Reflection Paper: Ethical and Legal Aspects of Health Care and the Role of the Advanced Practice Nurse

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Ethical and legal aspects of health care present challenges for many providers. When reviewing the course outcomes that pertain to the topic of ethics, I feel Course Outcome #7: “Incorporate principles of ethical and legal practice in primary care settings” is obviously the most appropriate course outcome to discuss. In terms of program outcomes, “In terms of Program Outcomes, #4: “Demonstrate sound critical thinking and clinical decision making” also fits nicely into the aspects of ethical and legal issues related to the advanced nursing role.

Beginning with ethics, there have been many ethical dilemmas that have come into light during my twelve years as a nurse; however, during this clinical rotation, one specific example has presented itself repeatedly. This ethical issue has been one that has involved my preceptor more than me directly. My preceptor has a firm Catholic faith that he carries into his practice as a primary care physician. In 1968, Pope Paul VI issued his landmark encyclical letter Humanae Vitae (Latin, "Human Life"), which reemphasized the Church’s (Catholic) constant teaching that it is always intrinsically wrong to use contraception to prevent new human beings from coming into existence. This includes sterilization, condoms and other barrier methods, spermicides, coitus interruptus (withdrawal method), the Pill, and all other such methods (Catholic Answers, 2004).

Following Catholicism directly impacts some of the medications and procedures my preceptor chooses to provide for his patients. While I can and do appreciate the religious belief systems of others, I am conflicted as to whether or not this is always in the patients’ best interest. For example, one continued area of conflict is my preceptor’s refusal to prescribe oral birth control pills. He states that he did not begin his practice with this same opinion but rather began to feel conflicted, as his Catholic faith does not believe in birth control methods involving oral pills or other contraceptive devices. He informed me that he felt as if he was betraying his own personal religious views by prescribing such medications to his patients, which created an ethical dilemma for him personally. He stated that “I could not be one person on Sunday mornings and another in my professional practice.” My own personal ethical dilemma becomes apparent, as I believe that each patient is entitled to make his/her own decisions regarding birth control choices, or lack thereof. I feel all information should be offered to each and every patient, allowing him/her to make informed personal choices that are independent of my own convictions. Fortunately, my preceptor does a nice job of broaching this topic gently with patients, explaining his personal “conflict of interest” without creating a sense of judgment toward his patients, if they choose to seek birth control methods from another provider.

When addressing the legal aspects of the advance nurse practitioner role, the most pressing issues that come to mind are those involving the legal aspects of licensing and credentialing. Advanced Practice Registered Nurses (APRNs) have been practicing in various capacities for years; however, a consensus on the components involved in the regulation of APRNs has been argued for some time. Disagreements on uniform state regulations are limiting the accessibility of the high quality, cost-effective care APRNs can provide. Much of the debate involved in defining the APRN profession has involved credentialing, education, scope of practice, and the actual title of APRNs. The evolving landscape of healthcare and patient demographics give APRNs the opportunity to assume a more prominent role in the delivery of care and prove the impact of APRN care on patient outcomes (Stanley, 2009). Currently, there is a lack of uniformity across states in defining the APRN role, including advanced practice education, licensing, and credentialing requirements. In 2007, the Alliance APRN Consensus Work Group met with the APRN Advisory Committee to produce complementary recommendations that would together guide future regulation, thus giving rise to the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education* (LACE) (Stanley, 2009). Their goal is to have this model fully implemented by 2015 (ANA, 2008).

The LACE Consensus Model recognizes four APRN roles: certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), certified nurse-midwife (CNM), and certified nurse practitioner (CNP) (ANA, 2008). The model also states that all APRNs will be educated in one of these four roles, in addition to at least one of six population foci: family, adult-gerontology, pediatrics, neonatal, women’s health, or mental health (Stanley, 2009).

From an ethical standpoint, it is important for the public to trust that any APRN providing care is educated, certified, and licensed within his/her scope of practice. This will ensure patients that they are receiving safe and equitable care from providers with the title of APRN. Creating and implementing a timely consensus for APRNs is critical to assure the public about the consistency and quality of their healthcare providers (Yoder-Wise, 2010).

Politically, APRNs need an effective consensus model to more clearly define the profession and to move forward in healthcare as a united front with agreement on the regulations of the profession across all 50 states. As health care reform begins to change the delivery of care to individuals in our country, the APRN profession needs to be ready to speak as a unified voice about what care APRNs can contribute and why the professional development plan is essential (Yoder-Wise, 2010).

From a legal perspective, a consensus model is required to outline the scope of practice for each of the four APRN roles. As the APRN profession attempts to maximize the existing scope of practice, there is potential to do so by expanding: amendments to state nurse practice acts, judicial decisions, and federal enactments (Watson & Hillman, 2010).

Further, agreement among states is needed to align the prescriptive authority of APRNs. Currently, APRNs have some degree of prescriptive authority in all 50 states; however, these varying degrees of authority cause much confusion among consumers. Legislative changes are needed to expand APRN prescription privileges in all states to include:

* Authority to prescribe without physician involvement
* Authority to prescribe with physician collaboration
* Written protocol required to prescribe
* Authority to prescribe controlled substances (Watson & Hillman, 2010)

A consensus regarding prescriptive authority is needed to bring uniformity in scope of practice and alleviate confusion among healthcare consumers.

Additional liability issues that exist for APRNs include:

* Unlicensed practice of medicine
* Failure to adequately diagnose
* Negligence in the delivery of healthcare
* Conduct exceeding physician-delegated authority—resulting in harm
* Conduct exceeding scope of practice –resulting in harm
* Failure to refer appropriately (Guido, 2010).

Essentially, APRNs have dual legal liability including nurse adherence to the state nurse practice act and the APRN’s requirement to national specialty certification and/or secondary licensure requirement. If APRNs continue to expand practice roles, there will likely be an increase in the APRNs level of accountability and liability (Watson & Hillman, 2010).

References

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