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Independent Licensure for Nurse Practitioners in Maine: Lessons in Passion, Patience, and Persistence

EDITOR'S NOTE

In recognition of the 50th anniversary of the nurse practitioner role, we are publishing the following article documenting Maine's legislative trials and successes for nurse practitioners (NPs). Most states have had similar experiences and we hope that NPs or the NP state organizations make an effort to write and preserve for their members a similar record of the state's struggles to implement and expand the NP's role.

This account is based on interviews with people involved and includes a review of legislative records and newsletters from organizations involved in the process.

IN MY OPINION

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NPs are a key to transforming health care in the United States. They bring a unique combination of caring, connecting, and education to health care. NP care emphasizes relationships along with science and this is what our ailing health care system needs. The role of NPs in this transformation will not be realized if we as NPs are only doing our work in the exam room.

Independent licensure, autonomous practice for NPs, is what all states need to permit full scope of practice. For too long NPs have been limited by legislative and political barriers with regard to what they can do as professionals. These changes sometimes seem insurmountable and it is assumed someone else will do that work.

Legislative efforts are not where many of us are drawn. If a message arrives asking us to contact our legislators about a bill, how many of us make the contact and how many of us ignore it, leaving it for someone else to do? We may think we have little power to influence change. This is a story about people who did respond, did make an effort, and their effort made a difference. It also serves as a reminder that in so many ways our colleagues before us have created the practice environment we have today.

Twenty years ago a law was passed in Maine establishing independent licensure for NPs, ending the requirements for physician oversight and supervision and increasing availability of health care. The process of establishing independent licensing in Maine was much more than passing a law, it was an 8-year grassroots effort—a story of nurses seeing a need, coming together, building consensus, and developing relationships to achieve what many said at the time was impossible. This story is inspiring and holds many lessons for advancing the NP profession today.

From the inception of the role of the NP in 1965, advanced practice nurses (APNs) in Maine were regulated by the Maine Nurse Practice Act. NPs completed their education and worked under this broad definition of nursing. Scope of practice was based on education with no guidelines for supervision or delegation.

In 1985, the Maine legislature amended language in the Nurse Practice Act to read, "Medical diagnosis or prescription of therapeutic or corrective measures *when those services are delegated by a licensed physician* to a registered nurse…" (Personal communications and internal MNP documents). The legislation included a

directive to develop rules "defining the appropriate scope of practice for advanced practice nurses." The rules were also to define the "appropriate relationship with the physician." The legislation directed the Board of Nursing (BON) to "invite comment from the Board of Medicine" (BOM). This was the first legislation in Maine to guide the practice of APNs.

The BOM regulated physician supervision of NPs through its "Rules and Regulations for Physician Supervision of Physician Extenders." These rules limited the number of "physician extenders" (physician assistants or NPs) a physician could supervise to 2, and required that medical records of all patients seen by a physician "extender" be reviewed, countersigned, and dated by the supervising physician within 5 days of treatment by the extender. The "extender" could only perform medical services that were within the scope of practice and proficiency of the supervising physician.

There was no requirement in the rules that the physician be present where the "extender" was working and, in fact, many NPs were practicing in sites without physicians. Nurses were often working in locations where nobody else wanted to work. Many nurses or their employers were paying physicians to visit their site on a regular basis to sign charts. A different physician had to be found for every 2 NPs working that site. APNs who could not find a physician to supervise them could not practice as an APN.

In 1987, an invitation from the BON went out seeking APNs to help write the rules directed by the 1985 legislation. Three APNs responded, Pat Philbrook, NP, Dawna Coughlin, CNM, and Alfreda Mouland, NP. Meeting weekly they developed rules with the view that APNs practiced nursing, not medicine. As long as they were working within their scope of practice, they should not need supervision or delegation. Their aim was to have a collaborative practice with physicians. This reflected the existing practice, as APNs were practicing autonomously in many settings, with physicians just signing their medical records.

At this same time, Family Planning in Maine was operating under the federal Medicare rule, mandating that only 10% of NP charts had to be signed by a physician. This was not consistent with the practice throughout the state. The BOM wanted to implement cosigning of 100% of their charts, something Family Planning could not afford. The NPs had a track record of safe, effective care, using protocols, with no complaints about their care. Resolution was reached by adding an additional protocol that stated, "…if a condition was expected to improve but did not after 3 consecutive visits, the patient must be referred to a physician." The APNs added this protocol to the APN rules.

The group wrote the rules but the BON did not accept them, stating they did not fit with the board's interpretation of the "delegated" practice in the 1985 statute. The APNs continued to work with the BON and the BOM but neither board supported the concept of independent practice at this time. At the final meeting of both boards, the APNs were told, if they wanted to practice independently they would have to change the law or go to medical school.

The BON eventually developed rules in June 1993. These rules were supported by physician organizations but opposed by APNs. Maintained was the delegated medical practice and the supervisory relationship of physicians along with the 5-day chart reviews/signatures and the role of the BOM in regulating APNs.

Philbrook stated, "This was a huge turning point." The rules did not support the work APNs were doing, working independently. The APNs at Family Planning and elsewhere had proven they could provide safe and quality care (personal communication, Pat Philbrook, April 11, 2015). Nurses recall Philbrook saying, "Then we'll have to change the law." This is what Philbrook and Coughlin set out to do.

A coalition was formed called the Nurses in Advanced Practice, a group of APNs, chaired by Philbrook. Coalition members included NPs, certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), and

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