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DePaul Journal of Health Care Law

Volume 22
Issue 2 *2021*

Article 3

April 2021

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I. Introduction

The use of mid-level practitioners is much more prevalent today than it was years ago. Examples of mid-level practitioners include a nurse practitioner ("NP"), advanced registered nurse practitioner ("ARNP"), or physician assistant ("PA"). These practitioners are employed to help individuals get better access to care at a lower cost. Physicians delegate certain tasks that fall within these practitioners' scope of practice. The mid-level practitioners then perform the task instead of the physician. These tasks are billed for by the mid-level practitioner rather than the physician, allowing care to be provided more cost effectively.

In addition to cost, care is performed more efficiently because physicians can delegate the delivery of care. While the demand for care has continued to increase, the supply of physicians has not, but there has been an increase in the supply of mid-level practitioners. Therefore, care can still be delivered, but by a mid-level practitioner rather than a physician. Because there are more mid-level practitioners delivering care normally delivered by a physician, their scope of care is expanding. Courts, as well as individuals seeking care, recognize that the scope of care a mid-level practitioner can provide encompasses more than it did at its inception.

The use of mid-level practitioners has proven to be a more cost-effective way of providing care as well as allowing for better access because their scope of care has expanded. Healthcare is needed all over the world and will always be a necessity in any individual's life, so the use of mid-level practitioners will help make it easier for these individuals to access quality care more cost-effectively.

This paper will address the history of physicians and mid-level practitioners before discussing the applicable statutes and case law for the mid-level practitioner profession. Lastly, the cost effectiveness, the increased access to care, and the scope of practice for mid-level practitioners will be analyzed as to how it effects the delivery of health care today.

II. History

The physician profession began prior to the creation of the mid-level practitioner profession. The mid-level practitioner profession was created as a reaction to the changes occurring in health care delivery. Physicians can work in collaboration with mid-level practitioners to provide care to patients. Together, the mid-level practitioners and physicians can serve a combination of needs through multiple practitioners to provide cost-effective and quality care.

a. Nurse Practitioners

The nurse practitioner role made its inception in the 1960s as a health care provider that could serve a combination of needs that a patient requires.[1] The Nurse Practitioner Project ("Project") was designed to prepare nurses to provide comprehensive care.[2] The Project was initially designed for the care of children and the management of common childhood health issues.[3] The idea behind the nurse practitioner role was to work collaboratively with the physicians and to develop a collegial relationship.[4] The role of a nurse practitioner was not to act as a physician substitute.[5]

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[1] Arlene W. Keeling, *A Historical Perspectives on an Expanded Role for Nursing*, ONLINE J. ISSUES NURSING (May 31, 2015), https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No2-May-2015/Historical-Perspectives-Expanded-Role-Nursing.html.
[2] *Id.* para. 18.
[3] *Id.*
[4] *Id.*
[5] *Id.*

As physicians in rural areas welcomed nurse practitioners' help because of the shortage of care provided in those areas, the line between medicine and nursing became blurred, complicating the role that nurse practitioners played.[6] Physicians who followed a more organized approach to medicine were less willing to welcome the nurse practitioner role and fought to keep the scope of nurse practitioners' practice within certain boundaries.[7] Although nurse practitioners were welcomed in rural areas, organized medicine kept their scope of practice within certain boundaries.[8]

In *Sermchief v. Gonzalez*, action was taken against two nurse practitioners alleging the unlicensed practice of medicine.[9] The Missouri Medical Board charged two nurse practitioners for practicing medicine without a license because they performed tasks not customarily performed by nurse practitioners, but rather by physicians.[10] The Missouri Supreme Court held for the nurse practitioners because the State Practice Act was meant to evolve over time regarding a nurse practitioner's scope of practice.[11] The State Practice Act used general wording in its definition of a nurse practitioner, which conveyed the legislative intent to allow for an expanded role for the nurse practitioners.[12]

The expanded role for nurse practitioners is what the health care field has been working towards. In 2010, the Institute of Medicine made a recommendation for the future of nursing.[13] Their recommendation stated that "nurses, and particularly advanced practice nurses, should work at the full extent of their training to provide timely, efficient, and cost-effective care to people

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[6] *Id.* para. 19.
[7] *Id.*
[8] *Id.*
[9] *Id.* para. 24 (citing Sermchief v. Gonzalez, 660 S.W.2d 683, 684 (Mo. 1983)).
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] Keeling, *supra* note 1.

across the United States."[14] The movement towards greater involvement of nurse practitioners will help the overall health care system provide more as well as better quality care.

b. Physician Assistants

The physician assistant career started in the mid 20th century as a reaction to the changing methods of health care.[15] After World War II, the number of general physicians decreased, and the number of patients increased, leading more physicians to begin specializing in particular fields.[16] Advances in technology also drew physicians to take on a specialty rather than become a general provider.[17] Between 1940 and 1964, physicians changed how they practiced medicine, and payment for physician services changed dramatically, with the number of insured individuals rising substantially.[18] Many individuals in rural or impoverished areas did not have insurance until 1965, when the federal government passed the Medicare and Medicaid amendments.[19] This led to a physician shortage as many more individuals were insured than there were physicians.[20]

In 1965, Dr. Eugene Stead opened the first academic physician assistant program at Duke University as a solution to the physician shortage problem.[21] Dr. Stead wanted the program to train people with previous medical experience to become general assistants for physicians and assist them while under the physician's supervision.[22] The model of the physician assistant program was based on the collaborative relationship between Dr. Amos Johnson and his assistant, Buddy Treadwell, who had worked together in this type of relationship since the 1940s.[23] The

[14] *Id.*
[15] Loren Miller, *The Birth Of The Physician Assistant*, U.S. NAT'L LIBR. MED. (Nov. 15, 2016), https://circulatingnow.nlm.nih.gov/2016/11/15/the-birth-of-the-physician-assistant/.
[16] *Id.* para. 2.
[17] *Id.*
[18] *Id.*
[19] *Id.* para. 4.
[20] *Id.* para. 5.
[21] *Id.* para. 6.
[22] *Id.*
[23] *Id.* para. 5.

program was nine months of broad medical training and then an additional fifteen months of clinical rotations.[24]

The first physician assistant class consisted of Navy Corpsmen.[25] Many of these Navy Corpsman were returning from war and had previous medical experience.[26] The corpsmen were looking for work, so the new physician assistant program was a perfect fit for them and many veterans alike.[27]

In 1971, the American Medical Association recommended that physician assistants be primary care providers.[28] The cost of seeing a physician assistant is less expensive than seeing a physician for a primary care visit.[29] This cost-effectiveness led to an increase in federal funding for physician assistant programs with the hopes of decreasing costs for patients and the health care system.[30]

c. Physicians

The purpose of medicine is to serve patients' needs, and physicians are charged with carrying out that purpose.[31] The central function of the physician is to diagnose the patient accurately by identifying the problem that the patient presents.[32] Once the physician diagnoses the patient, they must then take action and make a plan for the patient's care.[33] Physicians decide

[24] *Id.* para. 6.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.* para. 7.
[29] *Id.*
[30] *Id.*
[31] STEPHEN J. WILLIAMS ET AL., *The Physicians Role in a Changing Health Care System*, *in* MEDICAL EDUCATION AND SOCIETAL NEEDS: A PLANNING REPORT FOR THE HEALTH PROFESSIONS 92 (1983).
[32] *Id.*
[33] *Id.*

which tests to order, what therapies to employ, which drugs to prescribe, what procedures are to be performed, and when to hospitalize and discharge patients.[34]

The patient-physician relationship involves the patient placing trust in the physician in how the physician provides care to the patient.[35] Further, the patient is placing trust in the institution that the provider is affiliated with.[36] There has been a rise in the questioning of this trust.[37] A number of factors have affected how individuals see the patient-physician relationship. These factors include: the changing status of the population, the increase in public skepticism about science and technology, third-party payors willingness to reimburse for a second opinion, and the publicity about the physician abuses in the Medicare and Medicaid system.[38] Today, patients want to be more involved in the decision-making process to express their individual autonomy.[39] Because of the rise of this consumer movement, the patient-physician relationship is suffering from many individuals and families dissatisfied with their physician or going so far as to change their primary care physician altogether.[40]

The physician is employed to make the patient feel better, and to do this, the physician needs to exercise some paternalism and domination.[41] The rise in the desire for more patient autonomy makes it harder for the physician to exercise that paternalism.[42] For the physician to provide effective care, the patient needs to place confidence in the physician and the care they provide.[43] This confidence comes from the patient-physician relationship of trust that the patient

[34] *Id.*
[35] *Id.* at 93.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*

places in the physician.[44] Without that strong patient-physician relationship, a physician is impeded from carrying out their medical duties and patients may not be receiving the best care.

III. Statutes and Legislation

Each state has its own statutes that govern the practice of medicine for physicians and mid-level practitioners. These statutes define the scope of practice for mid-level practitioners and physicians. The statutes also provide rules on how the collaboration of mid-level practitioners with physicians must be carried out, including specific requirements and limitations. For the purpose of this comment, there will be a focus on Illinois Statutes.

The Nurse Practice Act in Illinois governs the practice of nursing for nurse practitioners.[45] This Act states that an advanced practice registered nurse is one who meets the qualifications of a certified nurse practitioner and has been licensed by the Illinois Department of Financial and Professional Regulation.[46] The scope of practice under the Nurse Practice Act includes, but is not limited to: patient assessment and diagnosis, ordering diagnostic and therapeutic tests, performing those tests, ordering treatments, providing end-of-life care, providing patient education and advocacy, prescriptive authority, and delegating to a licensed practical nurse or registered nurse.[47] An Illinois licensed nurse practitioner is deemed to have "full practice authority" to practice without a collaborative agreement.[48] Further, the nurse practitioner is held fully accountable for all the tasks performed in the rendering of care to their patient.[49] These tasks include: rendering the care, planning for situations beyond their expertise, accepting referrals, consulting, collaborating, and referring to other health care professionals, and prescribing medications.[50]

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[44] *Id.*
[45] 225 ILL. COMP. STAT. 65/50 (2021).
[46] *Id.* § 50-10.
[47] *Id.* § 65-30(c).
[48] *Id.* § 65-43.
[49] *Id.*
[50] *Id.* § 65-43(c).

The Physician Assistant Practice Act in Illinois governs the practice of physician assistants.[51] This Act defines a physician assistant as "any person not holding an active license or permit issued by the Department pursuant to the Medical Practice Act of 1987 who has been certified as a physician assistant by the National Commission on the Certification of Physician Assistants . . . and performs procedures in collaboration with a physician . . ."[52] The physician assistant must perform procedures within the specialty of the collaborating physician and be able to perform a variety of tasks within the specialty.[53] The collaborating physician must provide direction, collaborate, and control the physician assistant to assure patients receive quality care, but may delegate a variety of tasks to the physician assistant in accordance with the written collaboration agreement.[54] The collaborating physician's presence is not required at all times when the physician assistant renders services to a patient, but there must be communication between the physician assistant and collaborating physician.[55] If the collaborating physician is not physically present, there must be guidelines established for communication for consultation by telephone, telecommunication, or radio.[56]

The Medical Practice Act ("Act") in Illinois governs the practice of physicians.[57] This Act prohibits the practice of medicine without a valid, active license to do so.[58] The Act states that a physician is "a person licensed under the Medical Practice Act to practice medicine in all of its branches or a chiropractic physician."[59] A physician may delegate authority of patient care to a licensed person practicing within the scope of their governing act, such as the Nurse Practice Act

[51] 225 ILL. COM. STAT. 95/1 (2021).
[52] *Id.* § 4.
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *See generally* 225 ILL. COMP. STAT. 60/1-65 (2021).
[58] *Id.* § 3.
[59] *Id.*

for nurse practitioners or Physician Assistant Practice Act for physician assistant.[60] The licensed person may be a registered professional nurse, physician assistant, or advanced practice registered nurse.[61] The physician assistant or nurse practitioner with the delegated authority of patient care must collaborate and act within their governing acts.[62]

IV. Common Law

With the growing use of physician assistants and nurse practitioners in the delivery of care, two main questions arise: (1) what does the mid-level practitioners' scope of care include and, (2) what does the mid-level practitioner duty consist of? Many cases have been brought forth to help explain and decide the answers to these questions.

In *Cox v. M.A. Primary & Urgent Care Clinic*, a patient visited the clinic several times for various issues, where she was examined and treated by a physician assistant.[63] In addition to visiting the clinic, the patient spoke with a physician, Dr. Adams, over the phone regarding her symptoms of chest pressure and inability to breathe normally.[64] The physician assistant referred the patient to a pulmonologist.[65] After multiple visits to the emergency room, the patient was diagnosed with cardiomyopathy, and she underwent surgery.[66] The patient alleged that the physician assistant and Dr. Adams owed a duty of care and breached that duty when they failed to make a proper diagnosis.[67] The court held for the defendant-clinic in finding that the standard of care applicable to physician assistants is different from that of a physician. Thus, the duty of care was not breached by either professional.[68] The Supreme Court of Tennessee held for the defendant

[60] *Id.* § 54.2.
[61] *Id.* § 54.4.
[62] *Id.* § 54.5(b).
[63] Cox v. M.A. Primary & Urgent Care Clinic, 313 S.W.3d 240, 243 (Tenn. 2010).
[64] *Id.* at 243–44.
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.* at 262.

clinic because the physician assistant was statutorily limited to perform only those tasks within their skill and competence, so the patient-plaintiff failed to prove that the physician assistant violated the standard of care applicable to physician assistants.[69]

In *Harper v. Hippensteel*, a nurse practitioner and doctor entered into a collaborative agreement where the doctor agreed to be available for the nurse practitioner's consultations.[70] Dr. Hippensteel was engaged in private practice in Vincennes, and the nurse practitioner Vories worked at a primary care clinic in Vincennes.[71] The patient received care from Vories at the primary care clinic and passed soon after from an acute pulmonary embolism and deep venous thrombosis.[72] The patient's parents argued that the doctor owed a duty to the patient because of the collaborative agreement between him and the nurse practitioner.[73] The Court held that Dr. Hippensteel did not owe a duty to the patient because there was no physician-patient relationship.[74] The collaborative agreement explicitly stated that it was not intended to serve as a substitute for the nurse practitioner's independent clinical judgment, and therefore the nurse practitioner had independent authority to treat patients.[75] The Court held in favor of Dr. Hippensteel because no increased liability was placed on him and Vories had the authority to assess clients, diagnose, develop and implement treatment, and evaluate care.[76]

In *United States ex rel. Walker v. R & F Props. Of Lake County, Inc.*, Walker alleged that R & F Properties of Lake County, Inc., formerly known as, Leesburg Family Medicine ("LFM"), filed false claims for Medicare reimbursement by billing Medicare for services rendered by nurse

[69] *Id.* at 243.
[70] Harper v. Hippensteel, 994 N.E.2d 1233, 1235 (Ind. Ct. App. 2013).
[71] *Id.* at 1235.
[72] *Id.* at 1236.
[73] *Id.*
[74] *Id.*
[75] *Id.* at 1242.
[76] *Id.*

practitioners and physician assistants as services "incident to the service of a physician."[77] The physician assistants and nurse practitioners treated patients without the physical presence of the physician on site.[78] Walker reasoned that the services could not be billed incident to a physician's service if the physician was not present.[79] On appeal, the Appellate Court reversed the Trial Court's grant of summary judgment in favor of LFM.[80] LFM knew that a physician was required to be physically present to bill for services "incident to the service of a physician" but the physician assistants and nurse practitioners still billed for those services, so there was an issue of fact raised as to the falsity of LFM's billing.[81] Therefore, LFM may be liable under the False Claims Act for failure to bill properly.

In *Landau v. Lucasti*, the office manager brought a qui tam relator suit under the False Claims Act, alleging that Dr. Lucasti submitted a false claim that sought payment for Medicare services incident to Dr. Lucasti's outpatient treatment.[82] The Court pointed out that a nurse practitioner or physician assistant's services need not be directly supervised by the physician but cannot be billed at the physician's rate.[83] The physician must be physically present in the office while the nurse practitioner or physician assistant is rendering services. However, while present in the office, the physician does not need to supervise the mid-level practitioner directly but must be readily available.[84]

Mid-level practitioners and physicians are similar but different professions, and because of this, their duties, applicable standards, and billing rates will differ. The standard of care applicable

[77] United States v. RF Properties of Lake County, Inc., 433 F.3d 1349, 1353 (11th Cir. 2005).
[78] *Id.*
[79] *Id.*
[80] *Id.* at 1351.
[81] *Id.* at 1358.
[82] Landau v. Lucasti, 680 F. Supp. 2d 659 (D.N.J. 2010).
[83] *Id.* at 667.
[84] *Id.* at 671.

to physicians is greater than the standard applicable to mid-level practitioners. Further, a collaborative agreement does not automatically create a duty. For there to be a duty to the patient, there must be a patient-physician relationship. Mid-level practitioners must not bill for services at the same rate as a physician. Even when the physician is physically present in the office, if the mid-level practitioner performs the service, then the service must be billed at the mid-level practitioner's rate. These differences make the delivery of care more cost-effective, and even with a lesser duty, the mid-level practitioner is still required to provide quality care.

V. Analysis: Is The Use Of Mid-Level Practitioners Better For The Health Care Industry?

a. Cost Saving

The use of nurse practitioners and physician assistants to perform tasks in collaboration with the physician leads to a decrease in costs.[85] Studies show that providing care through a physician assistant or nurse practitioner will help achieve more cost-saving initiatives.[86] Managed Care Organizations ("MCO") reconfigure their division of labor to track utilization of services provided to patients.[87] The MCO then makes sure to align the care needed with a qualified professional to provide that care.[88] When this care is within the mid-level practitioner's scope, it can be provided more cost-effectively because mid-level practitioners bill at lower rates than physicians.[89] Even though physician assistants and nurse practitioners are compensated at lower rates than physicians, their training enables them to provide treatment for acute minor and stable chronic conditions.[90] These conditions frequently show up in primary care, where most nurse

[85] Douglas W. Roblin et al., *Use of Midlevel Practitioners to Achieve Labor Cost Savings in the Primary Care Practice of an MCO*, 39 HEALTH SERVS. RES. 607, 619 (2004).
[86] *Id.*
[87] *Id.* at 607.
[88] *Id.*
[89] *Id.* at 607–08.
[90] *Id.*

practitioners and physician assistants are utilized.[91] An adult medicine practice realized practitioner labor cost savings of at least $1.44 per visit and total labor cost savings of at least $1.11 per visit.[92] This shows that health care practices and MCOs that reconfigured their delivery of care to be offered by mid-level practitioners realized lower costs per visit.[93]

Moving towards a collaborative multi-disciplinary approach will help drive costs down.[94] This collaborative approach centers on mid-level practitioners functioning independently as primary care providers.[95] However, the variations in the scope of practice and licensure laws for mid-level practitioners stand as an obstacle to cost-effective quality care.[96] If state laws governing licensure and the scope of practice are unified, they will provide predictable, cost-efficient, and quality medical care. [97] There are questions on how this uniformity can be achieved because each state sets its quality measures based on its resources and population needs.[98] If states structure their laws more uniformly, mid-level practitioners will be able to deliver care without the fear of disciplinary action, which would lead to more care being delivered to those that need it.

b. Better Access

The number of physician assistants and nurse practitioners is projected to increase by over 72% from 2010 to 2025.[99] This increase correlates to the physician shortage, as more are entering the profession of mid-level practitioners rather than becoming physicians.[100] Physician assistants

[91] *Id.* at 608.
[92] *Id.* at 618.
[93] *Id.*
[94] Thomas R. McLean, *Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery*, 12 HEALTH MATRIX 239, 257 (2002).
[95] *Id.* at 250.
[96] *Id.* at 250–51.
[97] *Id.* at 251.
[98] *Id.* at 252.
[99] RODERICK S. HOOKER ET AL., *PREDICTIVE MODELING THE PHYSICIAN ASSISTANT SUPPLY: 2010-2025*, 126 PUB. HEALTH REP. 708 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3151188/.
[100] *Id.* at 709.

have filled many primary care provider positions, while other physician assistants work in specialty fields.[101] Individuals are disincentivized from becoming a physician due to the lengthy process it takes to begin their practice.[102] The education programs for both nurse practitioners and physician assistants do not require residencies as the physician profession does. This has led the degree programs for mid-level professions to grow as more individuals are applying and enrolling.[103] Therefore, more and more individuals are choosing to pursue a career as a physician assistant or a nurse practitioner rather than becoming a medical physician.[104]

Analysts have predicted that the shortage of physicians will continue to grow and create an increased reliance on physician assistants and nurse practitioners.[105] The aging population is in need of medical care, and the supply of physicians will not be able to provide all the necessary services.[106] Even with an increase in the number of individuals enrolling in medical school, the demand for care will increase faster than the increase in physicians.[107] Therefore, the demand for physician assistants and nurse practitioners to help fill primary care spots is increasing and will continue to do so.[108]

The number of nurse practitioners has nearly doubled over the last two years.[109] Approximately 87% of nurse practitioners are certified in primary care and provide care where it is needed most; in rural and underserved areas.[110] Because nurse practitioners provide care to such

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[101] *Id.* at 712.
[102] David I. Auerbach et al., *Growing Ranks of Advanced Practice Clinicians – Implications for the Physician Workforce*, 25 NEW ENG. J. MED. 2358, 2358 (2018).
[103] *Id.* at 2358.
[104] *Id.*
[105] Harper v. Hippensteel, 994 N.E.2d 1233, 1242 (Ind. Ct. App. 2013).
[106] Auerbach et al., *supra* note 102, at 2359.
[107] *Id.* at 2358.
[108] *Id.*
[109] *National Nurse Practitioner Week: NPs Increase Access*, *Provide Choice for Better Patient Outcomes*, AM. ASSOC. NURSE PRACS. (Nov. 15, 2019), https://www.aanp.org/news-feed/national-nurse-practitioner-week-nps-increase-access-provide-choice-for-better-patient-outcomes.
[110] *Id.* para. 4.

communities, it increases those underserved populations' access to care. Further, the increase in demand for primary care services is met with an increase in nurse practitioners certified in primary care.

Patients continue to encounter more nurse practitioners and physician assistants in the delivery of health care services.[111] These mid-level practitioners are increasingly prevalent because of the health care industry's shift to greater access and better quality care.[112] Physician assistants and nurse practitioners can also provide care that overlaps with services that a physician usually provides.[113] The use of mid-level practitioners will not threaten the quality of care provided, and in fact, it has sometimes been found that mid-level practitioners deliver higher quality care than physicians.

c. Physicians v. Mid-Level Practitioners Scope of Practice

The scope of practice is changing for physician assistants.[114] A physician assistant's scope of practice is defined by their education, experience, preference, physician delegation, facility credentialing and privileging, and state law and regulation.[115] Even though their scope of practice is limited compared to a physician, physician assistants are accepted publicly.[116] One in four patients have received treatment from a physician assistant, and the care provided does not differ from the care that a physician would provide.[117] Medicare beneficiaries indicated that they were equally satisfied with the care provided by a physician assistant, nurse practitioner, or physician.[118] The delivery of health care services has taken on a team-based approach to coordinate care among

[111] Auerbach et al., *supra* note 102, at 2358, 2360.
[112] *Id.*
[113] *Id.* at 2358.
[114] Ann Davis et al., *Access and Innovation in a Time of Rapid Change: Physician Assistant Scope of Practice*, 24 ANN. HEALTH L. 286, 287, 316–17 (2015).
[115] *Id.* at 296.
[116] *Id.* at 310.
[117] *Id.*
[118] *Id.*

physicians and mid-level practitioners.[119] Physician assistants perform tasks according to their delegated autonomy, which reinforces their primary care delivery role, allowing the physician assistant to set the pace for innovation.[120] The Affordable Care Act promotes the team-based approach by encouraging new models of care, such as Patient Centered Medical Homes and Accountable Care Organizations.[121] These health care delivery models focus on the effectiveness of care coordination in which mid-level practitioners play a vital role.[122]

Nurse practitioners are emerging as primary care providers to fill the shortage of physicians in the primary care workforce.[123] The nursing profession's scope and capacity have grown immensely since the inception of the nurse practitioner role.[124] Every state legislature has amended Nurse Practice Acts to allow nurse practitioners to prescribe for primary care-related diagnoses, which shows the expanded role that nurse practitioners play in primary care.[125] Studies have shown that nurse practitioners provide similar care to patients that a physician would have provided, which further demonstrates the expanded role nurse practitioners play.[126] Nurse practitioners, properly authorized and licensed under the law, serve a vital role in providing quality care and increasing access to care.[127] The nurse practitioner profession should be encouraged to provide care in their expanding role as they are "important contributors to the primary care workforce," capable of delivering quality care.[128]

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[119] *Id.* at 316.
[120] *Id.* at 320.
[121] *Id.* at 316.
[122] *Id.* at 316–17.
[123] Tine Hansen-Turton, *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1236, 1237 (2010).
[124] *Id.* at 1237.
[125] *Id.*
[126] *Id.* at 1241; *see generally* U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS (1986).
[127] *Id.* at 1260.
[128] *Id.* at 1241.

Increasing the scope of practice for mid-level practitioners decreases the monopolistic hold that physicians have on current health care delivery because there are more health care professionals involved, and not all of those involved are physicians.[129] Because physicians delegate certain tasks to the mid-level practitioners, society sees mid-level practitioners as subordinate to physicians.[130] Therefore, physicians and mid-level practitioners are held to different standards of care.[131]

VI. Conclusion

The use of mid-level practitioners will help improve the cost, quality, and access to care. The scope of practice is expanding for physician assistants and nurse practitioners because mid-level practitioners are recognized as an essential part of improving care delivery. Furthermore, individuals can obtain a master's degree as a mid-level practitioner in a shorter period of time than a physician obtaining their doctorate, which is an influential part of why individuals choose to become mid-level practitioners. Finally, the cost of receiving health care from a mid-level practitioner is less, it is easier to access care from a mid-level practitioner, and with the scope of practice of mid-level practitioners expanding, they will be able to treat more patients for more conditions.

[129] Cox v. M.A. Primary & Urgent Care Clinic, 313 S.W.3d 240, 255 (Tenn. 2010).
[130] *Id.* at 257.
[131] *Id.*