of Reason, it was dominated by European philosophers, many of whom were also scientists. This group, including Spinoza, Locke, Newton, Rousseau and Voltaire, advocated the primacy of science in explaining the world around us. With this new world view, the notion of unreasoned action was questioned. If murder was a sin, why was the taking of life in war not the same? The dialogue between the obedience to God and the reasoned action according to conscience continues today as evidenced by the early discussions surrounding AIDS when it was seen by some as a punishment for sinful behavior.

1.2.5. The Reformation, Kant and Deontology

Immanuel Kant (1724–1804) is credited with the development of one of the major ethical schools of thought that of deontology or what is sometimes called rule-utilitarianism (Kant, 1998). Writing after the time of the Reformation, he conceptualized *Moral Law* as not so much a replacement of Divine Law, but as an outgrowth. Kant was raised as a deeply religious conservative Protestant but began his career as a mathematical physicist. He later turned to the broader questions of philosophy. He strove to identify those actions or virtues that can be universally accepted. Kant wrote of the Moral Imperative, saying that

there are certain acts that all agree are right. According to Kant, if one knows of these acts, then one should follow them. Kant's basic premise was that "A person ought to act in accordance with the rule that, if generally followed, would produce the greatest balance of good over evil, everyone considered." (Mappes and DeGrazia, 2001, p.13). He focused on adherence to the rules but not the consequences of such adherence. Kant argued instead for the respect of rules as guiding forces as long as they are universal in acceptance or can be universally accepted. In other words, one's actions should be such that they could serve as a model for universal law if everyone were to adopt them. A high standard indeed!

Kant's influence on ethics can be summarized as follows (Blackburn, 2001; Johnson, 2008; Kant, 1998; Rohlf, 2010):

1. Ethics should not be concerned with consequences of the act but with duty to the act (rule adherence).
2. The right act can be universalized. Others can and should act in the same way.
3. The right act treats humans as ends in themselves, not as a means to an end.
4. The right act is a rational act, not a habit but rather one of free will.

1.2.6. Mill, Bentham and Utilitarianism

While Kant wrote that duty to laws and rules was more important than the outcome of that duty, not all philosophers concurred. There were many who felt that the consequences of actions do matter. To ignore the consequences seemed wrong-sighted when such acts could result in harm. As a result, the consequentialist or utilitarian view evolved. The consequentialists said that the outcome was what was important; therefore the right actions that lead to the wrong outcome was the wrong thing to do. The two main proponents of this thinking were Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873).

Bentham's Utilitarianism was based on the notion of pleasure, or 'happiness', as the ultimate good (Bentham, 1861). To Bentham, acts that bring happiness are morally better than those that do not. In general, we now understand the Utilitarian view, not as Bentham did in terms of the individual but rather as the collective decisions whose actions bring the greatest good to the greatest number of people. The utility of the act is the happiness, pleasure, or goodness that it produces.

John Stuart Mill expanded upon the work of Bentham, considering not only the amount of pleasure but the quality of the pleasure (Mill,

1971). To Mill, some pleasures were worth more than others. The more a pleasure contributes to a human's growth—whether it be intellectually, spiritually or aesthetically—the better the quality of that pleasure. For example, the pleasure obtained from a successful work day as a nurse may be of better quality than a night spent in a bar, even though both could bring pleasure. Mill argued that it is also the long-term outcomes of such acts that are important. Thus moral guidelines that are developed should be devoted to maximization of pleasure and minimization of pain.

While Bentham and Mill focused on pleasure, in health care we use the notion of health utility to examine what health care actions produce the greatest good for the greatest number of people (Ahronheim, Moreno, and Zuckerman, 2000; Faden and Shebaya, 2010). Is it better to provide free immunizations for those who can't afford them or to rely on the herd response from those who can afford to be immunized? In the utilitarian view, costs (financial and otherwise) would be considered in relation to the benefits derived.

Utilitarianism can be summarized as follows (Beauchamp and Childress, 2008; Bentham, 1961; Blackburn, 2001; Driver, 2009; Mill, 1871):

1. Consequences are of ultimate concern. Intentions are only as important as the consequences they produce.
2. The more people who benefit from the consequences the better.
3. The best consequences produce pleasure or what the person desires.
4. Each person's consequence is important but no more important than another's.

1.3. ETHICS IN HEALTHCARE

Ethical dilemmas in the health care system are different from those in other professions, such as education and business. This has to do, in part, with the life and death results that may flow directly from any given decision and also from the sense that health care decisions should be made in such a way that reflects care for the group as well as the individual.

Many of the codes of ethics that guide health care share a history with research codes of ethics. The first general code of ethics grew out of the Nuremberg trials following World War II, when the world was first alerted to the human devastation wrought by Nazi doctors and

nurses (Benedict and Kuhla, 1999; Mappes and DeGrazia, 2001). The trials uncovered evidence of the horrible experiments done on humans in the name of science. As a result, the following code, still used today, was developed. Its ten tenets (ORI, 2012) are:

1. The voluntary consent of the human subject is absolutely essential.
2. The experiment should be such as to yield fruitful results for the good of society.
3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
8. The experiment should be conducted only by scientifically qualified persons.
9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

Following the Nuremberg Code, the Declaration of Helsinki sought to clarify and strengthen protection of humans. This document underscores the fundamental importance of human self-determination in participation in research. It also emphasizes the role the researcher has in protecting the individual in the process, as well as the care that must be given to vulnerable populations under study (Bulger, Heitman and Reiser, 2002). The Belmont Report, put forth by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral

Research in 1979, first identified three principles important with human research as being respect for persons, beneficence and justice (Bulger, Heitman and Reiser, 2002).

In addition to concerns with human research, the development of bioethics was driven by the technological advances of the 20th century. Antibiotics, the heart-lung machine, organ transplants, in vitro fertilization and other discoveries changed the health care landscape from one where nature had the last word to one where life could be prolonged and altered. It wasn't until 1968 that the Harvard Medical School first defined brain death in conjunction with transplants. At that time brain death, labelled irreversible coma, had three major criteria: unresponsiveness to painful stimuli, no movement and no reflexes (Ad Hoc Committee, Harvard, 1968).

1.3.1. Ethical Principles

Four major ethical principles have been identified as critical in health care by Beauchamp and Childress (2008). These so-called major bioethical principles are autonomy, beneficence, nonmaleficence and justice. While these four principles are considered foundational, there are others that are also important. Ross (1930) speaks to prima facie duties that include fidelity, reparation, gratitude, and self-improvement. Other writers have added veracity and even care (Held, 2005; Thomasa, 2008).

1.3.2. Autonomy

Provision One of the ANA Code of Ethics for Nurses (Fowler, 2010) states that:

> *"The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems." (p. 1)*

Autonomy is the notion that competent adults have the right of self-determination and this right should be respected by health care providers. Many ethicists consider autonomy to be the major overriding bioethical principle (Fry and Veatch, 2006). That is, adults have the right to decide what health care they want, as well as when, how and who will be involved in that care. It is taken for granted by most that no competent adult can be forced to have surgery or to undergo treatment if they do not want to do so. In fact, the ideal of autonomy posits that

adults do not even have to seek care. In reality, the concept of autonomy is not so absolute. Tuberculosis patients can be forced into care if they are contagious, and soldiers can be forced to be immunized.

In another deviation, children are not generally considered fully autonomous agents until they reach the age of 18. But even legal age is fungible and has changed over time. For example, an emancipated minor is in a different legal class than one who is not. A child undergoing surgery may not give consent but rather assent. The nuances of ethics and children's health care are more fully explored in Chapter 6.

Although autonomy is defined as self-determination or self-governance, there are qualifiers even for competent adults. To be autonomous and be able to self-govern health care decisions, an individual must have the will to do so and also the intention, understanding or knowledge, and freedom from extensive internal and external constraints. In other words, to qualify as an autonomous act it must be an intentional act, a knowledgeable act and the person must want to act in the way he or she did (Beauchamp and Childress, 2008). An accident is not an autonomous act. Nor is a person who agrees to experimental treatment without fully understanding the side effects acting autonomously, or thoughtfully. In the rush and confusion of hospitalization it is not unusual for accidental or non-autonomous decisions to be made. Decisions may be made without complete information or real understanding of what the information means. Research subjects may not truly understand what random assignment implies; that they may not receive the experimental treatment. Surgical patients may not comprehend the unintended consequences of surgery. Understanding may be best thought of as a continuum, in which the goal is to achieve as complete an understanding as possible.

There are other barriers to autonomous actions. In fact, it may not always be a singular decision made by an individual; sometimes autonomous-type decisions are shared by family and patient or by patient and provider. Other external barriers may include judicial laws and physical restraints. Internal constraints may result from substance abuse, psychological disease or pain. Thus autonomy becomes the desired ideal, but not always the realized ideal.

Informed consent is an everyday occurrence representative of the principle of autonomy. When patients sign an informed consent document, it is assumed that they do so of their own free will, with an understanding of what is involved, and free from any constraints in coming to their decision. In reality, an individual may not fully understand what is involved and it also may not be possible to explain every possible outcome. Patients may feel obligated to consent because of pressure

from their physicians or family or they may be signing in times of pain or other physical constraints to autonomy.

1.3.3. Beneficence

According to Beauchamp (2008), the word 'beneficence' implies mercy, kindness and charity. While beneficence is the act, the moral virtue is benevolence. Many philosophers have explored what beneficence means in life. The philosopher David Hume (Morris, 2009) thought that beneficence was a central principle of human goodness, while Kant saw it as a duty (Kant, 1998). More recently, Beauchamp and Childress (2008) wrote of two aspects of this principle—positive beneficence and utility beneficence—both of which are important to bioethics.

Positive beneficence refers to the principle that individuals have positive obligations to others (Beauchamp and Childress, 2008). Beauchamp and Childress give examples of positive beneficence, including rescuing people in danger, helping people with disabilities and so forth. They refer to these as moral rules of obligation.

There has been much recent discussion about moral obligations and how far they extend (Scheffler, 1997). In general terms, it appears that individuals feel more obligated to those with whom they are close in terms of friendship, kinship or proximity and less obligation is felt to those further away (Murphy, 1993). Some modern philosophers see this as wrong and write that our concern should be for every human soul, not just the ones we may know (Singer, 1972; 1999). Singer is a strong advocate for the general obligation of beneficence—to do what is good no matter our relationship. Other writers speak of situational or specific beneficence where one's obligation is only to those known (Murphy, 1993). There may be limits to our obligation to be beneficent. No one has the perfect gift of time, money, strength, and compassion to meet all needs, yet that is what beneficence would ideally have us do.

We all want health care providers to do good and contribute to the overall welfare of patients. Within the professional nursing role there is an obligation, a duty to provide care. This also implies there is a duty to beneficence, although this is not directly stated in the ANA Code of Ethics. In part, the duty of beneficence is a reflection of reciprocity (Rawls, 1971). Nurses are paid to care, or at least to provide care, thus illustrating reciprocity. Within that arrangement, care is the unspoken obligation to work towards the welfare of the patient. The social contract between patient and nurse is one that is focused on what is best for the patient, both because it is a paid obligation but also because it is a professional and societal expectation.

CHAPTER 9

Legal Issues for Advanced Practice Registered Nurses

ELIZABETH W. COCHRANE

This chapter is intended to provide APRNs with basic tools to allow them to understand and to stay abreast of the regulatory environment and requirements that will impact their own practices. As advanced practice registered nurses (APRN) continue to expand their scope of practice into areas that were previously reserved for physicians, APRNs will face increasing regulatory oversight and legal risk. Given the increasingly autonomous nature of APRN practice, APRNs have more responsibility and authority over their practice than do registered nurses. This results in a personal and professional mandate to stay current with legal and regulatory changes.

It is important to note that nothing in the following chapter is intended to be legal advice. APRNs have a responsibility to understand the legal framework in which they are operating, whether by their own research or by talking to legal and nursing professionals in their own jurisdiction. The Appendix to this Chapter provides a state-by-state analysis of the regulatory framework for nurse practitioners (as of the date of publication of this book). Given the rapidly evolving nature of advanced nursing practice and the oversight of advanced practice nurses, all APRNs should anticipate having to incorporate continued legal and regulatory education into their existing continuing education practices.

9.1. STATE REGULATION OF ADVANCED PRACTICE REGISTERED NURSES

The regulatory body that oversees APRN practice is generally a state's Board of Nursing. Illinois and Nebraska have created separate Advanced Practice Registered Nursing Boards to oversee APRNs. Other states have delegated APRN oversight to both the Board of Nursing and the Board of Medicine. These states include Alabama, Delaware,

Massachusetts, North Carolina, South Carolina, South Dakota, and Virginia.

States regulate APRNs through some combination of statute and regulation, each state with its own unique combination. A State's legislature may enact statutes to articulate the definition of licensure requirements, scope of practice and prescriptive authority of an APRN. These statutes are with one exception called Nurse Practice Acts. The exception to this is Michigan, which is the only state in the United States that does not have a Nurse Practice Act.

A state's legislature may delegate the authority to make rules and regulations governing the definition of licensure requirements, scope of practice and prescriptive authority of an ARPN to a state agency, such as the State's Board of Nursing. Statutes and regulations have equal weight from a legal perspective, but a regulation can never contradict a statute. This is why one may find more granularity in a state regulation versus a state statute.

9.2. ADVANCED PRACTICE NURSE PRACTITIONER SPECIALIZATION

As APRNs have expanded their roles into more specialized fields of care, there have been recent efforts by the APRN Consensus Work Group and the National Council of State Boards of Nursing's (NCSBN) APRN Advisory Committee to clarify titles and definitions of advanced practice through the Consensus Model for APRN Regulation. The Consensus Work Group's Licensure, Accreditation, Certification and Education Model (LACE) defines four APRN roles:

1. Certified registered nurse anesthetist (CRNA)
2. Certified nurse midwife (CNM)
3. Clinical nurse specialist (CNS)
4. Certified nurse practitioner (CNP)

The regulatory model proposed by the Consensus Work Group has a target implementation date of 2015. Many states have adopted these four APRN roles into their statutes and regulations, but others have yet to do so as of the date hereof (see Appendix).

As Boards of Nursing adopt this new regulatory language, nurses currently functioning as APRNs can expect that exemption of those already in the system (grandfathering) will occur. After the expected implementation of the LACE model, APRNs will be required to le-

gally identify themselves as APRNs plus the specific role; for example, APRN CNP and, if appropriate, a specialty role preparation such as oncology.

9.3. DEFINITIONS

The American Academy of Nurse Practitioners (AANP) defines nurse practitioners (CNPs) as licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. Standard definitions of the APRN roles of CNMs, CRNAs and CNSs are delineated below. Certified Nurse Midwives define their scope of practice as: "Midwifery as practiced by certified nurse-midwives (CNMs®) and certified midwives (CMs®) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections." (http://www.midwife.org/Our-Scope-of-Practice)

According to the American Association of Nurse Anesthetists, "Certified Registered Nurse Anesthetists (CRNAs) are registered nurses who have become anesthesia specialists by taking a graduate curriculum which focuses on the development of clinical judgment and critical thinking. They are qualified to make independent judgments concerning all aspects of anesthesia care based on their education, licensure, and certification. As anesthesia professionals, CRNAs provide anesthesia and anesthesia-related care upon request, assignment, or referral by the patient's physician or other healthcare provider authorized by law, most often to facilitate diagnostic, therapeutic, and surgical procedures. In other instances, the referral or request for consultation or assistance may be for management of pain associated with obstetrical labor and delivery, management of acute and chronic ventilation problems, or management of acute and chronic pain through the performance of selected diagnostic and therapeutic blocks or other forms of pain management." (http://www.aana.com/aboutus/Documents/scopeofpractice.pdf).

Finally, the National Association of Clinical Nurse Specialists offers the following definition: "Clinical Nurse Specialists (CNS) are licensed registered nurses who have graduate preparation (Master's or Doctorate) in nursing as a Clinical Nurse Specialist. Clinical Nurse Special-

ists are expert clinicians in a specialized area of nursing practice. The specialty may be identified in terms of population, setting, disease or medical specialty, type of care, or type of problem. Clinical Nurse Specialists practice in a wide variety of health care settings. In addition to providing direct patient care, Clinical Nurse Specialists influence care outcomes by providing expert consultation for nursing staffs and by implementing improvements in health care delivery systems. Clinical Nurse Specialist practice integrates nursing practice, which focuses on assisting patients in the prevention or resolution of illness, with medical diagnosis and treatment of disease, injury and disability." (http://www.nacns.org/html/cns-faqs1.php)

However, regardless of these standardized model definitions, there is no national standard definition of a nurse practitioner, as each state has its own definition and title for what it means to be a nurse practitioner. The variety of definitions between states is vast. Contrast the definition of an Advanced Practice Registered Nurse articulated by New York with that articulated by New Hampshire:

New York:

> *"The practice of registered nursing by a nurse practitioner, certifies under Section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols" (N.Y. Educ. Law § 6902.3(a)).*

New Hampshire:

> *"Advanced Registered Nurse Practitioner" or 'A.R.N.P.' means a registered nurse currently licensed by the board under RSA 326-B:18" (N.H. Rev. Stat. Ann. §326-B:2.I.).*

Whereas New York uses the title "nurse practitioner", New Hampshire uses "Advanced Registered Nurse Practitioner". Whereas New York provides authority to diagnose and treat in collaboration with a physician in the definition of the nurse practitioner, New Hampshire is silent on the scope of practice in the definition of an ARNP. The distinctions between these two states alone highlight why a nurse practitioner must be familiar with how their own state defines and titles advanced practice nurses. The website for each state's nursing oversight authority is found at the end of the chapter.

9.4. WHAT ARE THE CERTIFYING/LICENSURE REQUIREMENTS FOR ADVANCED PRACTICE?

All states have an interest in who is licensed and/or certified to provide health care. To be an advanced practice nurse, all states require current licensure as a registered nurse. Almost all states require national certification as well as minimum of a master's degree. However, there are no nationally applicable standards. The National Council of State Boards of Nursing is (NCSBN) trying to reduce the variability between states and is moving to have all states adopt the APRN Consensus Model regulatory requirements. If adopted, all states would require:

1. Graduate level preparation at either the masters or doctoral level
2. National Certification and recertification to demonstrate continued competence
3. Acquisition of advanced clinical knowledge with significant educational emphasis on the direct care of individuals in an acute care or primary care setting
4. A practice built upon the competency of the RN
5. Educationally prepared to assume responsibility and accountability of care
6. Clinical experience of sufficient depth and breadth

However, until such a time as the APRN Consensus Model Regulatory requirements are universally adopted throughout the United States, APRNS should consult with their own state's Board of Nursing to become familiar with applicable certification standards in their state.

9.5. WHAT IS AN APRN'S SCOPE OF PRACTICE?

The NCSBN in their model Nurse Practice Act defines the scope of nursing practice as:

> *"Practice of Nursing. Nursing is a scientific process founded on a professional body of knowledge; it is a learned profession based on an understanding of the human condition across the lifespan and the relationship of a client with others and within the environment; and it is an art dedicated to caring for others. The practice of nursing means assisting clients to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals within the context of a client*

centered health care plan and evaluating responses to nursing care and treatment. Nursing is a dynamic discipline that increasingly involves more sophisticated knowledge, technologies and client care activities." (NCSBN Model Nursing Practice Acts, page 3) (https://www.ncsbn.org/Model_Nursing_Practice_Act_March2011.pdf).

The NCSBN defines the scope of advanced nursing practice as:

"Practice of APRNs. Advanced practice registered nursing by certified nurse practitioners (CNP), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM) or clinical nurse specialists (CNS) is based on knowledge and skills acquired in basic nursing education; licensure as an RN; and graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN role and at least one population focus.

Practice as an APRN means an expanded scope of nursing in a role and population focus approved by the BON, with or without compensation or personal profit, and includes the RN scope of practice. The scope of an APRN includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing and ordering. APRNs may serve as primary care providers of record.

APRNs are expected to practice as licensed independent practitioners within standards established and/or recognized by the BON. Each APRN is accountable to patients, the nursing profession and the BON for complying with the requirements of this Act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience; planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate." (NCSBN Model Nursing Practice Acts, page 91) (https://www.ncsbn.org/Model_Nursing_Practice_Act_March2011.pdf)

These model definitions highlight that in general, the APRN scope of practice is an extension of nursing practice which allows for the diagnosing and treatment of disease. States vary as to scopes of APRN practice codified in their statutes and regulations. Again, statutes are created by state legislatures and rules and regulations are created by state agencies with authority granted to them by a state legislature. Again, it must be emphasized that statutes and regulations have the same force of law, but a regulation cannot contradict a statute.

The majority of states require nurse practitioners to have a collaborative relationship with a physician. Some states, such as California, only permit nurse practitioners to practice through standardized procedures developed in collaboration with physicians. Some states permit nurse

practitioners to practice autonomously without the need for collaboration or oversight from a physician. These states include Alaska, Colorado, District of Columbia, Hawaii, Iowa, Idaho, Maine (after 24 months of oversight), Montana, New Hampshire, New Mexico, Oregon, Rhode Island, Utah (apart from prescriptive authority for Schedule II-III controlled substances which requires consultant/referral plan), Washington and Wyoming.

Some states require direct physician supervision. These states include Florida, North Carolina, Oklahoma, Tennessee and Virginia. Some states only permit nurse practitioners to practice pursuant to authority delegated to them by a physician. These states include Georgia, Michigan and South Carolina.

Beyond the variety of requirements for physician involvement, states also vary in the breadth of practice afforded to advanced practice registered nurses. Nevada permits nurse practitioners the authority to suture lacerations. Arizona, Oregon and Washington permit nurse practitioners to admit patients to the hospital. Most states explicitly permit nurse practitioners to diagnosis and treat medical conditions. Some states explicitly permit nurse practitioners to refer, teach and order tests.

All of the 50 States and the District of Columbia grant nurse practitioners some form of prescriptive authority; however, the scope, nature and conditions of that authority vary from state to state. Some states do not permit nurse practitioners to prescribe controlled substances. (Controlled substances are narcotics, depressants, stimulants and hallucinogenic drugs listed on DEA Schedules I-V.) Others permit nurse practitioners to prescribe controlled substances without restriction, while some states permit nurse practitioners to prescribe controlled substances under the supervision or in collaboration with a physician.

It is critical for APRNs to understand what is explicitly permitted under their state's scope of practice. They should not act in the absence of explicit authority (either by statute, regulation or physician collaboration/delegation/direction). There have been physician challenges to APRN scope of practice. For example, in *Sermchief v Gonzoles* (660 S.W2d 683. (Mo 1984)), nurse practitioners in collaborative practice with physicians were charged with violating their scope of practice for performing routine gynecological exams and tests, but the court found that the nurse practitioners were acting within legislative standard of their practice. Since the 1980s, these challenges have been fewer and far between. However, in the absence of clearly defined statutory or regulatory authority, a nurse practitioner is vulnerable to challenges

that he or she is acting outside the scope of their practice and therefore practicing medicine without a license. Scope of practice is a major component in the analysis of medical malpractice claims against nurse practitioners, so it is vital that APRNs understand and function within the scope of practice in their individual state.

9.6. LEGAL ACTIONS AGAINST APRNs

In the litigious society of the United States, lawsuits are an unfortunate fact of life. The most common lawsuit brought against health care providers is a medical malpractice claim. A medical malpractice claim is (1) a tort that (2) alleges negligence. A tort is a civil wrong in which a person's actions or omissions have unfairly caused someone else to suffer loss or harm. A claim in tort may be brought by anyone who has suffered loss. Negligence is a legal theory that describes a failure to exercise the care that a reasonably prudent person would exercise in like circumstances.

To bring a medical malpractice claim against an APRN, a plaintiff has to prove:

1. *Duty:* The APRN owned the plaintiff a duty.
    a. An APRN has a duty to a person when there is a provider-patient relationship between the APRN and that person. While an office visit establishes an obvious provider-patient relationship, whenever an APRN provides professional advice or treatment in any setting (even over the phone), a provider-patient relationship may be established.
2. *Breach:* The APRN's conduct breached that duty (i.e., that the APRN's conduct fell below the standard of care)
    a. An APRN has a duty to act with a degree of care, skill and judgment that would be exercised by a reasonable nurse practitioner in the same or similar circumstances.
3. *Causation:* The APRN's conduct caused the plaintiff's injury.
4. *Harm:* The plaintiff was injured.

In order to succeed in court, the plaintiff must prove all of four elements of the claim (duty, breach, causation and harm). However, the plaintiff does not have to prove all four elements to file a lawsuit—they just have to be able to state that all four elements of the claim have occurred (i.e. that (1) the APRN owed a duty to a patient, (2) that the APRN's conduct breached that duty because the APRN did not act with

the degree of care, skill and judgment that would be exercised by a reasonable nurse practitioner in the same or similar circumstances, (3) that the APRN's conduct was the cause of the patient's injury and that (4) the patient was injured). While filing a false claim is against the law, there are very few deterrents to prevent an injured person from filing a claim if they truly believe that an APRN has committed medical malpractice. Even the commencement of a suit can be costly and harmful to an APRN's practice.

The vast majority of lawsuits are settled. Very few lawsuits reach the courtroom and even fewer reach a verdict. Therefore, in order to understand the landscape of lawsuits filed, one must take claims settled into consideration. One malpractice insurer, CNA, has published a recent study, "Understanding Nurse Practitioner Liability," surveying claims it paid from 1998–2008 for nurse practitioners. CNA highlighted that "a threshold issue in such litigation often is the express regulatory authority of a nurse practitioner to render certain types of patient care." Of the claims surveyed, 39% were related to diagnosis, 28.3% were related to treatment and 17.7% were related to medication. While scope of practice claims accounted for only 1.1% of claims, those claims had the highest paid indemnity of an average of $450,000, whereas the average diagnosis indemnity was $186,168 (National Service Organization, 2011).

Malpractice insurers are also required by federal law to report damage awards paid on behalf of medical providers (including nurse practitioners) to the National Practitioner Data Bank. Of all claims reported to the National Practitioner Data Bank, diagnosis-related, treatment-related and medication-related incidents are the top malpractice allegations, accounting for approximately 44% of all malpractice claims against nurse practitioners (Miller, 2011).

9.7. FEDERAL LEGAL ISSUES FOR APRNs

While states and their respective boards of nursing are the entities charged with overseeing and regulating nurse practitioners, APRNs may also have to comply with the requirements of the federal government in certain areas. The following provides a brief overview of some of the federal legal issues APRNs may face in their practice.

9.7.1. DEA Registration

If a state's scope of practice permits APRNS to prescribe controlled substances, they must obtain a DEA number in order to do so.

9.7.2. Medicare & Medicaid

Medicare, which is a federal program funded out of Social Security to provide health care primarily for the elderly, and Medicaid, which is a joint federal-state program that provides healthcare and long-term care assistance to those who fall below a certain income level, both allow APRNs to bill Medicare and Medicaid directly for services provided. However, if an APRN bills Medicare or a state Medicaid program directly for their services, the APRN will receive only receive 85% of the physician fee schedule (CNMs receive even less). If an APRN's services are billed by a physician as "incident to" the services of the physician, the physician's practice will receive 100% of the physician fee schedule for the service. However, in order to qualify for "incident to" billing, the ". . . services must be performed under the direct personal supervision of the physician as an integral part of the physician's personal in-office service. Such direct personal supervision requires that the physician initiate the course of treatment for which the service being performed by the nurse practitioner is an incidental part and that the physician remain actively involved with the patient's care. The physician must also be physically present in the same office suite and be immediately available to render assistance if necessary. In addition, the nurse practitioner must be employed by the physician (or be a leased employee)." (American College of Nurse Practitioners - http://www.acnpweb.org/what-incident-billing, see also, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Information_for_APNs_and_PAs_Booklet_ICN901623.pdf and http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0441.pdf)

In order to stem the rising cost of health care in this country, federal and state governments are aggressively pursuing fraudulent billing practices. APRNs must be familiar with the requirements of Medicare and Medicaid billing and should expect to have their reimbursements audited. APRNs should also become familiar with the Medicaid eligibility and billing requirements for their own state.

9.7.3. HIPAA

Medical records have strict guidelines as to who can access records, for what reasons, how and how long they must be stored. With the Health Insurance Portability and Accountability Act of 1996 (HIPAA), most health care providers have to take steps to protect patient con-

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