

# Kansas Law Review

## PHYSICIAN'S ASSISTANT AND NURSE PRACTITIONER LAWS: A STUDY OF HEALTH LAW REFORM\*

Philip C. Kissam\*\*

One of the most promising ways to expand the supply of medical care and to reduce its cost is through a greater use of allied health personnel, especially those who work as physicians' and dentists' assistants, nurse pediatric practitioners, and nurse midwives. Such persons are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not require the skills of a doctor. Such assistance frees a physician to focus his skills where they are most needed and often allows him to treat many additional patients.<sup>1</sup>

In February 1971 when President Nixon made that statement, the laws of most states severely limited the legal rights of physicians to delegate medical acts in an innovative manner.<sup>2</sup> This situation is changing. At this writing, at least 41 states have 66 statutes that allow physicians to delegate medical acts innovatively to broadly defined categories of nonphysicians. Thirty-eight of these statutes authorize delegation to qualified nonphysicians (physician's assistants or PAs).<sup>3</sup> The other 28 statutes authorize delegation only to qualified professional nurses and, in four cases, to qualified practical nurses as well (nurse practitioners or NPs).<sup>4</sup> These statutes and regulations there-

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\*\* Associate Professor of Law, University of Kansas. B.A., Amherst College, 1963; LL.B. Yale University Law School, 1968.

<sup>1</sup> President Nixon, Message to the Congress Relative to Building a National Health Strategy, Feb. 18, 1971, 117 CONG. REC. 3119, 3122 (1971) [hereinafter cited as President Nixon, Message].

<sup>2</sup> President Nixon, Message, *supra* note 1, at 3122; see section I.C. *infra*. Before 1971 only California, Colorado (2 statutes), Florida, Kansas, and Oklahoma had laws that authorized physicians to delegate medical acts in addition to delegations authorized by custom and by allied health personnel licensure statutes. CAL. BUS. & PROF. CODE §§ 2510-22 (West 1974); COLO. REV. STAT. ANN. §§ 12-31-101 to -115 (1973); COLO. REV. STAT. ANN. § 12-36-106(3)(1) (1973); FLA. STAT. ANN. § 458.13(4) (Supp. 1975); KAN. STAT. ANN. § 65-2872(g) (1972); ORLA. STAT. ANN. tit. 59, § 492 (Supp. 1974).

<sup>3</sup> These statutes are cited in notes 144 and 152 *infra*. Hereinafter the terms "physician's assistant" and "PA" will be used interchangeably to refer to any person recognized under a PA statute as qualified to perform medical acts under the supervision of a physician. The terms "physician's associate," "child health associate," and "assistant to a physician" are given the same meaning by some statutes, and these terms are included within the meaning of PA. Although PA as a matter of ordinary language would seem to refer to any nonphysician who assists a physician, the new PA statutes are not intended to apply to traditional delegations by physicians. See, e.g., N.C. GEN. STAT. § 90-18(13) (Supp. 1974). Professional nurses generally qualify to perform additional medical acts under separate statutes. See note 4 *infra*.

<sup>4</sup> These statutes are cited in notes 168 and 177 *infra*. Hereinafter the terms "nurse practitioner" and "NP" will be used interchangeably to refer to any nurse recognized under a NP statute as qualified to perform medical acts in addition to those traditionally delegated to nurses. The terms "nurse-midwife," "nurse associate," and "nurse clinician" are employed under some NP statutes, and these terms are included within the meaning of NP.

under (the new legislation)<sup>5</sup> provide in varying degrees for the delegation of medical acts traditionally performed only by physicians and the delegation of certain other medical acts to a wider range of nonphysicians than previously has been the case (expanded medical delegation).<sup>6</sup>

The new legislation applies to a growing phenomenon in American medical practice. Although the number of persons engaged in expanded medical delegation is difficult to estimate,<sup>7</sup> the rapid growth of new formal training programs for PAs and NPs has been impressive. Directories prepared for 1973-74 identified 86 PA training programs and 83 certificate NP training programs in 42 states, the District of Columbia and Puerto Rico,<sup>8</sup> all initiated since 1965.<sup>9</sup>

This Article examines the new legislation in order to describe different legislative rules that have been used to authorize and regulate expanded medical delegation and to assess the relative value of these rules. The Article suggests that much of the new legislation is incomplete and unduly restrictive and that consequently the maximum feasible amount of expanded delegation may not be achieved. These failures may be explained by two basic factors. Legislators and administrators appreciate easily articulated and administered standards regulating the quality of care, but in many cases these standards appear to unduly restrict expanded delegation. A more significant factor has been the political power of physicians and other health professionals, whose economic interests are well served by maintenance of strict controls over expanded medical delegation.

Part I of this Article discusses some of the background to the new legislation: the nature of expanded delegation, the perceived benefits to be obtained, the need for statutory authorization, and the economic and political context within which the new legislation has been established. Part II describes and

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<sup>5</sup> Any consideration of the new laws necessarily must include an examination of administrative regulations promulgated thereunder because a substantial majority of the rules governing new medical delegations have been established by regulations. Hereinafter the terms "legislation" and "legislative" will be used to refer to both statutes and regulations.

<sup>6</sup> A more complete description of expanded medical delegation is provided in section I A *infra*.

<sup>7</sup> As of March 1, 1974, 655 PAs were registered or "known to be working" under 24 PA statutes. This number, however, was based upon incomplete reporting under PA statutes in effect at the time, and it did not include NPs or PAs in states without PA statutes, for which such data is apparently not available. Cohen & Dean, *To Practice or Not to Practice: Developing State Law and Policy on Physician Assistants*, 52 MILBANK MEM. FUND Q. 349, 353 (1974) [hereinafter cited as Cohen & Dean, *To Practice or Not to Practice*].

<sup>8</sup> AMERICAN MEDICAL ASSOCIATION & BUREAU OF HEALTH RESOURCES DEVELOPMENT, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, PHYSICIAN SUPPORT PERSONNEL 1973-74, DHEW Pub. No. NIH 74-318, (1974); AMERICAN NURSES ASSOCIATION & BUREAU OF HEALTH RESOURCES DEVELOPMENT, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, PREPARING REGISTERED NURSES FOR EXPANDED ROLES 1973-74, Part I, DHEW Pub. No. NIH 74-31 (1974). Certificate NP programs refer to short-term training programs, generally three to 12 months, designed specifically to prepare professional nurses for an expanded medical role. In addition, graduate degree programs for professional nurses may provide such training. See *id.* Part II.

<sup>9</sup> The first PA program was started in 1965 at the Duke University Medical Center. Estes & Howard, *Potential for Newer Classes of Personnel: Experiences of the Duke Physician's Assistant Program*, 45 J. MED. ED. 149, 151 (1970). Apart from earlier training of nurse-midwives, the first NP training program was started in the same year at the University of Colorado Medical School. A. SADLER, B. SADLER & A. BLISS, *THE PHYSICIAN'S ASSISTANT—TODAY AND TOMORROW* 21 (1972) [hereinafter cited as SADLER & BLISS].

categorizes the new legislation. Part III analyzes several important rule-making choices that have confronted legislatures and administrative agencies in establishing the new laws. Part IV offers some recommendations for future rule-making concerning expanded medical delegation.<sup>10</sup>

## I. THE BACKGROUND OF THE NEW LEGISLATION

A preliminary discussion of some relevant aspects of medical practice, law, and economics will be helpful in providing a basis for understanding and evaluating the new legislation. Expanded medical delegation needs further definition and illustration because it is a technical subject with contours that are not readily discerned by the outside observer. The potential social benefits from expanded delegation and the traditional legal barriers to it need description to clarify what is at stake when questions are raised about the legality of particular delegations. Finally, certain economic and political aspects of medical practice deserve examination because these suggest a powerful explanation for the prevailing patterns and restrictions in the new legislation.

### A. *The Nature of Expanded Medical Delegation*

The nature of expanded medical delegation may be illustrated by a simple model of medical practice and medical delegation, both traditional and new. The purpose of this model is to analyze the potential medical and economic feasibility of delegating a wide range of medical acts to a variety of non-physicians, delegation that transcends the scope of traditional medical responsibilities of allied health personnel. Medical practice for this purpose may be defined as all acts of patient care that physicians are trained to perform.<sup>11</sup> It will help to think of these acts as forming a spectrum that consists of three distinct albeit overlapping categories. At one end of the spectrum are "diagnostic and treatment judgments," which include initial determinations of a disease or other abnormal condition based upon an evaluation of symptoms

<sup>10</sup> Most earlier recommendations for rule-making in the area of expanded medical delegation were made before the recent explosion of new laws and were general in nature or keyed to some of the earlier statutes. See, e.g., DEPARTMENT OF COMMUNITY HEALTH SCIENCES, DUKE UNIVERSITY, MODEL LEGISLATION PROJECT FOR PHYSICIAN'S ASSISTANTS (1970) [hereinafter cited as DUKE PROJECT]; Forgotson, Roemer and Newman, *Legal Regulation of Health Personnel in the United States*, in 2 REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER, 279, 290-95 (1967), [hereinafter cited as Forgotson]; SADLER & BLISS, *supra* note 9, at 93-132 (1972); Carlson, *Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care*, 35 LAW & CONTEMP. PROB. 849, 864-74 (1970) [hereinafter cited as Carlson]; Curran, *New Paramedical Personnel—to License or Not to License?*, 282 N. ENG. J. MED. 1085 (1970); Curran, *The California "Physicians' Assistants" Law*, 283 N. ENG. J. MED. 1274 (1970); Sadler & Sadler, *Recent Developments in the Law Relating to the Physician's Assistants*, 24 VAND. L. REV. 1193, 1196-1202 (1971) [hereinafter cited as Sadler & Sadler]; Silver, *New Allied Health Professionals: Implications of the Colorado Child Health Associate Law*, 284 N. ENG. J. MED. 304 (1971); *Paramedics and the Medical Manpower Shortage: The Case for Statutory Legitimization*, 60 GEO. L.J. 157, 182-84 (1971); *The Physician's Assistant and the Problem of Statutory Authorization*, 7 U.C.D.L. REV. 413, 419-31 [hereinafter cited as *Problem of Statutory Authorization*]. More recent writing by HEW's Dean and Cohen does focus upon the new statutes and regulations. Cohen & Dean, *To Practice or Not to Practice*, *supra* note 7; Dean, *State Legislation for Physician's Assistants: A Review and Analysis*, 88 HEALTH SERV. REP. 3, 6-7 (1973) [hereinafter cited as Dean].

<sup>11</sup> This definition follows the typically broad definition of medical practice in state physician licensure laws. See, e.g., N.Y. EDUC. LAWS § 6521 (McKinney 1972), which defines medical practice as "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition."

and the development of an appropriate treatment plan for the diagnosed condition.<sup>12</sup> The middle category consists of "treatment modifications," which include judgments about the severity of symptoms of an already diagnosed condition and the need to continue, modify, or alter the prescribed treatment.<sup>18</sup> The third category consists of "medical procedures," which include all remaining medical acts that are necessary to implement diagnostic and treatment judgments and treatment modifications. Medical procedures include diagnostic or data-gathering procedures such as physical examinations, medical histories, and laboratory tests and therapeutic procedures such as administering medication by injection and suturing wounds.<sup>14</sup>

These categories cannot be defined in a precise way because many medical acts will not be easily classified in one or another category. For example, should the interpretation of X-ray pictures be classified as a diagnostic judgment or a data-gathering procedure?<sup>15</sup> It also will be difficult in particular cases to draw a line between the administration of a prescribed treatment (a therapeutic procedure) and a treatment modification or between a treatment modification and the diagnosis and treatment of a new condition.<sup>16</sup> The classification of many particular medical acts will depend upon the purpose of the classification.<sup>17</sup> Notwithstanding this lack of precision, these three categories will be helpful in describing the possibilities for expanded medical delegation and in analyzing many of the new legislative rules that make use of these and similar terms.<sup>18</sup>

Traditionally, some opportunities for delegation of medical acts have been utilized. For example, podiatrists and optometrists perform independently certain medical acts relating to specific parts of the body;<sup>19</sup> physical therapists carry out treatments upon referral from physicians;<sup>20</sup> and nurses administer physician-prescribed medications and treatments.<sup>21</sup> But traditional medical delegation has not included all or even most relatively simple, routine medical acts. With the exception of independent practitioners such as optometrists,

<sup>12</sup> This definition is based upon the definition of a "doctor's diagnosis" as distinguished from a "nursing diagnosis" in *Acts of Diagnosis by Nurses and the Colorado Professional Nursing Practice Act*, 45 DENVER L.J. 467, 469-75 (1968) [hereinafter cited as *Acts of Diagnosis by Nurses*]. It also appears to be what the American Medical Association (AMA) meant by "decision-making required to establish a diagnosis and plan therapy," when it recommended functions for PAs and NPs that did not include such decision-making. AMA HOUSE OF DELEGATES, ESSENTIALS OF AN APPROVED EDUCATIONAL PROGRAM FOR THE ASSISTANT TO THE PRIMARY CARE PHYSICIAN I (Dec. 1971) [hereinafter cited as *AMA ESSENTIALS*].

<sup>13</sup> This definition is based on the definition of "nursing diagnosis" outlined in *Acts of Diagnosis by Nurses*, *supra* note 12, at 469-75.

<sup>14</sup> See *AMA ESSENTIALS*, *supra* note 12, at 1-2.

<sup>15</sup> This classification issue was the one at stake in *Maranville v. State Bd. of Equalization*, 99 Cal. App. 2d 841, 222 P.2d 898 (1950).

<sup>16</sup> See, e.g., *Acts of Diagnosis by Nurses*, *supra* note 12, at 467.

<sup>17</sup> See *id.* at 469-75 for a discussion of various meanings of diagnosis that can follow from different purposes.

<sup>18</sup> See, e.g., text at notes 302-29 *infra*.

<sup>19</sup> See, e.g., KAN. STAT. ANN. §§ 65-1501, 2001 (1972); N.Y. EDUC. LAW §§ 7001, 7101 (McKinney 1972).

<sup>20</sup> See, e.g., KAN. STAT. ANN. § 65-2901 (Supp. 1974); N.Y. EDUC. LAW § 6531 (McKinney Supp. 1973).

<sup>21</sup> See, e.g., KAN. STAT. ANN. § 65-1113(b) (1972); N.Y. EDUC. LAW § 6902 (McKinney Supp. 1973).

diagnostic and treatment judgments, treatment modifications, and many closely related medical procedures have not been delegated, no matter how simple and routine the acts may be. Physical examinations, medical histories, diagnosis and treatment of common illnesses, minor surgery, and decisions to continue or modify prescribed treatment for convalescing or chronically-ill patients generally have not been delegated.<sup>22</sup> Furthermore, delegated medical acts have been entrusted only to limited groups of licensed allied health personnel, notwithstanding other nonphysicians' ability to perform the same acts.<sup>23</sup> For example, a practical nurse qualified by on-the-job training to give inoculations may not have legal authority to do so because only professional nurses have been licensed to give inoculations.<sup>24</sup>

Diagnostic and treatment judgments, treatment modifications, and medical procedures vary from relatively simple, routine acts to highly complex ones. A priori it would seem that many simple, routine acts in all three categories might be performed as competently by nonphysicians as by physicians.<sup>25</sup> For example, compare the decision whether an upper-respiratory tract complaint is a symptom of a common cold, a common throat infection for which penicillin should be prescribed, or some more complex disorder, with the decision as to what the more complex disorder is. Both decisions involve diagnostic and treatment judgments and medical procedures, but the former will be more common and usually will require far fewer considerations, judgments, and medically sophisticated techniques than the latter.<sup>26</sup> Recent medical studies suggest that the former, more limited decision and other similar medical acts, including diagnostic and treatment judgments and treatment modifications, may under appropriate conditions be performed competently by nonphysicians with limited and varied medical training.<sup>27</sup> The nonphysicians studied ranged

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<sup>22</sup> Evidence for this lies with new PA and NP statutes and regulations that now authorize such practices by nonphysicians. See, e.g., S.D. COMP. LAWS § 36-4A-22 (Supp. 1974) (authorizing many of these tasks for PAs); WASH. AD. CODE § 308-120-200 (1975) (authorizing many of these tasks for NPs).

<sup>23</sup> See text at notes 81-86 *infra* for a description of statutes limiting traditional medical delegations.

<sup>24</sup> See *Barber v. Reinking*, 68 Wash. 2d 139, 411 P.2d 861 (1966).

<sup>25</sup> In this Article, the standard for competent performance of medical acts by PAs and NPs will be assumed to be the level of competence that is expected of physicians. This conservative assumption is made for practical reasons. It relies on an existing standard of competence and is in accord with both the standard employed in medical evaluations of PAs and NPs, see, e.g., the studies cited in note 27 *infra*, and the standard apparently assumed by legislators in enacting the new statutes, see, e.g., CAL. BUS. AND PROF. CODE § 2510 (West 1974). This assumption begs the important but currently unanswerable question of what the appropriate standard should be. Should it be physician equivalence or some lower standard that is still acceptable in the sense that total social value of services performed exceeds total social cost? The availability of any such lower standard can only be ascertained by further experience with PAs and NPs.

<sup>26</sup> See Greenfield, Bragg, McGraith & Blackburn, *Upper-Respiratory Tract Complaint/Protocol for Physician-Extenders*, 133 ARCH. INTERN. MED. 294 (1974) [hereinafter cited as Greenfield]. This study found that the initial, more limited diagnostic and treatment judgment of upper-respiratory tract complaints was performed as competently by trained nonphysicians, both nurses and others, working under written protocols, as it was performed by physicians.

<sup>27</sup> *Id.* At least two other studies of initial, limited diagnostic and treatment judgments by nonphysicians have found similar results. Chappell & Drogos, *Evaluation of Infant Health Care by a Nurse Practitioner*, 49 PEDIATRICS 871 (1972) [hereinafter cited as Chappell & Drogos] (a professional nurse with five years' experience in a pediatrics emergency room and short-term medical training was responsible for all well-baby care and also diagnosed acute illnesses, treating some and referring others); Spitzer, Sackett, Sibley, Roberts, Gent, Kergin, Hackett & Olynich, *The Burlington Randomized Trial of the Nurse Practitioner*, 290 N. ENG. J. MED. 251 (1974) [hereinafter cited as Spitzer] (professional nurses

from high school graduates with four to six weeks training in diagnosing certain types of medical complaints under written protocols<sup>28</sup> to professional nurses with three months of additional medical training who conducted a general medical practice on an independent basis, referring more difficult problems to appropriate physicians.<sup>29</sup>

The usefulness of expanded medical delegation will depend on its economic as well as its medical feasibility. Economic feasibility requires that the economic value of the services delegated exceed the costs of such delegation. The high cost of physicians' services relative to the cost of nonphysicians' services suggests that much expanded delegation may be economically feasible. Physicians' incomes today appear to be in excess of four times those of professional nurses,<sup>30</sup> the allied health professionals whose functions most closely approximate those of PAs and NPs. It will be necessary to pay PAs and NPs something more than professional nurses, but not much more in view of relatively low PA and NP training costs.<sup>31</sup> Thus, if PAs and NPs earn a salary equal to one-third of physicians' incomes,<sup>32</sup> and if their use in expanded delegation increases physicians' productivity by more than a third, it will pay physicians to

with three months' additional medical training treated patients in a family practice on an independent basis, referring more difficult problems [approximately one-third of all visits] to appropriate physicians); see also Silver, Ford & Day, *The Pediatric Nurse-Practitioner Program*, 204 J.A.M.A. 298 (1968) (pediatric nurse practitioners were able to give "total care" to more than 75% of all children who came to pediatric clinics, including almost all well-children and approximately half of the children with illnesses or injuries). A larger number of studies have found that various types of nonphysicians can perform as competently as physicians certain treatment modifications and medical procedures not traditionally delegated. Bessman, *Comparison of Medical Care in Nurse Clinician and Physician Clinics in Medical School Affiliated Hospitals*, 27 J. CHRON. DIS. 115 (1974) [hereinafter cited as Bessman]; Charles, Stimson, Maurier & Good, *Physician's Assistants and Clinical Algorithms in Health Care Delivery*, 81 ANN. INTERN. MED. 733 (1974); Charney & Kitzman, *The Child-Health Nurse (Pediatric Nurse Practitioner) in Private Practice*, 285 N. ENG. J. MED. 1353 (1971); Komaroff, Black, Flatley, Knopp, Reiffen & Sherman, *Protocols for Physician Assistants—Management of Diabetes and Hypertension*, 290 N. ENG. J. MED. 307 (1974) [hereinafter cited as Komaroff]; Lewis, Resnik, Schmidt & Waxman, *Activities, Events and Outcomes in Ambulatory Patient Care*, 280 N. ENG. J. MED. 645 (1969) [hereinafter cited as Lewis]; Runyon, *The Memphis Chronic Disease Program: Comparisons in Outcome and the Nurse's Extended Role*, 231 J.A.M.A. 264 (1975) [hereinafter cited as Runyon]. Cf. Dellaportas, Swords & Ball, *Diagnostic Efficiency of Paraprofessionals*, 64 AM. J. PUB. HEALTH 993 (1974). This study of physicians and nonphysicians diagnosing gonorrhea patients found that physicians exhibited diagnostic superiority, but that the diagnostic competence of the nonphysicians was sufficient to be useful in treating male but not female patients.

<sup>28</sup> Greenfield, *supra* note 26, at 295; Komaroff, *supra* note 27, at 308.

<sup>29</sup> Spitzer, *supra* note 27, at 252; Spitzer & Kergin, *Nurse Practitioners in Primary Care, I. The McMaster University Educational Program*, 108 CAN. MED. ASSOC. J. 991 (1973). Cf. Chappell & Drogos, *supra* note 27; Silver, Ford & Day, *The Pediatric Nurse-Practitioner Program*, 204 J.A.M.A. 298 (1968).

<sup>30</sup> The AMA's 1973 estimates for average net incomes of physicians by specialty range from a little over \$40,000 for pediatricians and general practitioners to more than \$58,000 for surgeons. D. HAPGOOD, *THE SCREWING OF THE AVERAGE MAN* 129 (1974). In 1973 the average annual salaries of general duty registered nurses in public hospitals in 21 major cities ranged from \$8,500 to \$11,000, with salaries over \$9,800 only in two of the 21 cities. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, MONTHLY LABOR REVIEW (April 1974).

<sup>31</sup> The total costs of training a professional nurse as a pediatric nurse practitioner was estimated for one program to be \$1,755. Yankauer, Tripp, Andrews & Connelly, *The Costs of Training and the Income Generation Potential of Pediatric Nurse Practitioners*, 49 PEDIATRICS 878, 881 (1972) [hereinafter cited as Yankauer]. With such minimal training costs, only small increases above professional nurse salaries should be sufficient to induce nurses to train and seek employment as NPs.

<sup>32</sup> This estimate for the level of PA and NP salaries may be slightly high. One survey found that average PA salaries by specialty in 1972 varied from \$10,000 to \$14,000. Scheffler, *The Market for Paraprofessionals: The Physician Assistant*, Q. REV. ECON. & BUS., Autumn 1974, at 47, 50-51. A survey of pediatric nurse practitioners from one program found their average salary in 1971 to be \$9,300. Yankauer, *supra* note 31, at 880 table III. Compare these PA and NP salaries with physician incomes for 1973 described in note 30 *supra*.

employ such persons. Recent economic evaluations of PAs and NPs indicate that gains in physician productivity from effective use of full-time PAs and NPs are likely to be far in excess of 33 percent.<sup>33</sup>

Finally, it should be noted that feasible medical delegations are likely to vary substantially in the manner in which they are implemented. The different types of nonphysicians who might be employed has already been suggested. The nature of the physician-nonphysician relationship also may vary. Depending upon the nature of the delegated acts and the skills of the nonphysician, these acts might be performed on a limited, independent basis, with referral of more difficult problems to physicians;<sup>34</sup> upon referral from a physician after an initial diagnosis has been made;<sup>35</sup> or under a physician's supervision, which may vary from personal observation<sup>36</sup> to periodic communication with and review of the work of the nonphysician.<sup>37</sup> The medical acts considered delegable and the necessary qualifications of any nonphysician to perform them also will vary over time, as physicians and nonphysicians obtain new knowledge and skills from experience and as medical technology and economic conditions change.<sup>38</sup>

Professional and public interest in a coordinated effort to expand medical delegation has developed only in the last ten years. The Duke University Medical Center began its Physicians' Assistants Program and the University of Colorado Medical School its Pediatric Nurse Practitioner Program in 1965.<sup>39</sup> Only two years later the National Advisory Commission on Health Manpower recommended that federal financial support be given to training and employing PAs and NPs,<sup>40</sup> and by 1971, President Nixon was recommending substantial funding of these programs.<sup>41</sup> Since then the multiplicity of training programs<sup>42</sup> and medical and economic studies<sup>43</sup> seem to indicate that substantial expansion of medical delegation is both medically and economically feasible.

### B. *Potential Benefits from Expanded Medical Delegation*

Proponents of a planned expansion of medical delegation have argued that

<sup>33</sup> One economic study has found that current use of PAs in physicians' offices may increase physician productivity from 49% to 74%, depending upon the extent of delegation by the physician. Smith, Miller & Golladay, *An Analysis of the Optimal Use of Inputs in the Production of Medical Services*, 7 J. HUM. RES. 208, 218-23 (1972). A less rigorous economic evaluation of NPs found some economic benefit for physicians employing NPs instead of professional nurses in their office practices, although this study did not take into account the possibility of increased physician time spent supervising and consulting with NPs or the likely need to adjust assignments and salaries of other personnel in the physicians' offices. Yankauer, *supra* note 31, at 882-84.

<sup>34</sup> See Chappell & Drogos, *supra* note 27; Spitzer, *supra* note 27.

<sup>35</sup> See Bessman, *supra* note 27; Komaroff, *supra* note 27; Lewis, *supra* note 27; Runyon, *supra* note 27.

<sup>36</sup> Supervision by personal observation will occur, for example, when a PA or NP takes over the role of an assisting physician in surgery.

<sup>37</sup> See Charney & Kitzman, *The Child-Health Nurse (Pediatric Nurse Practitioner) in Private Practice*, 285 N. ENG. J. MED. 1353 (1971).

<sup>38</sup> See Forgotson, *supra* note 10, at 291.

<sup>39</sup> See note 9 and accompanying text *supra*.

<sup>40</sup> 1 NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER, REPORT OF THE PANEL ON EDUCATION & SUPPLY 25, 32-33 (1967).

<sup>41</sup> President Nixon, *Message*, *supra* note 1, at 3122.

<sup>42</sup> See text at note 7 *supra*.

<sup>43</sup> See notes 27 and 33 and accompanying text *supra*.

this expansion would serve two important social needs—an economic need to provide medical services at lower cost<sup>44</sup> and a social need to provide more responsible, more challenging, and better-paid job opportunities for a variety of social groups, including under-employed members of minority groups and unemployed and under-employed nurses.<sup>45</sup> A brief analysis of these claims will help indicate the potential significance and potentially complex purposes of expanded delegation.

Perceptions of a general economic need to provide lower cost medical services seem to have resulted in large part from the extraordinary increase in physicians' fees that has occurred since World War II.<sup>46</sup> From 1950 to 1972, physicians' fees increased almost twice as much as the overall consumer price index.<sup>47</sup> This increase has apparent causes that suggest that expanded delegation may be useful in constraining future medical costs. First, during the post-World War II period the demand for physician services has increased much more rapidly than the supply, due to expanding personal incomes and, importantly, the increasing availability of medical insurance.<sup>48</sup> On the other hand, the supply of physician services has increased slowly because of a variety of factors, including unduly restrictive professional controls over the expansion of medical schools,<sup>49</sup> the lack of response by nonprofit medical schools to price signals,<sup>50</sup> and the failure or inability of physicians to delegate additional medical functions to nonphysicians.<sup>51</sup> Secondly, another and perhaps substantial part of the increase in physicians' fees may be explained as payment for higher costs of higher quality services.<sup>52</sup> Higher quality physician services are not an un-mixed blessing, however, because they may result merely from the availability of medical insurance and the consequent discretion of physicians to provide the highest quality and highest priced services possible, rather than from consumer demand for higher quality services.<sup>53</sup> Determination of quality and

<sup>44</sup> See, e.g., President Nixon, Message, *supra* note 1. State legislatures have expressed similar concern with rising medical costs and interest in diminishing costs by expanded delegation in the purposes sections of many PA statutes. See, e.g., CAL. BUS. & PROF. CODE § 2510 (West 1974).

<sup>45</sup> See, e.g., SADLER & BLISS, *supra* note 9, at 16-18.

<sup>46</sup> See, e.g., President Nixon, Message, *supra* note 1, at 3120-23.

<sup>47</sup> Feldstein, *The Medical Economy*, SCIENTIFIC AM., Sept. 1973, 151, 152-53 (1973) [hereinafter cited as Feldstein, *Medical Economy*].

<sup>48</sup> See Posner, *Regulatory Aspects of National Health Insurance Plans*, 39 U. CHI. L. REV. 1, 2 (1971). Cf. Feldstein, *Medical Economy*, *supra* note 47, at 153-55.

<sup>49</sup> See text at notes 94-102 *infra*.

<sup>50</sup> Arrow, *Uncertainty and the Welfare Economics of Medical Care* 53 AM. ECON. REV. 941, 952-53 (1963); Lindsay, *Real Returns to Medical Education*, 8 J. HUM. RES. 331, 332 n.1 (1973). Professional controls over medical education help explain the prevalence of nonprofit medical schools. See R. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST*, 66-69 (1971) [hereinafter cited as STEVENS].

<sup>51</sup> Posner, *Regulatory Aspects of National Health Insurance Plans*, 39 U. CHI. L. REV. 1 (1971). See also section I. C. *infra*.

<sup>52</sup> See Feldstein, *The Rising Price of Physicians' Services*, 52 REV. OF ECON. & STAT. 121, 122 (1970) [hereinafter cited as Feldstein, *Rising Price*]. Cf. Feldstein, *Medical Economy*, *supra* note 47, at 154.

<sup>53</sup> Consumers generally will choose a product by balancing price and quality, in many cases accepting a lower quality product because of lower price. In medicine, however, the availability of insurance keeps consumers' out-of-pocket costs for particular services at relatively low levels. This low "net price" to consumers and their relative inability or unwillingness to question physicians about the quality of any particular service give physicians broad discretion to establish the quality and price of their services. See Feldstein, *Medical Economy*, *supra* note 47, at 153-55. Also see Feldstein, *Rising Price*, *supra* note 52, at 121.



price in this manner causes unnecessary resources to be used in medical care.<sup>54</sup>

Expanded medical delegation may increase the effective supply of physician services relative to demand.<sup>55</sup> To the extent this happens, expanded delegation will be a faster and less expensive way to increase the supply of physician services than the alternative of training additional physicians. In addition, expanded delegation may impress upon consumers the idea that they can judge the quality of at least some simpler, more routine medical acts. This would induce greater price consciousness in consumers and reduce the discretion of physicians to make quality and price decisions alone. Both of these potential characteristics of expanded delegation will tend to reduce medical costs, and such reductions might be substantial in view of the recent history of medical prices.

Expanded delegation may provide particularly significant economic benefits in two sectors of the medical economy. The first is the urban-based, specialty-oriented medical center, where physicians already rely on physician-directed "health teams" to provide much care. Modern medicine's frequent development of new methods of treatment in this setting requires that team members as well as physicians obtain and apply new medical skills at a rapid rate.<sup>56</sup> The second sector consists of rural and some low-income urban areas in which physicians have become a vanishing breed.<sup>57</sup> In these areas the ability of the remaining physicians to provide medical care may be expanded substantially by the use of PAs or NPs, who may practice in different towns from their supervising physician<sup>58</sup> or on an independent basis, referring more difficult cases to physicians.<sup>59</sup> Clearly, the two sectors require quite different types of new delegations. In specialty-oriented medical centers, these delegations frequently will be narrowly defined ones, for which short-term on-the-job training is appropriate, and the nature of these delegations is likely to change at a relatively rapid pace. In areas of physician shortage, delegations are more likely to consist of a broad range of medical acts involving more independent judgment by the nonphysician. In the latter setting, the PA or NP will function more as a "junior doctor" and less as a "team member," and appropriate training may parallel somewhat the medical school model. Appropriate legis-

<sup>54</sup> Feldstein, *Medical Economy*, *supra* note 47, at 154.

<sup>55</sup> See text at notes 25-33 *supra* for a discussion of the potential feasibility of substantial expanded delegation. Physician services will not be increased, however, to the extent supervising physicians employ PAs and NPs to obtain greater leisure time for themselves rather than to expand their practices. In addition, the ability of physicians to generate new demand for their services may reduce the effect of expanded delegation on medical costs. See text at notes 117-18 *infra*.

<sup>56</sup> Forgotson, *supra* note 10, at 291.

<sup>57</sup> In 1970 over one-third of the counties in the United States had a physician/population ratio less than one-third the national average of one physician for every 630 persons. No private physicians were found in 130 of these counties. Similar low physician/population ratios exist in low income inner city areas. President Nixon, Message, *supra* note 1, at 3122.

<sup>58</sup> Nevada, South Dakota, Washington, and Wisconsin have authorized such remote practice by PAs. Regulations for the Certification of Physician's Assistants, Board of Medical Examiners of Nevada, § I.4 (1974); S.D. COMP. LAWS § 36-4A-29 (Supp. 1974); WASH. AD. CODE § 308-52-130(5)(b)(i); WIS. AD. CODE ch. Med. § 50.06 (effective April 1, 1975).

<sup>59</sup> Alaska, Nevada, and New Hampshire have authorized varying degrees of independent practice by NPs. See text at notes 442-48 *infra*.

lation to authorize and regulate expanded medical delegation should take account of these very different economic needs.

Medical delegation can help provide more adequate job opportunities whenever a set of medical services to be performed by a nonphysician is sufficient to constitute a full-time or part-time job that offers more responsibility and higher income than the nonphysician could otherwise obtain. Recent recognition of a need to provide more adequate nonphysician job opportunities in health care has arisen from three different sources. In each case expanded delegation has been viewed as a means of tapping under-utilized human resources and satisfying job expectations of particular disadvantaged groups. First, many nurses are under-utilized and correspondingly under-paid with respect to their medical training and skills.<sup>60</sup> At any given time a very large number of trained nurses are not practicing,<sup>61</sup> perhaps in good part because of the lack of professional challenge, under-utilization, and low pay. Secondly, the rise and fall of the war in Vietnam has trained and released into civilian life a large number of former medical corpsmen who have been trained to perform medical acts not traditionally delegated to civilian health care personnel.<sup>62</sup> Thirdly, many of the anti-poverty manpower programs promoted by the federal government in the 1960's attempted to develop "new career" opportunities in health care by providing remedial education and health care training at relatively low cost.<sup>63</sup>

It should be noted that attempts to serve the economic need to provide medical services at lower cost and the social need to provide more adequate job opportunities may not be complementary and in some cases may conflict. Expanded delegation may be made feasible only by employing persons with college or even medical school training, who are capable of obtaining adequate jobs outside the health care industry.<sup>64</sup> Additionally, much expanded delegation may involve narrowly defined, highly repetitive medical acts, and such delegation need not result in substantially increased responsibility or income for the nonphysicians involved.<sup>65</sup> On the other hand, programs to use expanded delegation to provide more adequate job opportunities may have legislative goals and draw legislative responses that reduce the possibility of maximum economic benefits from expanded delegation. Those sponsoring PA and NP

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<sup>60</sup> See SADLER & BLISS, *supra* note 9, at 58-64.

<sup>61</sup> *Id.* at 60 figure 2.

<sup>62</sup> See Smith, *MEDEX—An Operational and Replicated Manpower Program: Increasing the Delivery of Health Services*, 62 AM. J. PUB. HEALTH 1563 (1972); SADLER & BLISS, *supra* note 9, at 16.

<sup>63</sup> Such programs included those financed under the Manpower Development and Training Act of 1962, Act of Mar. 15, 1962, Pub. L. No. 87-415, 76 Stat. 23 (repealed by Act of Dec. 28, 1973, Pub. L. No. 93-203, tit. VI, 614, 87 Stat. 883); work training, workstudy, and special work and career development programs financed under the Economic Opportunity Act of 1964, 42 U.S.C. §§ 2701, 2737-49, 2751-56a, 2769-69f (§§ 2737-49 and 2769-69f repealed by Act of Dec. 28, 1973, Pub. L. No. 93-203, tit. VI, 614, 87 Stat. 883); and "Model Cities" programs financed under the Demonstration Cities and Metropolitan Development Act of 1966, 42 U.S.C. §§ 3301-74.

<sup>64</sup> For example, medical school graduates unable to obtain a physician's license may qualify as PAs, *see, e.g.*, Rules and Regulations for Physician's Assistants, Board of Medical Examiners of Alabama, Rule IX, § 2 (1971), and only persons with college degrees and additional training may qualify as PAs under Colorado's Child Health Associate Law, COLO. REV. STAT. ANN. §§ 12-31-106(d),(e) (1973).

<sup>65</sup> *See, e.g.*, Greenfield, *supra* note 26.

training programs are likely to be satisfied by and may even encourage legislation that recognizes expanded delegation only to a narrowly defined group, one that includes graduates of the program in question and excludes others.<sup>66</sup> If this traditional model of medical licensing legislation is followed,<sup>67</sup> the new legislation will ignore the general economic need for a broad variety of new delegations to persons with variable training and skills. In addition, in the face of claims that new legislation is needed to provide better jobs for persons with relatively little formal education, legislators and administrators may react adversely and set unnecessarily high education requirements as a condition to participation in expanded delegation.<sup>68</sup>

### C. *Legal Barriers to Expanded Delegation: The Need for Statutory Authorization*

Traditionally structured state statutes governing medical and allied health practices limit the legal rights of physicians to delegate medical acts in an innovative manner.<sup>69</sup> Thus some form of statutory amendment is necessary to obtain clear legal authorization for expanded medical delegation. The medical practice acts of all states require that the "practice of medicine" be conducted only by licensed physicians or persons specifically exempted by the acts.<sup>70</sup> These acts typically define the practice of medicine in broad although imprecise terms,<sup>71</sup> and they provide criminal, civil, and administrative sanctions (fines, imprisonment, injunctions, and revocation of physician licenses) for the unlicensed practice of medicine and for aiding and abetting another in such practice.<sup>72</sup>

In the few relevant court decisions testing the legality of delegation of medical acts to unlicensed persons, courts have tended to give a broad reading to the "practice of medicine" in finding the delegation illegal.<sup>73</sup> They also have rejected the defense that the only "practitioner" was the delegating physician and that unlicensed persons working under physician supervision were not

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<sup>66</sup> For example, a prime force behind enactment of New York's PA statute was the Brooklyn Hospital-Long Island University Physician's Associate Program, a two-year training program. The program lobbied for enactment of a PA statute during the 1970 and 1971 sessions of the New York legislature, supporting a requirement that PAs have at least two years training in a formal education program. Interview with Arnold Lewis, M.D., Director, in New York City, Spring 1971. New York enacted such a requirement, N.Y. Educ. Law § 6531(1)(d) (McKinney 1972), and it has been one of the few states to specify a minimum of two academic years' training for primary care PAs. See note 255 *infra*.

<sup>67</sup> The traditional model of medical licensing laws is discussed in section I. C. *infra*.

<sup>68</sup> For example, the Brooklyn Hospital PA program mentioned in note 66 *supra* was originally funded in part by Model Cities funds, and it accepted students who had not completed high school, although these students were required to obtain a high school equivalency certificate as a condition of completing the program. Interview with Arnold Lewis, M.D., Director, in New York City, Spring 1971. It was the author's observation, in the course of lobbying for the New York City Health Services Administration for more liberal PA qualification requirements in New York, that New York's relatively high formal training requirements for PAs resulted in part from concern by both legislators and administrators about the practice of medicine by persons with little formal education.

<sup>69</sup> The discussion in this section follows Forgotson, *supra* note 10, at 290-95, 414-28.

<sup>70</sup> *Id.* at 290.

<sup>71</sup> *Id.* See, e.g., New York's definition of the practice of medicine at note 11 *supra*.

<sup>72</sup> See, e.g., N.Y. Educ. Law §§ 6509-15 (McKinney 1972).

<sup>73</sup> See, e.g., *Magit v. Board of Medical Examiners*, 57 Cal. 2d 74, ..., 17 Cal. Rptr. 488, 490-93, 366 P.2d 816, 818-21 (1961).

themselves practicing medicine but acting as mere agents of the physician.<sup>74</sup> These holdings have been based upon the theory that the policy underlying medical practice acts was to protect the public by utilizing the state licensure process to determine a person's competency.<sup>75</sup>

Any unlicensed person to whom medical acts are delegated, any physician who supervises such a person, and any employer may risk imposition of additional liability in malpractice cases because of the delegation. This additional liability may result from judicially created rules that disfavor the unlicensed practice of medicine, such as a presumption of negligence, conclusive or rebuttable, from the fact of unlicensed practice<sup>76</sup> or the refusal to admit evidence of a custom of the unlicensed practice, despite the custom's relevance to the issue of the unlicensed person's ability to perform the delegated act with reasonable care.<sup>77</sup> These disfavoring rules, like broad interpretations of medical practice and rejection of the agency defense in criminal and administrative proceedings concerning the unlicensed practice of medicine, have been based upon medical practice acts' underlying policy of protecting the public by a licensure process.<sup>78</sup>

State statutory law does recognize two types of medical practice by persons who are not licensed physicians. The first type is authorized by specific exemptions from the medical practice acts. These exemptions are limited to well-identified groups such as consulting physicians from out of state, good samaritans, and medical students and interns working under the supervision of a licensed physician.<sup>79</sup> These exemptions generally have not provided legal authority for expanded medical delegation.<sup>80</sup>

Allied health personnel licensure laws authorize the second type of medical practice by persons not licensed as physicians. These laws generally are not appropriate vehicles for authorizing expanded medical delegation because they authorize only limited medical practice by specific groups of allied health personnel, who qualify by showing competence to perform an entire range of medical and nonmedical acts.<sup>81</sup> In terms of expanded medical delegation, professional nursing practice acts are probably the most important of these laws, and they reveal the legal problem for expanded medical delegation that is

<sup>74</sup> *Id.* at ...., 17 Cal. Rptr. at 492, 366 P.2d at 820.

<sup>75</sup> *Id.* at ...., 17 Cal. Rptr. at 493, 366 P.2d at 821; Forgotson, *supra* note 10, at 293.

<sup>76</sup> See Leff, *Medical Devices and Paramedical Personnel: A Preliminary Context for Emerging Problems*, 1967 WASH. U.L.Q. 332, 387-88 [hereinafter cited as Leff].

<sup>77</sup> Barber v. Reinking, 68 Wash. 2d 139, ...., 411 P.2d 861, 864 (1966).

<sup>78</sup> *Id.* at ...., 411 P.2d at 864.

<sup>79</sup> Forgotson, *supra* note 10, at 290.

<sup>80</sup> See *id.* Exceptions are the two earliest PA statutes, Colorado's first PA statute and Kansas' statute, which provided specific exemptions for "services" rendered under a physician's "supervision." COLO. REV. STAT. ANN. § 12-36-106(3)(L) (1973) (enacted 1951); KAN. STAT. ANN. § 65-2872(g) (1972) (enacted 1957), amended in effect by KAN. STAT. ANN. § 65-2896 to -2896c (Supp. 1975). These statutes were enacted in the 1950s, in an apparent attempt to codify the existing custom of limited medical delegations to practical nurses and relatives of at-home patients. See letter from Leo B. Dixon to Vicki Courtney, Mar. 25, 1974. These statutes subsequently have been interpreted as authorizing use of the modern-day PA. Letter from Loretta Arduser, Secretary, Colorado State Board of Medical Examiners, to Philip Kissam, June 17, 1975; Opinion Letter of the Kansas Attorney General, Opinion No. 73-420, Dec. 28, 1973.

<sup>81</sup> See Forgotson, *supra* note 10, at 423-28.

common to all such statutes. Nursing practice acts typically require that the "practice of professional nursing" be conducted only by licensed, registered professional nurses (RNs).<sup>82</sup> The "practice of professional nursing" is usually defined in broad and imprecise terms,<sup>83</sup> which might seem to authorize delegation of any medical act to an RN, except that specific authority is usually provided for RNs to perform limited types of medical acts, typically, "the administration of medications and treatments as prescribed by a licensed physician."<sup>84</sup> Frequently these acts also provide that professional nursing practice shall not include "acts of diagnosis or prescription of therapeutic or corrective measures."<sup>85</sup> Thus many, if not all, traditional professional nursing practice acts appear to preclude the delegation of diagnostic and treatment judgments to RNs. Moreover, the ambiguous definition of nursing practice, which includes specific authority for limited medical acts, creates substantial uncertainty about the legality of other new medical delegations to RNs. To establish legal authority for such delegations under these statutes, it is necessary to rely upon case-by-case interpretations of the statutes by state Attorneys General, state licensing boards, and occasionally the courts, with the possibility of subsequent reinterpretations as well. This process is likely to inhibit even those innovative medical delegations that might be authorized by the statutes as written.<sup>86</sup>

In summary, the traditional form of state law substantially limits the legal rights of physicians to delegate medical acts, both as to the persons to whom they may delegate and as to the nature of delegated acts. Delegations to unlicensed personnel are authorized only if the acts are deemed not to constitute "the practice of medicine," which has been defined broadly by statutes and judicial decisions. Delegations to licensed allied health personnel are authorized only if they fit within the provisions of a particular allied health personnel licensure act, which have been intended to authorize only a limited kind of medical practice. Statutory change is necessary to provide clear legal authority for any expanded delegation.

#### D. *The Economic and Political Context*

The medical and allied health practice acts described in the preceding section have helped create and now help protect areas of exclusive albeit overlapping practice by licensed groups. Substantial expanded medical delegation may threaten the economic and political interests based on this structure, and it is not surprising that many organizations of health professionals have participated actively in the establishment of the new legislation. Parts II and III of

<sup>82</sup> *Id.* at 413.

<sup>83</sup> *Id.* at 414. See, e.g., KAN. STAT. ANN. § 65-1113(b) (1972), which defines the practice of professional nursing as "any act in the observation, care, and counsel of the ill, injured or infirm, or in the maintenance of health or prevention of illness of others . . . or the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social science."

<sup>84</sup> See, e.g., KAN. STAT. ANN. § 65-1113(b) (1972).

<sup>85</sup> *Id.*

<sup>86</sup> Forgotson, *supra* note 10, at 423-25.

this Article indicate several instances in which these organizations have succeeded in protecting the interests of their members. There is, however, a complex relationship between expanded delegation and the interests of physicians and nurses. A preliminary analysis of this relationship will help explain many prevailing patterns in the new legislation.

### 1. *Specific Economic Interests and Expanded Delegation*

Arguably, organized medicine, represented in particular by the American Medical Association (AMA) and State Medical Societies,<sup>87</sup> has played an important, even essential, role in creating two significant characteristics of the medical economy that support physicians' fees and incomes<sup>88</sup> at an artificially high level.<sup>89</sup> The first characteristic is an unduly restricted supply of physician services caused by organized medicine's control over entry into the profession.<sup>90</sup> The second characteristic is the apparent absence of vigorous price competition among physicians,<sup>91</sup> resulting in part from organized medicine's control over competitive practices by physicians.<sup>92</sup> Substantial expansion of medical delegation may mitigate both characteristics, and it will be argued that organized

<sup>87</sup> Organized medicine may be defined as all national and state organizations of physicians. For a description of the history and present structure of organized medicine in the United States, see STEVENS, *supra* note 50, Parts I-IV. For a more specific description of the structure and political operations of the AMA and State Medical Societies, see *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L.J. 938 (1954) [hereinafter cited as *The AMA*].

<sup>88</sup> For purposes of economic analysis, it seems appropriate to treat physicians as utility maximizers rather than as simple profit maximizers. Feldstein, *Rising Price*, *supra* note 52, at 122. Accordingly, a physician's income may include not only monetary benefits but also such nonmonetary ones as satisfaction from providing charitable services, from handling interesting cases, and from obtaining nonphysicians' respect for the physician's prowess, whether justified or not. *Id.*; Lindsay, *Real Returns to Medical Education*, 8 J. HUM. RES. 331, 346-47 (1973); Ruffin and Leigh, *Charity, Competition and the Pricing of Doctors' Services*, 8 J. HUM. RES. 212, 216-17 (1973) [hereinafter cited as Ruffin and Leigh].

<sup>89</sup> To claim that physicians' fees and incomes are artificially high, one must propose and justify an appropriate standard against which these fees and incomes may be compared. One standard might be that level of fees and incomes that would result from a perfectly competitive market for physician services, *i.e.* one that is free of all state and professional controls over entrance and economic competition. This standard, however, assumes that any form of physician licensure is unjustified. This may not be the case. See text at note 230 *infra*. A standard that avoids questioning physician licensure would be the level of fees and incomes that would result if physician licensure laws were administered only for the purpose of determining the competence of new physicians and if physician pricing and other competitive practices were free of state and professional controls. The justification for this standard consists of two policy arguments—one against special interest legislation and another against anti-competitive practices whether embodied in legislation or professional practices.

<sup>90</sup> See Kessel, *The AMA and the Supply of Physicians*, 35 LAW & CONTEMP. PROB. 267, 267-79 (1970) [hereinafter cited as Kessel, *Supply of Physicians*].

<sup>91</sup> Economists have taken different theoretical positions about whether or not there is price competition among physicians, differences that have not yet been resolved by empirical studies. See Newhouse, *A Model of Physician Pricing*, 37 SO. ECON. J. 174 (1970) [hereinafter cited as Newhouse]; Frech & Ginsburg, *Physician Pricing: Monopolistic or Competitive? Comment*, 38 SO. ECON. J. 573 (1972); Newhouse & Sloan, *Physician Pricing: Monopolistic or Competitive? Reply*, 38 SO. ECON. J. 577 (1972) [hereinafter cited as Newhouse & Sloan] (the first of these three articles presented a model showing empirically that physician pricing is monopolistic rather than competitive; the comment found a crucial error in the model and the reply admitted error). Notwithstanding this absence of empirical verification, the apparent inability of consumers to assess the quality of different physician services and the unavailability to consumers of information about comparative prices for physician services strongly suggest that most consumers do not seek out lower-priced medical services among those of the same quality. See Newhouse, *supra* at 175. In this situation, price competition will not be a factor in the pricing of physician services, and physicians will have the ability to price their services at levels above those that would prevail in price competitive markets. See P. AREEDA, *ANTITRUST ANALYSIS*, ¶ 114 (2d ed. 1974) [hereinafter cited as AREEDA].

<sup>92</sup> See Kessel, *Price Discrimination in Medicine*, 1 J. LAW & ECON. 20 (1958) [hereinafter cited as Kessel, *Price Discrimination*].

medicine has attempted to limit any such impact by establishing unduly restrictive rules in the new legislation.<sup>98</sup>

In this century, organized medicine has controlled the supply of physicians through two mechanisms—state licensure of physicians and accreditation of medical schools by the AMA's Council on Medical Education.<sup>94</sup> State medical practice acts almost uniformly require graduation from an "approved" medical school and satisfactory completion of basic science and medical examinations as conditions of licensure.<sup>95</sup> State medical licensing boards are responsible for approving medical schools and setting examinations, and these boards are composed almost entirely of physicians appointed usually on the recommendation and sometimes by nomination of State Medical Societies.<sup>96</sup> These boards have relied almost exclusively on AMA accreditation as the standard for approval of medical schools.<sup>97</sup> Because of this link between state laws and medical school accreditation, the AMA's Council on Medical Education has been able to reduce the number of new physicians entering the profession by increasing the standards for accreditation of medical schools, thereby driving some schools out of business, discouraging new schools from opening, and reducing the size of others.<sup>98</sup>

The social justification for state licensing of physicians and AMA accreditation of medical schools is, of course, that these controls are necessary to protect the public from incompetent practitioners.<sup>99</sup> Available evidence indicates, however, that organized medicine has been at least equally concerned with using these controls to protect physicians' incomes by reducing the supply of physicians. The quality standards imposed for physician licensure have never been carefully correlated with definitions of acceptable medical performance,<sup>100</sup> nor have quality standards always been administered to ensure the highest possible quality of physicians, as evidenced by the failure of licensing boards to monitor the quality of care delivered by physicians after they are licensed.<sup>101</sup> Most significantly, major "improvements" in standards for accredited medical schools generally have been imposed at times when physicians' incomes were relatively depressed and have been accompanied by open expressions of concern by leaders of organized medicine about the "over-crowded" medical profession.<sup>102</sup>

The apparent absence of vigorous price competition among physicians has complex causes and complex consequences that are relevant to the relationship between physicians' economic interests and expanded delegation. One cause appears to be consumers' relative inability to evaluate the quality of medical

<sup>98</sup> See part III. *infra*.

<sup>94</sup> See STEVENS, *supra* note 50, at 55-73; Kessel, *Supply of Physicians*, *supra* note 90, at 267-68.

<sup>95</sup> Forgotson, *supra* note 10, at 303-04.

<sup>96</sup> *Id.* at 296-97.

<sup>97</sup> STEVENS, *supra* note 50, at 68.

<sup>98</sup> *Id.* at 66-68, 177; Kessel, *Supply of Physicians*, *supra* note 90, at 268-70; *The AMA*, *supra* note 87, at 971-74.

<sup>99</sup> Kessel, *Supply of Physicians*, *supra* note 90, at 274.

<sup>100</sup> *Id.* at 268-69; Carlson, *supra* note 10, at 859-61.

<sup>101</sup> Carlson, *supra* note 10, at 864; Forgotson, *supra* note 10, at 312-15; Kessel, *Supply of Physicians*, *supra* note 90, at 275.

<sup>102</sup> See STEVENS, *supra* note 50, at 60-61, particularly n.13, 176-77.

services, a lack that renders them incapable of choosing a lower-priced service among those of similar quality.<sup>103</sup> A second cause may be the unavailability of comparative prices for medical services resulting from a number of legal, professional, and social controls that organized medicine has established and used for the apparent purpose of limiting price competition by physicians.<sup>104</sup> These controls have included statutory and other less formal prohibitions against price advertising by physicians;<sup>105</sup> exclusion of "price-competing" physicians from county medical societies, in which membership has often been a prerequisite for either staff privileges in hospitals or certification by medical specialty boards;<sup>106</sup> and in some extreme cases attempts to revoke the licenses of price-competing physicians by state medical boards.<sup>107</sup> In a less organized way, physicians can sanction price competition by refusing to refer patients or grant hospital privileges to price competitors and by refusing to testify in their defense in malpractice cases.<sup>108</sup>

Absence of price competition will provide individual physicians with some degree of "market power"; that is, the ability to establish their own prices for medical services in contrast to a price competitor who accepts a market-determined price.<sup>109</sup> The ability to establish prices as a monopolist enables a

<sup>103</sup> See Newhouse, *supra* note 91, at 174-75.

<sup>104</sup> See Kessel, *Price Discrimination*, *supra* note 92, at 29-45. As with organized medicine's control over entry, the usual argument made to support the establishment or exercise of any control over price competition among physicians is that the control is necessary to protect the public from incompetent practice. This argument, however, appears to be extremely weak in many instances. It is unclear, for example, why membership in a county medical society should be a necessary condition for admitting privileges in a hospital when the hospital can establish its own quality control procedures. See Ludlam, *Physician—Hospital Relations: The Role of Staff Privileges*, 35 *LAW & CONTEMP. PROB.* 879, 885-86 (1970). Yet historically, the AMA has induced hospitals to require such membership, and expulsion from county medical societies has therefore been a powerful sanction for organized medicine to use against price competitors. See Kessel, *Price Discrimination*, *supra* note 92, at 29-38.

<sup>105</sup> An example of a current statutory prohibition against price advertising by physicians is *KAN. STAT. ANN.* § 65-2837(i) (1972); see Kessel, *Price Discrimination*, *supra* note 92, at 43-44, for a description of less formal prohibitions.

<sup>106</sup> See Kessel, *Price Discrimination*, *supra* note 92, at 29-38.

<sup>107</sup> *Id.* at 34-36.

<sup>108</sup> *Id.* at 44-45.

<sup>109</sup> In classical economic terms, the pricing of physician services without price competition may take any one of three forms: simple, price discriminating, or collective monopolization. See Newhouse, *supra* note 91 (these terms correspond to Newhouse's terms "simple monopolies," "price discriminating monopolies," and "cartels"). Simple monopolization involves a supplier setting its own prices without reference to prices charged by other suppliers. Simple monopolizers may not experience any economic competition from other suppliers or they may compete with other suppliers by nonprice methods. All economic competition will be absent in one-physician or one-specialist communities or in situations wherein patients select physicians in a totally random manner. See *id.* at 175. Nonprice methods of competition exist if patients in fact select physicians on the basis of such criteria as the geographic location of physician offices, the relative waiting time for appointments, and the amount of personal attention a physician and his or her staff provide to patients. *Id.* Price discriminating monopolization also involves individual suppliers setting their own prices without reference to prices charged by others, but in this case consumers of an individual supplier are charged different prices for the same service depending upon their relative ability to pay. Kessel, *Price Discrimination*, *supra* note 92, at 20. Price discrimination will not succeed if other suppliers are able to cut their prices and take away the relatively high-priced business of the price discriminating supplier. *Id.* Price discrimination by physicians may occur most frequently among surgical and other hospital based specialists, whose service is less standardized and whose patients have less information about other physicians' prices and less opportunity to choose among practitioners than patients of primary care physicians. *Id.* at 42-43. *But see* Ruffin and Leigh, *supra* note 88, at 220. The third form of pricing without price competition, collective monopolization, involves suppliers setting a common price for a relatively standardized product or service, either by price fixing agreements or by tacit collusion among a limited number of suppliers serving one market. *AREEDA*, *supra* note 91, ¶¶ 114(c), 261, 306. Unlike simple or price discriminating monopolization, which may exist either because price competition is impossible or because it has been



physician to price services at levels above those that would prevail in competitive markets<sup>110</sup> and to engage in other monopolistic pricing practices that provide non-monetary benefits to the physician. Such non-monetary benefits may include, for example, the satisfaction of providing charitable services by varying prices to patients based upon their ability to pay<sup>111</sup> or the satisfaction from handling more challenging and interesting cases, which may be increased by setting prices to ensure an excess demand for physician services.<sup>112</sup>

Expanded medical delegation seems likely to increase the effective supply of physician services and to introduce into physician markets increased opportunities and pressures for effective economic competition. These effects may diminish the extraordinary income of physicians as well as the non-monetary benefits that result from undue supply restrictions and monopolistic physician pricing. Physicians and profit-making medical institutions are likely to discover that they can increase their incomes through employment of PAs and NPs, but only if their practices are substantially expanded.<sup>113</sup> Similarly, not-for-profit private and public medical institutions may find it more economical to open or expand ambulatory services by employing PAs and NPs.<sup>114</sup> Such expansions of service may be possible only if patients can be drawn away from other physicians and institutions through increasing price and nonprice competition. In addition to creating these incentives and opportunities to expand services, expanded delegation may change the nature of medical markets in two ways that increase the likelihood of competition among physicians. First, it is possible that the performance of many routine medical acts by nonphysicians will encourage medical consumers to develop their ability to evaluate the quality of care they purchase, thereby helping to create greater

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eliminated, collective monopolization eliminates price competition that would otherwise exist and establishes a "monopoly" price that provides suppliers with greater collective and individual incomes than otherwise. *Id.* ¶ 114(c). In medicine such pricing may be most likely to occur in relatively small communities among primary care physicians such as internists, pediatricians, and general practitioners whose service (*i.e.* periodic check-ups, management of common illnesses, etc.) is relatively standardized. In larger communities, collective monopolization would be possible only with explicit price-fixing agreements among the relatively large numbers of providers. There is some evidence that such agreements do not exist, *see* Newhouse & Sloan, *supra* note 91, at 578, and in any event such agreements are probably illegal under the recent Supreme Court decision holding price-fixing by lawyers to be illegal under the Sherman Act. *Goldfarb v. Virginia State Bar*, 95 S. Ct. 2004 (1975).

<sup>110</sup> See AREEDA, *supra* note 91, ¶ 114.

<sup>111</sup> See Ruffin and Leigh, *supra* note 88.

<sup>112</sup> See Feldstein, *Rising Price*, *supra* note 52; Brown & Lapan, *The Rising Price of Physicians' Services: A Comment*, 54 REV. OF ECON. & STAT. 101 (1972); Feldstein, *The Rising Price of Physicians' Services: A Reply*, 54 REV. OF ECON. & STAT. 105 (1972); Brown, Feldstein & Lapan, *The Rising Price of Physicians' Services: A Clarification*, 56 REV. OF ECON. & STAT. 396 (1974). This series of articles discusses, *inter alia*, whether physicians set prices to clear the market by equating demand and supply or whether they set prices at some lower level to ensure excess demand for their services and an abundant supply of interesting cases. Although the commentators do not reach a final resolution, they do conclude that there is some evidence to support the hypothesis that physicians set prices to ensure excess demand.

<sup>113</sup> See Golladay, Manser, & Smith, *Scale Economics in the Delivery of Medical Care: A Mixed Integer Programming Analysis of Efficient Manpower Utilization*, 9 J. HUM. RES. 50, 52 (1974). This study found that the use of PAs and NPs is likely to increase the scale of physician operations at which minimum cost is achieved and that diseconomies attributable to operating at a suboptimal scale are likely to be greater with PAs than in a system employing only traditional health workers.

<sup>114</sup> For example, the Health Maintenance Organization Act of 1973 contemplates that pre-paid medical group practices subsidized thereunder shall utilize such "allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services." 42 U.S.C. §§ 1302(4)(C), (5)(B) (Supp. IV, 1974).

price-consciousness among consumers and making price competition by providers more effective. Secondly, medical studies showing that PAs and NPs tend to provide more personal attention to patients than physicians in comparable situations suggest that PAs and NPs may be potent means of nonprice competition for their employers.<sup>115</sup>

One special feature of the medical economy qualifies organized medicine's interest in restricting the supply of physician services and offers a possible explanation for its willingness to tolerate some amount of expanded medical delegation.<sup>116</sup> Providers of medical services to some extent determine the demand for their services because of consumer ignorance about and dependence on the medical services they purchase and because of the existence of third-party reimbursements for a major share of medical costs.<sup>117</sup> For example, as a physician's capacity to serve patients expands, it may be relatively easy for him to schedule follow-up visits more frequently or to recommend a greater amount of elective surgery, particularly if the extra costs will be covered by health insurance.<sup>118</sup> Increasing the supply of physician services through expanded delegation will not jeopardize physicians' economic interests to the extent that the new supply generates an equal amount of new demand. Generation of demand by new supply will vary throughout the medical economy. One arena in which the use of physician-extendors would seem most likely to generate new demand is that of the medically underserved rural areas, where, by definition, an unmet demand for physicians' services already exists. Another likely area of new demand generation is the use of PAs and NPs to perform services that merely supplement and improve the quality of physician services, but do not substitute for them. These factors indicate that some limited expansion of medical delegation may not harm the economic interests of physicians.

The new legislation also may affect the economic interests of nurses and of PAs and NPs. Nurses correctly have feared harm to their economic interests to the extent that the duties of non-nurse PAs will overlap with nursing duties.<sup>119</sup> Such overlap seems likely to occur in the area of administration of physician-prescribed medications and treatments. If a PA is given authority to perform or to participate in patient diagnoses and treatments, it seems inevitable that the PA also will be given responsibility to administer medications and treatments. On the other hand, expanded medical delegations to nurses themselves should improve their compensation.<sup>120</sup> The new legislation may encourage the development of categories of PAs and NPs with specified qualifica-

<sup>115</sup> See, e.g., Bessman, *supra* note 27; Lewis, *supra* note 27; Runyon, *supra* note 27.

<sup>116</sup> Since 1970 the AMA has officially supported the general concept of the new legislation. See text at notes 210-20 *infra*.

<sup>117</sup> See Havighurst, *Regulation of Health Facilities and Services By "Certificate of Need"*, 59 VA. L. REV. 1143, 1156-60 (1973).

<sup>118</sup> *Id.* at 1158 n.56.

<sup>119</sup> See, e.g., AMERICAN NURSES' ASSOCIATION BOARD OF DIRECTORS, THE AMERICAN NURSES' ASSOCIATION VIEWS THE EMERGING PHYSICIAN'S ASSISTANT (Dec. 17, 1971); NEW YORK STATE NURSES ASSOCIATION BOARD OF DIRECTORS, NEW YORK STATE NURSES' ASSOCIATION'S STATEMENT ON THE PHYSICIAN'S ASSOCIATE AND SPECIALIST'S ASSISTANT (Jan. 31, 1972), reprinted in SADLER & BLISS, *supra* note 9, at apps. E & F.

<sup>120</sup> See Yankauer, *supra* note 31, at 880.

tions and duties. Such groups may be expected to have the traditional economic interest of licensed occupations in controlling supply by obtaining legislative rules that prohibit all persons without minimum like qualifications from performing a specified range of medical acts.<sup>121</sup>

## 2. *Other Political Interests and Expanded Delegation*

The new laws have been proposed, amended, enacted, and in some cases defeated<sup>122</sup> in a political environment involving relatively few interest groups: organized medicine; organized groups of allied health personnel such as state associations of nurses, dentists, and optometrists; educational institutions conducting PA or NP training programs; and, occasionally, interested public health agencies and consumer groups.<sup>123</sup> Proposals for PA statutes often have resulted from the existence of PA training programs,<sup>124</sup> while State Nurses' Associations often have provided the impetus for NP statutes.<sup>125</sup> Organized medicine and the allied health professions have frequently been in the position of responding to proposals from others.<sup>126</sup> Individual PA and NP training programs and their graduates have had relatively clear and limited political goals in seeking legislation to authorize expanded medical delegation. The training programs naturally have been most interested in obtaining legislation that authorizes immediate, effective employment of their graduates, no matter what the legislation may provide about medical delegations generally.<sup>127</sup> The graduates of such programs clearly have an interest in including themselves but excluding others from the new economic opportunities offered by expanded medical delegation.<sup>128</sup>

Organized nursing at times has opposed enactment of PA statutes or

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<sup>121</sup> See text at note 66 *supra*.

<sup>122</sup> Dean, *supra* note 10, at 1, lists 15 states in which legislatures had "considered but rejected a variety of PA proposals" as of the end of 1972. As of this writing, nine of these states had subsequently enacted PA statutes.

<sup>123</sup> See, e.g., notes 66, 68 *supra*.

<sup>124</sup> See note 66 and accompanying text *supra*; DUKE PROJECT, *supra* note 10, at 13-15 (recognizing that an express purpose of the conference on model PA legislation initiated by Duke University's PA program was to develop PA legislation for North Carolina).

<sup>125</sup> See letters to Philip Kissam from Michael R. Buggy, State of Cal. Bd. of Registered Nursing, Jan. 10, 1975; Marion M. Klappmeier, Me. State Bd. of Nursing, Jan. 8, 1975; Sister Vincent Fuller, S.D. State Bd. of Nursing, Mar. 10, 1975.

<sup>126</sup> See letters to Philip Kissam from Michael R. Buggy, State of Cal. Bd. of Registered Nursing, Jan. 10, 1975; Marguerite Hastings, State of N.H. Bd. of Nursing Education and Nurse Registration, Jan. 3, 1975; Sister Vincent Fuller, S.D. State Bd. of Nursing, Mar. 10, 1975, indicating participation of state medical societies in enactment of NP statutes. The provisions in many PA statutes that exclude PAs from competing with optometrists, dentists, podiatrists, and chiropractors indicate participation by other health professionals in PA legislation. See, e.g., WASH. REV. CODE ANN. § 18.71A.060 (Supp. 1974); WIS. STAT. § 448.51(4) (Supp. 1974). Nurses have obtained similar limiting provisions in at least three PA statutes, although the unusually muddy language of these provisions suggests legislative compromise with nursing opposition to the statutes. See NEB. REV. STAT. § 85-179.16 (Supp. 1974) (PAs not authorized "to engage in any of the health professions licensed by the department," which includes nursing) (emphasis added); N.Y. EDUC. LAW § 6532(7) (McKinney 1972) (PAs not authorized "to perform those specific functions and duties specifically delegated by law to those persons licensed as allied health professionals") (emphasis added); Nurse Practice Act of North Dakota, N.D. CENT. CODE § 43-17-02(10) (Interim Supp. 1975) (PAs not authorized "to perform any services which must be performed by persons licensed pursuant to chapter 43-12") (emphasis added).

<sup>127</sup> See text at note 66 *supra*.

<sup>128</sup> See text at note 121 *supra*.

attempted to restrict their provisions,<sup>129</sup> despite the apparent opportunity offered by these statutes for nurses as well as non-nurses to qualify for expanded medical roles. This opposition, although couched in terms of concern for the quality of medical care, seems to have been based upon fears of economic competition between nurses and non-nurse PAs (and perhaps between RNs and practical nurses), continuing domination of the nursing profession by physicians through the administration of PA statutes by medical licensing boards, and the interposition of PAs between the physician and nurse in the medical hierarchy.<sup>130</sup> As an alternative, organized nursing has begun to promote NP statutes that authorize expanded delegations only to RNs and place regulatory controls with state nurse licensing boards.<sup>131</sup> These boards are effectively controlled by State Nurses Associations in a manner similar to the way State Medical Societies control medical licensing boards.<sup>132</sup>

The political goals of organized medicine with respect to the new legislation have been complex. As already noted, the economic interests of physicians seem to dictate at best carefully controlled expansion of medical delegation. Nonetheless, at a time when public concern with health care threatens to increase public controls over the entire field, the leaders of organized medicine may be willing to ignore immediate economic interests and support "health reforms" so long as the reforms do not entail lay intervention with medical practice and can be controlled by the profession.<sup>133</sup> Expanded medical delegation, which by definition will be controlled by practicing physicians and by statute can be controlled by medical licensing boards, would seem to be the kind of reform that is politically acceptable and useful to organized medicine. The power of organized medicine to influence, if not control, the form of the new legislation seems beyond doubt. It historically has demonstrated substantial political power at the state level.<sup>134</sup> In addition, state medical licensing boards controlled by organized medicine would appear to be the logical administrative agency to regulate expanded medical delegation, and in fact these agencies have been chosen to regulate expanded delegations in most instances.<sup>135</sup>

## II. THE NEW LEGISLATION

The feature common to PA and NP legislation is the use of broad terms to authorize expanded medical delegation to nonphysicians. The statutes differ

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<sup>129</sup> See note 126 and accompanying text *supra*. The author's experience leads him to conclude that the New York State Nurses' Association, the major opponent to enactment of a PA statute in New York, caused the defeat of such a proposal in 1970 and in 1971 obtained the ambiguous language intended to limit the PA's scope of practice that is quoted in note 126 *supra*.

<sup>130</sup> See SADLER & BLISS, *supra* note 9, at 44-47, apps. E & F.

<sup>131</sup> See text at notes 165-76 *infra*.

<sup>132</sup> PUBLIC HEALTH SERVICE, DEP'T OF HEALTH, EDUCATION AND WELFARE, STATE LICENSURE OF HEALTH OCCUPATIONS 7-9, 72-75 (1967).

<sup>133</sup> For example, the AMA-endorsed "Medicredit Plan" for national health insurance, in comparison with other proposals, seems designed in part to limit the amount of government regulation over health care financing. See AMERICAN ENTERPRISE INSTITUTE, NATIONAL HEALTH INSURANCE PROPOSALS, Legislative Analysis No. 19, 93d Cong., 2d Sess. 37-54 (1974).

<sup>134</sup> The AMA, *supra* note 87, at 957-58.

<sup>135</sup> See text at note 354 *infra*.

as to the nonphysicians covered, the nature of administrative controls imposed over expanded medical delegation, and the manner in which a number of important rule-making issues have been resolved. This part of the Article will describe four basic types of new statutes—two types of PA statutes and two kinds of NP statutes. The following part will discuss several important rule-making issues that have been resolved in different ways by the statutes and the regulations promulgated thereunder.

### A. *The PA Statutes*

At this writing, at least 38 PA statutes are in effect in 37 states,<sup>136</sup> and similar proposals are pending in others.<sup>137</sup> These statutes have two distinguishing characteristics: they authorize potentially varied groups of nonphysicians to qualify as PAs, and they authorize supervising physicians to delegate a potentially broad range of medical acts to qualified PAs. With one exception, PA statutes recognize that any licensed allied health professional and any unlicensed person may, with appropriate medical training, qualify as a PA.<sup>138</sup> The determination of appropriate training by and large has been delegated to administrative agencies<sup>139</sup> and, in some cases, supervising physicians.<sup>140</sup> The statutes typically authorize PAs to perform "medical services" or "patient's services" under the "supervision" of a licensed physician.<sup>141</sup> Generally the statutes do not otherwise limit the nature of medical acts that may be delegated, except for the frequent requirement that PAs not function as or compete with certain allied health professionals, usually optometrists, podiatrists, chiropractors, and dentists.<sup>142</sup> A few statutes prohibit diagnostic and treatment judgments and drug prescriptions by PAs.<sup>143</sup>

Thirty-three PA statutes provide explicitly for some form of administrative control over expanded medical delegation;<sup>144</sup> these statutes will be referred to

<sup>136</sup> See PA statutes cited in notes 144, 152 *infra*.

<sup>137</sup> In June 1957, the legislatures of Delaware, Illinois and Ohio were considering PA bills. Letters to Philip Kissam from Mary Jane Clark, Administrative Assistant, Medical Council of Delaware, June, 1975; Ronald E. Stackler, Director, Dep't of Registration & Education of Illinois, July 8, 1975; William J. Lee, Administrator, State Medical Board of Ohio, June 26, 1975.

<sup>138</sup> The exception is Colorado's Child Health Associate Law, which requires a college degree as a condition of qualification. COLO. REV. STAT. ANN. § 12-31-106(1)(d) (1974).

<sup>139</sup> See text at notes 253-60 *infra*.

<sup>140</sup> See text at notes 289-94 *infra*.

<sup>141</sup> See, e.g., CAL. BUS. & PROF. CODE § 2512 (1974) (PAs may "perform medical service . . . under the supervision of a licensed physician"); GA. CODE ANN. § 84-6203(c) (Supp. 1974) (a PA is a person qualified "to provide patients' services not necessarily within the physical presence but under the personal direction or supervision of [a] physician").

<sup>142</sup> See, e.g., WASH. REV. CODE § 18.71A.060 (Supp. 1974); WIS. STAT. ANN. § 448.51(4) (Supp. 1974).

<sup>143</sup> Oregon has prohibited PAs from exercising "independent judgment in determining and prescribing treatment except in life-threatening emergencies." ORE. REV. STAT. § 667.065(3) (1974). Virginia has prohibited PAs from "the establishment of a final diagnosis or treatment plan for the patient" and "the prescribing or dispensing of drugs." VA. CODE ANN. § 54-281.4(a) (1974). In contrast, Colorado's Child Health Associate Law authorizes child health associates to "practice pediatrics" and to prescribe certain non-narcotic drugs if approved by the state medical board. COLO. REV. STAT. ANN. §§ 12-31-102(2),-103(2) (1974).

<sup>144</sup> ALA. CODE tit. 46, §§ 297(22jj)-(22nn) (Cum. Supp. 1973) (enacted 1971); ALASKA STAT. §§ 08.64.107 (Supp. 1974) (enacted 1974), 08.64.170(a)(1) (Supp. 1974) (amended 1974); ARIZ. REV. STAT. ANN. §§ 32-1421(9) (Supp. 1974) (amended 1972), 32-2501 (Supp. 1974) (enacted 1972); CAL. BUS. & PROF. CODE §§ 2510-22 (1974) (enacted 1970); COLO. REV. STAT. ANN. §§ 12-31-101 to -115

as "PA Regulatory Statutes." These statutes generally delegate broad regulatory authority to an administrative agency or agencies,<sup>145</sup> and regulations have been promulgated under most of these statutes.<sup>146</sup> At least 31 PA Regulatory Statutes

(1973) (enacted 1969); FLA. STAT. ANN. § 458.135 (Supp. 1975) (enacted 1971); GA. CODE ANN. §§ 84-6201 to -6209 (Supp. 1974) (enacted 1972); HAWAII REV. STAT. § 453-2 (Supp. 1974) (amended 1973); IDAHO CODE § 54-1806(d) (Supp. 1974) (amended 1972); IOWA CODE ANN. §§ 148B.1-.10 (1972) (enacted 1971); KAN. STAT. ANN. § 65-2872(g) (1972) (enacted 1957), §§ 65-2896 to -2896c (Supp. 1975) (amended 1975); ME. REV. STAT. ANN. tit. 32, §§ 2594-A (Supp. 1974) (enacted 1973), 3270-A (Supp. 1973) (enacted 1973); MD. ANN. CODE art. 43, § 122(b)(6) (Supp. 1974) (amended 1972); MASS. GEN. LAWS ANN. ch. 112, §§ 9C-H (Supp. 1975) (enacted 1973); MINN. STAT. ANN. §§ 145.861-.866 (Supp. 1975) (enacted 1973); NEB. REV. STAT. §§ 85-179.01-.18 (Supp. 1974) (enacted 1972); NEV. REV. STAT. §§ 630.015, -.025, -.271, -.273, -.275 (1973) (enacted 1973); N.H. REV. STAT. ANN. §§ 329:21 (XII)-(XIII) (Supp. 1973) (enacted 1971); N.M. STAT. ANN. § 67-5-3.1, -3.6, -10.1G (1974) (enacted 1973); N.Y. EDUC. LAW §§ 6530-36 (McKinney 1972) (enacted 1971) and N.Y. PUB. HEALTH LAW §§ 3700-02 (McKinney Supp. 1973) (enacted 1971); N.C. GEN. STAT. § 90-18(13) (Supp. 1974) (amended 1971); N.D. CENT. CODE § 43-17-02(10) (Supp. 1975) (House Bill No. 1484, approved April 8, 1975); OKLA. STAT. ANN. tit. 59, §§ 519-23 (Supp. 1974) (enacted 1972); ORE. REV. STAT. §§ 677.012, .055, .090, .232, .255, .510 (1973) (enacted 1971); S.C. CODE ANN. § 56-1355(4) (Supp. 1974) (enacted 1974); S.D. COMPILED LAWS ANN. §§ 36-4A-1 to -42 (Supp. 1974) (enacted 1973); UTAH CODE ANN. § 58-12-40 (1973) (enacted 1971); VT. STAT. ANN. tit. 26, §§ 1313(d)-(e), tit. 31, §§ 1725-29 (1975) (enacted 1971); VA. CODE ANN. §§ 54-281.4 to .9 (1974) (enacted 1973); WASH. REV. CODE ANN. §§ 18.71A.010-.060 (Supp. 1974) (enacted 1971); W. VA. CODE ANN. §§ 30-3A-1 to -4 (1971) (enacted 1971); WIS. STAT. ANN. § 15.407(2) (Supp. 1975) and §§ 445.01(3), 448.51 (1974) (enacted 1973); WYO. STAT. ANN. §§ 33-338.1 to .8 (Supp. 1975) (enacted 1973).

At this writing, the nature of the administrative control over expanded delegation that is authorized by the Kansas PA statute is somewhat unclear. Prior to 1975, the Kansas statute authorized the Kansas Board of Healing Arts to maintain a register of physicians' assistants, but PAs could practice in Kansas without registering. Letter from Vern Miller, Kansas Attorney General, to Lee J. Dunn, Legal Counsel to the University of Kansas Medical Center, Dec. 28, 1973 (Opinion No. 73-420). In 1975, Kansas amended its statute to provide that no person may use the PA title or "represent himself or herself to be a physician's assistant unless such person's name is entered on the register of the names of physician's assistants in accordance with the provisions of this act." KAN. STAT. ANN. § 2896c(a) (Supp. 1975). Arguably any performance by a nonregistered person of direct patient care acts that are also performed by registered PAs will constitute a "representation" of that person as "a physician's assistant"; under this interpretation any such delegation to nonregistered persons would be prohibited under the new Kansas law. To the contrary, it might be argued that the new statutory provision prohibits only statements made by nonregistered persons that are intended to cause patients to believe that the nonregistered persons are registered PAs or have similar qualifications. This statement-act distinction does not seem entirely persuasive because the statutory language might have been but is not so limited and because the effect of the two situations may be similar. In any event, the second, more limited interpretation would still limit substantially the rights of physicians to delegate expanded medical acts to nonregistered persons because of grave uncertainty about what patients may be told. Thus it seems appropriate to classify the Kansas statute, as amended, as a PA statute that establishes administrative controls over expanded delegation.

<sup>145</sup>See text at notes 138-43 *supra* for a discussion of the relatively few statutory standards that govern PAs' qualifications and scope of practice. In such a vacuum, authority granted to an administrative agency under a PA Regulatory Statute to issue rules and regulations to carry out the purposes of the statute will be quite broad indeed.

<sup>146</sup>In June, 1974, the author requested copies of PA regulations from responsible administrative agencies under all PA Regulatory Statutes. Follow-up letters were sent to agencies not responding or indicating an intent to promulgate regulations at a future date. Colorado's medical licensing board has chosen not to issue regulations under Colorado's Child Health Associate Law. Letter from Loretta Arduser, Secretary, Colorado State Board of Medical Examiners, to Philip Kissam, June 17, 1975. Regulations under eight other statutes had not been developed or were not made available. The following regulations promulgated under 24 PA Regulatory Statutes were obtained, and hereinafter each will be cited as "(name of state) PA Regs." These regulations were in effect as of June 1974, unless otherwise indicated. Rules and Regulations for Physician's Assistants, Board of Medical Examiners of Ala.; Regulations for the Ariz. Physician's Assistant, Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery; CAL. AD. CODE tit. 16, ch. 13, art. 15, §§ 1379 to 1379.75 (as amended Oct. 7, 1974); Rules and Regulations for Physician's Assistant, State of Florida Board of Medical Examiners; Rules of Composite State Board of Medical Examiners of Georgia, ch. 360-5; IOWA DEP'T REGS. tit. XXVI, ch. 136; Rules and Regulations of State of Maine Board of Registration in Medicine, § 4; Rules of Maryland State Board of Medical Examiners, § 10.27.04 (received June, 1975); Regulations Governing Approval of Physician Assistant Training Programs and Employment of Physician Assistants, Massachusetts Board of Approval and Certification of Physician Assistant Programs (adopted Feb. 7, 1975); Rules and Regulations Relating to Physicians' Assistants in the State of Nebraska, Board of Medical Examiners and Surgery (received Dec. 1974); Regulations for the Certification of Physician's Assistants, Board of Medical Examiners of the State of Nevada; Regulations of the New York Commis-

provide for an administrative agency to determine the competence of all nonphysicians who perform delegated medical acts under the authority of such statutes.<sup>147</sup> Twenty-eight PA Regulatory Statutes also authorize an administrative agency to regulate PAs' scope of practice;<sup>148</sup> in at least 17 of these states, a primary form of such regulation is the requirement that an individual job description be approved by the administrative agency before a PA may practice.<sup>149</sup> Twenty-seven PA Regulatory Statutes delegate all responsibility for administrative control to state medical licensing boards,<sup>150</sup> and medical licensing boards have substantial administrative authority under two other statutes.<sup>151</sup>

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sioner of Education, §§ 52.26 and 60.8 (New York Educ. PA Regs) and Regulations of the New York Commissioner of Health, Part 94 (New York Health PA Regs); Regulations for Physician's Assistants, State of New Hampshire Board of Registration in Medicine; Rule 17, New Mexico Board of Medical Examiners; Rules and Regulations for Assistant to a Physician, Board of Medical Examiners of North Carolina; Rule 10, Oklahoma State Board of Medical Examiners; ORE. AD. RULES COMP. ch. 847, div. 5; Rules of South Dakota State Board of Medical and Osteopathic Examiners, ch. 20.50.01; Physician's Assistants Regulations, Secretary of the Vermont Agency of Human Services; Rules and Regulations for Assistant to a Physician, Virginia State Board of Medicine (as amended Nov. 10, 1974); WASH. AD. CODE § 308-52-130; Regulations for Physician's Assistants, The Medical Licensing Board of West Virginia (effective Aug. 15, 1974); WIS. AD. CODE ch. Med. 50 (effective Apr. 1, 1975); Rules and Regulations—Physician Support Personnel, Wyoming Board of Medical Examiners (received Dec. 1974).

<sup>147</sup> Wisconsin's PA Regulatory Statute provides for certification of PAs by the state medical board, but it does not require certification for practice, provided that any noncertified PA complies with the scope of practice regulations promulgated by the board. WIS. STAT. ANN. § 448.51(1) (1974). Kansas' PA Regulatory statute also may not require registration with the state medical board. See note 144 and accompanying text *supra*. The other 31 PA Regulatory statutes clearly require prior determination of the competence of all PAs, although in four cases this determination is limited to approval of PA training programs and does not include certification of an individual's competence. HAWAII REV. STAT. § 453-2 (Supp. 1974); MASS. GEN. LAWS ANN. ch. 112, § 9-C (Supp. 1975); ME. REV. STAT. ANN. tit. 32, § 3270-A (Supp. Pamph. 1973); UTAH CODE ANN. § 58-12-40 (1974).

<sup>148</sup> Five PA Regulatory Statutes limit the regulatory authority of designated administrative agencies to governing PAs' qualifications. HAWAII REV. STAT. § 453-2 (Supp. 1974); KAN. STAT. ANN. § 65-2872(g) (1972), §§ 65-2896 to -2896c (Supp. 1975); MASS. GEN. LAWS ANN. ch. 112, §§ 9C-H (1975); ME. REV. STAT. ANN. tit. 32, § 3270-A (Supp. Pamph. 1973); UTAH CODE ANN. § 58-12-40 (Supp. 1974).

<sup>149</sup> ALA. CODE tit. 46, § 297(22mm)(f)(3) (Supp. 1973); Ariz. PA Regs, *supra* note 146, *Method of Performance* (1); CAL. BUS. & PROF. CODE § 2516(c) (West 1974); Letter from Florida Board of Medical Examiners to Philip Kissam, June 18, 1975; GA. CODE ANN. § 84-6204(c) (Supp. 1974); Iowa CODE ANN. § 148B.3 (1972); Md. PA Regs, *supra* note 146, §§ B(3), C(1); NEB. REV. STAT. § 85-179.09(1) (1974); NEV. REV. STAT. § 630.271 (1973); N.C. PA Regs, *supra* note 146, PA Application Form; Okla. PA Regs, *supra* note 146, Rule 10D.(1); ORE. REV. STAT. § 677.510 (1973); Vermont PA Regs, *supra* note 146, Rule III(d); VA. CODE ANN. § 54-281.6 (1974); WASH. REV. CODE ANN. § 18.71A.040 (Supp. 1974); W. VA. CODE § 30-3A-1 (1971); WYO. STAT. ANN. § 33-338.3(a)(iii) (1975). Individual job descriptions for any PA tasks additional to those specified by statute or regulation must be approved under two other PA Regulatory Statutes. N.H. PA Regs, *supra* note 146, § I(D); S.D. COMP. LAWS ANN. § 36-4A-23 (Supp. 1974).

<sup>150</sup> The six exceptions are the statutes of Massachusetts, MASS. GEN. LAWS ANN. ch. 112, §§ 9C-H (1975) (delegating authority to a new Board of Approval and Certification of Physician's Assistant Programs established in the State Department of Health); Minnesota, MINN. STAT. ANN. §§ 145.861-.866 (Supp. 1975) (delegating authority to the State Board of Health); Nebraska, NEB. REV. STAT. § 85-179.13 (Supp. 1974) (requiring that PA rules and regulations of the state medical board be approved by the State Health Department); New York, N.Y. EDUC. LAW §§ 6530-6536 (McKinney 1972) and N.Y. PUB. HEALTH LAW §§ 3700-3702 (McKinney Supp. 1973) (authorizing the State Education Department, of which the state medical board is a part, to certify PAs and the State Health Department to regulate their scope of practice); Utah, UTAH CODE ANN. § 58-12-40 (Supp. 1973) (delegating administrative control to the Council on Scientific Education of the State Medical Society); Vermont, VT. STAT. ANN. tit. 31, §§ 1725-1729 (1975) (delegating authority to the Secretary of the Agency of Human Services).

<sup>151</sup> Nebraska's statute gives most administrative responsibility to the state medical board but requires that the board's rules and regulations be approved by the State Health Department. NEB. REV. STAT. §§ 85-179.01 to .18 (Supp. 1974). New York's statute authorizes the State Education Department to qualify PAs and the State Health Department to regulate their scope of practice. N.Y. EDUC. LAW §§ 6530-6536 (McKinney 1972) and N.Y. PUB. HEALTH LAW §§ 3700-3702. The Education Department's responsibilities have been delegated in fact to the state medical board, a division of the Education De-

The other five PA statutes recognize expanded medical delegation without explicitly authorizing administrative regulation of expanded delegation;<sup>152</sup> these statutes will be referred to as "PA Simple Authorization Statutes." These statutes consist merely of specific exemptions to state medical practice acts for services rendered by nonphysicians who work under a physician's "supervision"<sup>153</sup> or "direction and control."<sup>154</sup> Three of these statutes define qualified nonphysicians as "a physician's trained assistant, a registered professional nurse or licensed practical nurse";<sup>155</sup> one refers to "a person qualified by education, training and experience";<sup>156</sup> and one simply refers to any person.<sup>157</sup> Four PA Simple Authorization Statutes define expanded medical delegation simply as "services";<sup>158</sup> the fifth refers to "selected acts, tasks or functions."<sup>159</sup> None of these statutes provide further terms or procedures that otherwise define or limit PAs and their scope of practice, and it would appear that a physician has relatively broad discretion under these statutes to select nonphysicians to perform medical acts.<sup>160</sup>

The general statutory authority of medical licensing boards to ensure competent practice by physicians arguably might be sufficient authority for a board to promulgate specific PA regulations,<sup>161</sup> but the one medical board that has tried to do so has been effectively restrained by an unfavorable opinion from the State Attorney General as to the scope of the board's general regulatory authority.<sup>162</sup> In view of medical boards' traditional reluctance to regulate how

partment. See letter from William C. Sippel, Assistant Executive Secretary to the New York State Board for Medicine, to Philip Kissam, Nov. 8, 1974.

<sup>152</sup> ARK. STAT. ANN. § 72-604(2)(p) (Supp. 1973); COLO. REV. STAT. ANN. § 12-36-206(3)(1) (1973); CONN. GEN. STAT. ANN. § 20-9 (Supp. 1975); MICH. COMP. LAWS ANN. § 338.1816(1)(f) (Supp. 1975); TENN. CODE ANN. § 63-608 (Supp. 1974).

<sup>153</sup> ARK. STAT. ANN. § 72-604(2)(p) (Supp. 1973); COLO. REV. STAT. ANN. § 12-36-106(3)(1) (1973); CONN. GEN. STAT. ANN. § 20-9 (Supp. 1975); TENN. CODE ANN. § 63-608 (Supp. 1974).

<sup>154</sup> MICH. COMP. LAWS ANN. § 338.1816(1)(f) (Supp. 1975).

<sup>155</sup> ARK. STAT. ANN. § 72-604(2)(p) (Supp. 1973); CONN. GEN. STAT. ANN. § 20-9 (Supp. 1975); TENN. CODE ANN. § 63-608 (Supp. 1974).

<sup>156</sup> MICH. COMP. LAWS ANN. § 338.1816(1)(f) (Supp. 1975).

<sup>157</sup> COLO. REV. STAT. ANN. § 12-36-106(3)(1) (1973).

<sup>158</sup> ARK. STAT. ANN. § 72-604(2)(p) (Supp. 1973); COLO. REV. STAT. ANN. § 12-36-106(3)(1) (1973); CONN. GEN. STAT. ANN. § 20-9 (Supp. 1975); TENN. CODE ANN. § 63-608 (Supp. 1974).

<sup>159</sup> MICH. COMP. LAWS ANN. § 338.1816(1)(f) (Supp. 1975).

<sup>160</sup> See text at notes 289-94 *infra* for a discussion of possible limitations on nonphysicians whom a physician may select; see text at notes 311-14 *infra* for possible limitations on what medical acts may be delegated.

<sup>161</sup> Medical licensing boards typically are authorized to revoke or suspend a physician's license for "unprofessional conduct," a term generally given meaning by various statutory provisions. See, e.g., ARK. STAT. ANN. § 72-613(7) (1957) (defining unprofessional conduct to include "grossly negligent or ignorant malpractice"); MICH. COMP. LAWS ANN. § 338.1811(2)(i) (Supp. 1975) (defining unprofessional conduct to include "a departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established"). These boards generally are authorized to promulgate rules and regulations necessary or convenient to carry out their duties. See, e.g., ARK. STAT. ANN. § 72-602(H) (1957); MICH. COMP. LAWS ANN. § 338.1805(h) (Supp. 1975). Under such authority and the more general implied authority to ensure competent medical practice, it could be argued that a medical board is empowered to issue regulations defining the qualifications and scope of practice of PAs authorized by PA Simple Authorization Statutes. Such an argument would seem particularly persuasive under the provision of Michigan's law quoted above. *But see* note 162 *infra*.

<sup>162</sup> See letter from Bert C. Brennan, Executive Director, Michigan Medical Practice Board, to Philip Kissam, July 8, 1975, together with the Board's Proposed Rules Governing Physician Assistants, April 21, 1975, and an opinion letter from Frank J. Kelley, Michigan Attorney General, to the Honorable Jackie Vaughn III, May 19, 1975. The proposed rules would have required that each PA's qualifications



physicians practice<sup>163</sup> and the more general reluctance of state administrative agencies to promulgate substantive regulations without explicit statutory authority,<sup>164</sup> the promulgation of administrative regulations under PA Simple Authorization Statutes seems unlikely.

## 2. *The NP Statutes*

At this writing, at least 28 states have NP statutes that authorize expanded medical delegation to nurses.<sup>165</sup> Typically, NP statutes consist of simple amendments to the statutory definition of the practice of professional nursing, expanding the definition to include additional acts that are authorized by administrative regulations<sup>166</sup> or are performed "under the supervision" or "in collaboration with" a licensed physician.<sup>167</sup>

Eighteen NP statutes require that expanded medical delegation to RNs be authorized by some form of administrative regulation;<sup>168</sup> these statutes will be referred to as "NP Regulatory Statutes." Nine NP Regulatory Statutes use the terms "acts of medical diagnosis" and "prescription of therapeutic measures" or similar terms to define expanded delegation.<sup>169</sup> Typically, the other NP Regulatory Statutes define expanded delegation as "additional acts" authorized by regulatory action.<sup>170</sup> In both adopted and proposed regulations under NP Regulatory Statutes,<sup>171</sup> the marked tendency is to require prior certification of

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and job descriptions be approved by the Board before he or she could practice. The Attorney General opined that the Board lacked such authority without an affirmative legislative act to provide for certification of PAs.

<sup>163</sup> See text at note 101 *supra*.

<sup>164</sup> See I F. COOPER, *STATE ADMINISTRATIVE LAW* 176-77 (1965); opinion letter from Frank J. Kelley, Michigan Attorney General, to the Honorable Jackie Vaughn III, May 19, 1975; opinion letter from Terry P. O'Brien, Special Assistant Attorney General of Minnesota, to Joyce Schowalter, Minnesota Board of Nursing, Mar. 25, 1975.

<sup>165</sup> See NP statutes cited in notes 168, 177 *infra*.

<sup>166</sup> See NP statutes cited in note 168 *infra*.

<sup>167</sup> See NP statutes cited in note 177 *infra*.

<sup>168</sup> ALASKA STAT. §§ 08.68.410(5),(9) (1974) (amended 1973); ARIZ. REV. STAT. ANN. § 32-1601(5) (Supp. 1974) (amended 1974); IDAHO CODE § 54-1413(e) (Supp. 1973) (amended 1971); IND. STAT. ANN. § 25-23-1-1(b)(8) (Supp. 1974) (amended 1974); ME. REV. STAT. ANN. tit. 32, § 2102(2)(E) (Supp. 1973) (amended 1973); MD. ANN. CODE art. 43, § 291(b)(1)(ii) (Supp. 1974) (amended 1974); Ch. 354, § 1, [1974] Miss. Gen. Laws 405, *amending* MISS. CODE ANN. § 73-15-5(2) (1972); No. 422, [1975] Laws of Neb. 854 (adopted 1975); NEV. REV. STAT. § 632.010(7) (1973) (amended 1973); N.H. REV. STAT. ANN. §§ 326-A:2(I), 326-A:5-a (Supp. 1973) (amended 1973); N.C. GEN. STAT. § 90-158(3)(2) (Supp. 1974) (amended 1973); Ch. 584, § a, [1973] Ore. Laws 1295, *amending* ORE. REV. STAT. § 678.010 (1973); PA. STAT. ANN. tit. 63, § 212(1) (Supp. 1975) (amended 1974); UTAH CODE ANN. § 58-31-4(5) (Supp. 1973) (amended 1975); VT. STAT. ANN. tit. 26, § 1552(a)(2)(E) (1975) (amended 1973); VA. CODE ANN. § 54-274 (1974) (amended 1973); WASH. REV. CODE ANN. § 18.88030(2) (Supp. 1974) (amended 1973); WYO. STAT. ANN. § 33-279.1(a)(i)(D) (Supp. 1975) (enacted 1975). Virginia's NP statute authorizes expanded delegation to both registered professional nurses and licensed practical nurses, but regulations promulgated under this statute to date only authorize expanded delegation to RNs. See Regulations Governing the Certification of Nurse Practitioners (Virginia State Board of Medicine and State Board of Nursing).

<sup>169</sup> ALASKA STAT. §§ 08.68.410(5),(9) (1974); IDAHO CODE § 54-1413(e) (Supp. 1974); ME. REV. STAT. ANN. tit. 32, § 2102(2)(E) (Supp. 1973); Ch. 354, § 1, [1974] Miss. Gen. Laws 405, *amending* MISS. CODE ANN. § 73-15-5(2) (1972); NEV. REV. STAT. § 632.010(7) (1973); N.H. REV. STAT. ANN. § 326-A:2(I) (Supp. 1973); N.C. GEN. STAT. § 90-158(3)(a) (Supp. 1974); PA. STAT. ANN. tit. 63, § 212(1) (Supp. 1975); WYO. STAT. ANN. § 33-279.1(a)(i)(D) (Supp. 1975).

<sup>170</sup> See, e.g., ARIZ. REV. STAT. ANN. § 32-1601(5) (Supp. 1974).

<sup>171</sup> In December 1974 requests for copies of NP regulations were made to responsible administrative agencies under all NP Regulatory Statutes. Follow-up letters were sent to agencies not responding or indicating an intent to promulgate regulations at a future date. The following regulations promulgated or proposed under nine NP Regulatory Statutes were obtained, and hereinafter they will be cited indi-

an NP's competency by the responsible licensing board.<sup>172</sup> Such regulations also usually establish a general job description for NPs<sup>173</sup> or require approval of an individual job description by the responsible board before an NP may practice.<sup>174</sup> NP Regulatory Statutes typically authorize state nurse licensing boards to administer regulations for expanded medical delegation; but these regulations most often must be promulgated jointly with the state medical licensing board<sup>175</sup> or must accord with expanded nursing functions recognized "by the medical and nursing professions."<sup>176</sup>

Ten states have enacted NP statutes that authorize expanded medical delegations to RNs and, in three cases, to licensed practical nurses as well, without explicitly authorizing an administrative agency or professional society to regulate the process.<sup>177</sup> These statutes will be referred to as "NP Simple Authoriza-

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vidually as "(name of state) NP Regs." These regulations were in effect as of December 1974 unless otherwise indicated. Minimum Standards, Rules, and Regulations for the Expanding Role of the Registered Professional Nurse (Idaho State Board of Nursing and State Board of Medicine, adopted June 1972); Standards for Nurse Associate Programs State of Maine (Maine Board of Nursing, Board of Registration in Medicine, Board of Osteopathic Examination and Registration, adopted Sept. 4, 1974); Rules and Regulations of the Nevada State Board of Nursing, § III (effective July 10, 1975); Rules and Regulations —Advanced Registered Nurse Practitioner (New Hampshire Board of Registration in Medicine and Board of Nursing Education and Nurse Registration, adopted Dec. 3, 1973); Rules and Regulations for Registered Nurses Performing Medical Acts (Board of Medical Examiners of North Carolina); Oregon State Board of Nursing's Proposed Administrative Rules for Nursing Practice, § III (proposed Dec. 1974); (Statement of Policy on Nurse-Midwives, Vermont State Nurses Association, Vermont State Medical Society, Vermont Hospital Association, adopted Mar. 1974); Regulations Governing the Certification of Nurse Practitioners (Virginia State Board of Medicine and State Board of Nursing); WASH. AD. CODE §§ 308-120-190 to -250 (effective Feb. 1975).

<sup>172</sup> Under six of the nine NP Regulatory Statutes with available regulations, NPs must be certified by the responsible licensing board. Idaho NP Regs, *supra* note 171, § IV(B); Nevada NP Regs, *supra* note 171, § III(c); North Carolina NP Regs, *supra* note 171, Rule I(3); Oregon Proposed NP Regs, *supra* note 171, § III(B); Virginia NP Regs, *supra* note 171, § 1(A); Washington NP Regs, *supra* note 171, § 308-120-230. Two other NP Regulatory Statutes require certification of "advanced registered nurse practitioners," ALASKA STAT. ANN. § 08.68.410(9) (1974); N.H. REV. STAT. ANN. § 326-A:5-a (Supp. 1973), although these statutes have been interpreted to require certification only of those NPs who exercise relatively broad discretion. See text at note 239 *supra*.

<sup>173</sup> N.H. NP Regs, *supra* note 171, Part B, §§ 3.1(B), 3.2(B), 3.3(B), 3.4(B); Vt. NP Regs, *supra* note 171, § III; Wash. NP Regs, *supra* note 171, §§ 308-120-200, -220; Va. NP Regs, *supra* note 171, § I(A).

<sup>174</sup> Idaho NP Regs, *supra* note 171, § III(B); N.C. NP Regs, *supra* note 171, Rule I § 3; Ore. Proposed NP Regs, *supra* note 171, § III(B)(4).

<sup>175</sup> ALASKA STAT. ANN. § 08.68.410(5) (1974); IDAHO CODE § 54-1413(e) (Supp. 1974); No. 422, [1975] Laws of Neb. 854 (adopted 1975); N.H. REV. STAT. ANN. § 326-A:2(I) (Supp. 1973); PA. STAT. ANN. tit. 63, § 212(1) (Supp. 1975); WYO. STAT. ANN. § 33-279.1(i)(D) (Supp. 1975). The NP statutes of North Carolina and Virginia require that regulations be agreed to by the two boards but administered by the medical board. N.C. GEN. STAT. § 90-158(3)(a) (Supp. 1974); VA. CODE ANN. § 54-274 (1974) (amended 1973).

<sup>176</sup> ARIZ. REV. STAT. ANN. § 32-1601(5) (Supp. 1974); MD. ANN. CODE art. 43, § 291(b)(ii) (Supp. 1974); NEV. REV. STAT. § 632.010(7) (1973); WASH. REV. CODE ANN. § 18.88030(2) (Supp. 1974). In addition, Vermont's NP statute authorizes RNs to perform additional acts "recognized jointly by the medical and nursing profession" without requiring nursing board regulations, VT. STAT. ANN. tit. 26, § 1552(a)(2)(E) (1975), and Oregon's NP statute authorizes additional services "recognized by the nursing profession . . . and which are recognized by rules of the [nursing] board," ORE. REV. STAT. § 678.010(5) (1973). Expanded nursing functions are formally recognized by the medical and nursing professions at the state level through promulgation of "joint practice statements" by the state medical society and state nurses' association. See, e.g., VERMONT STATE NURSES ASSOCIATION, VERMONT STATE MEDICAL SOCIETY, VERMONT HOSPITAL ASSOCIATION, STATEMENT OF POLICY ON NURSE-MIDWIVES (1974). NP statutes referring to expanded medical delegation "recognized by the medical and nursing professions" appear to be references to such statements.

<sup>177</sup> CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1975) (amended 1974); COLO. REV. STAT. ANN. §§ 12-38-202(7),(9)(c) (1973) (amended 1973); FLA. STAT. ANN. § 458.13(4) (Supp. 1975) (amended 1970); KAN. STAT. ANN. § 65-2872(g) (1972) (enacted 1957); MINN. STAT. ANN. § 148.171(3) (Supp. 1975) (amended 1974); N.J. STAT. ANN. § 45:11-23(1)(b) (Supp. 1975) (amended 1974); N.Y. EDUC. LAW § 6902(1) (McKinney Supp. 1973) (amended 1972); OKLA. STAT. ANN. tit. 59, § 492 (Supp. 1974)

tion Statutes," although it should be noted that the nurse licensing board in one state is in the process of developing NP regulations notwithstanding the absence of explicit statutory authority.<sup>178</sup> NP Simple Authorization Statutes define qualified NPs simply as RNs in six cases,<sup>179</sup> as RNs and licensed practical nurses in three,<sup>180</sup> and as RNs "with appropriate training" to perform "special acts . . . delegated by a physician" in one.<sup>181</sup> These statutes define the new medical acts that are delegable to NPs in varying ways, ranging from California's "standardized procedures, or changes in treatment regimen in accordance with standardized procedures,"<sup>182</sup> to "services,"<sup>183</sup> to "executing medical regimen[s] as prescribed by a . . . physician."<sup>184</sup> Four of the ten NP Simple Authorization Statutes, including the three that authorize RNs merely to execute "medical regimens,"<sup>185</sup> appear to have been intended to authorize treatment modifications by RNs, but not diagnostic and treatment judgments or such closely related medical procedures as physician examinations or medical histories.<sup>186</sup> The other six NP Simple Authorization Statutes appear to grant relatively broad discretion to physicians to delegate medical acts to nurses.<sup>187</sup>

California's NP Simple Authorization Statute deserves special mention because of the unique way in which it authorizes and regulates expanded medical delegation to RNs who work within licensed health care facilities.<sup>188</sup>

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(amended 1965); S.D. COMPILED LAWS ANN. § 36-9-3(1) (1972) (amended 1972); TENN. CODE ANN. § 63-740 (Supp. 1974) (amended 1972). The NP statutes of Florida, Kansas and Oklahoma authorize expanded delegation to licensed practical nurses as well as to professional nurses. Tennessee's NP statute consists of a general definition of the practice of professional nursing from which a prohibition against medical diagnosis was removed by amendment in 1972. This definition as amended has been interpreted by Tennessee's nursing board as authorizing expanded functions by professional nurses in the management of cases already diagnosed by physicians. See Rules and Regulations of Tennessee Board of Nursing, Nsg RN 32 *Responsibility* (revised as of June 1974).

<sup>178</sup> Letters from Sister Vincent Fuller, Executive Secretary, South Dakota Board of Nursing, to Philip Kissam, Mar. 10 and July 8, 1975. A similar attempt by the Minnesota Board of Nursing was stopped by an opinion from the state Attorney General's Office ruling that the Board lacked statutory authority. Letter from Joyce Schowalter, Executive Director, Minnesota Board of Nursing, to Philip Kissam, June 19, 1975, together with an opinion letter from Terry P. O'Brien, Special Assistant Attorney General of Minnesota, to Joyce Schowalter, Minnesota Board of Nursing, Mar. 25, 1975. See also text at note 162 *supra*.

<sup>179</sup> CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1975); COLO. REV. STAT. ANN. §§ 12-38-202(7), (9)(c) (1973); MINN. STAT. ANN. § 148.171(3) (Supp. 1975); N.J. STAT. ANN. § 45:11-23(1)(b) (Supp. 1975); N.Y. EDUC. LAW § 6902(1) (McKinney Supp. 1973); TENN. CODE ANN. § 63-740 (Supp. 1974).

<sup>180</sup> FLA. STAT. ANN. § 458.13(4) (Supp. 1975); KAN. STAT. ANN. § 65-2872(g) (1972) (on its face this provision refers to any person, but the new Kansas PA Regulatory Statute, KAN. STAT. ANN. § 65-2896 (Supp. 1975), appears to limit it essentially to RNs and licensed practical nurses); OKLA. STAT. ANN. tit. 59, § 492 (Supp. 1974).

<sup>181</sup> S.D. COMPILED LAWS ANN. § 36-9-3(1) (1972).

<sup>182</sup> CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1975).

<sup>183</sup> FLA. STAT. ANN. § 458.13(4) (Supp. 1975); OKLA. STAT. ANN. tit. 59, § 492 (Supp. 1974).

<sup>184</sup> COLO. REV. STAT. ANN. §§ 12-38-202(7), (9)(c) (1974); N.J. STAT. ANN. § 45:11-23(1)(b) (Supp. 1975); N.Y. EDUC. LAW § 6902(1) (McKinney Supp. 1973).

<sup>185</sup> See statutes cited in previous footnote.

<sup>186</sup> See COLO. REV. STAT. ANN. § 12-38-202(7) (1974) (defining "medical regimen" as "that aspect of care which implements the medical plan as prescribed by a . . . physician"). See also letter from the New York State Board for Nursing to Philip Kissam, Dec. 26, 1974; Rules and Regulations of the Tennessee Board of Nursing, Nsg RN 32 *Responsibility* (revised as of June 1974).

<sup>187</sup> See text at notes 289-94 *infra* for possible limitations on nurses whom a physician may select; see text at notes 311-14 *infra* for possible limitations on what medical acts may be delegated.

<sup>188</sup> The licensing of health care institutions by state health agencies is described in the text at notes 361-66 *infra*.

The legislature added the following language to the statutory definition of the practice of nursing:

Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) *determination of* whether such signs, symptoms, reactions, behavior, or general appearance exhibit *abnormal characteristics*; and (2) *implementation, based on observed abnormalities, of* appropriate reporting, or referral, or *standardized procedures or changes in treatment regimen in accordance with standardized procedures*, or the initiation of emergency procedures.

"Standardized procedures" as used in this section means . . . policies and protocols developed . . . through collaboration among administrators and health professionals including physicians and nurses.<sup>189</sup>

The California NP statute classifies policies and protocols into two categories, those developed for use in licensed health care facilities, including hospitals and nursing homes, and those developed for use outside such facilities, primarily physicians' offices.<sup>190</sup> No express authority is provided for a state agency to regulate the former category of policies and protocols.<sup>191</sup> California's medical and nursing boards are authorized to promulgate joint "guidelines" to which the latter category of policies and protocols will be "subject," but these guidelines may not require "approval of standardized procedures" by either of the two boards.<sup>192</sup> It is unclear whether such guidelines are intended to be advisory or to have some binding effect, but in any event they apply only to expanded delegation in a non-institutional setting. California's NP statute appears to grant broad legal authority to physicians and RNs for expanded medical delegation in institutional settings, including the making of diagnostic and treatment judgments by RNs, provided only that the RNs work in accordance with policies and protocols—presumably written ones—developed by decentralized decision-makers. This approach avoids prior administrative controls over expanded medical delegation but attempts to ensure quality of medical care by requiring that the decentralized decision-makers think through and presumably write out precisely what RNs will be doing in the medical field. The relative merits of this approach to regulating expanded medical delegation will be discussed in the next part.<sup>193</sup>

Sixteen of the 28 NP statutes have been enacted by states that previously or concurrently had enacted PA Regulatory Statutes.<sup>194</sup> Since the latter provide authority for expanded medical delegation to qualified RNs as well as other PAs, the enactment of these NP statutes might seem to be a wasteful duplication of effort, undertaken merely because of organized nursing's desire that

<sup>189</sup> CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1975) (emphasis added).

<sup>190</sup> *Id.*

<sup>191</sup> *Id.*

<sup>192</sup> *Id.*

<sup>193</sup> See text at note 251 *infra*.

<sup>194</sup> The 16 states are Arizona, California, Maine, Maryland, Minnesota, Nebraska, Nevada, New Hampshire, New York, North Carolina, Oregon, Utah, Vermont, Virginia, Washington and Wyoming. Compare enactment dates for their NP statutes, notes 168, 177 *supra*, with enactment dates for their PA Regulatory Statutes, note 144 *supra*.

NPs be recognized and controlled as members of the nursing profession rather than as adjuncts of the medical profession.<sup>195</sup> NP statutes, however, may be more effective than existing PA Regulatory Statutes in promoting expanded medical delegation to RNs, who constitute the most important source of readily available personnel for expanded medical delegation.<sup>196</sup> NP statutes as enacted contain fewer restrictions on expanded medical delegation than PA Regulatory Statutes.<sup>197</sup> In addition, many NP statutes, particularly NP Regulatory Statutes, authorize the making of diagnostic and treatment judgments by nonphysicians more clearly than PA statutes.<sup>198</sup> As suggested above, diagnostic and treatment judgments by PAs or NPs in certain situations seem likely to be both medically feasible and economically valuable.<sup>199</sup>

### III. MAJOR LEGISLATIVE CHOICES

In establishing the new legislation, legislatures and administrative agencies face a number of important choices among different approaches to regulating expanded medical delegation. This part of the Article describes the decisions that have been made, offers explanations for the prevailing patterns of these decisions, and assesses the relative value of different kinds of rules for promoting the maximum amount of feasible expanded medical delegation.<sup>200</sup> The discussion will first examine the choice between Regulatory and Simple Authorization Statutes, then analyze qualification and scope of practice issues under both types of statutes, and finally examine certain legislative issues that are specific to Regulatory Statutes.

A few general observations are relevant to the issues discussed below. The dominant theme of this part is that unnecessary prior controls over expanded medical delegation have been established by the new legislation. Expanded delegation is innovative and in some cases experimental. It is tempting to conclude that an appropriate legislative policy should provide for strict prior legal controls over each type of expanded medical delegation until it has been shown to be medically feasible.<sup>201</sup> The danger is that statutory and regulatory

<sup>195</sup> See text at note 130 *supra*.

<sup>196</sup> See SADLER & BLISS, *supra* note 9, at 16-18.

<sup>197</sup> As discussed more fully in part III *infra*, some PA Regulatory Statutes establish a two-year minimum for approved training programs, limit physicians to supervising no more than two PAs, and prohibit PAs from making diagnostic and treatment judgments.

<sup>198</sup> See text at notes 311-14 *infra*.

<sup>199</sup> See text at notes 25-33 *supra*.

<sup>200</sup> As suggested above, medically feasible delegations may be considered to be those delegations that can be performed by nonphysicians as competently as physicians. See note 25 and accompanying text *supra*. The justification for using the maximum amount of feasible expanded medical delegation as the standard for assessing the value of the new legislation is the same as that for claiming that current physician fees and income are artificially high, *i.e.* that the provision of medical services free of protections for special interest groups is in the public interest. See note 89 and accompanying text *supra*. The purposes clauses of many PA statutes, which indicate that the primary purpose of the new legislation is to expand the supply of medical services in an efficient manner, support this justification. See, *e.g.*, CAL. BUS. & PROF. CODE § 2510 (West 1974); 1971 Laws of N.Y. ch. 1135, § 1; Wis. Laws of 1973 ch. 149, § 1.

<sup>201</sup> A majority of writers who have considered this issue seem to have so concluded. See, *e.g.*, Dean, *supra* note 10, at 6-7; Note, *Paramedics and the Medical Manpower Shortage: The Case for Statutory Legitimization*, 60 GEO. L.J. 157, 182-84 (1971); *Problem of Statutory Authorization*, *supra* note 10, at 421. But see Sadler & Sadler, *supra* note 10, at 1202.

rules that implement strict prior controls may become rigid, thus unduly limiting expanded medical delegation. This approach also ignores a fundamental characteristic of government regulation of medicine. With the exception of new drugs, medical innovations and experiments generally are not subject to prior legal controls to ensure the quality of patient care. The basic legal control in these situations is the law of malpractice, which imposes liability for personal injuries resulting from incidents that have already occurred. Because of these considerations, policy-makers should question carefully any claim for prior legal controls over expanded medical delegation. If prior controls are adopted, careful consideration should be given to the related issue of how to ensure against overly rigid administration of the controls.

Judgments about the value of different legislative rules can only be tentative at this time because of limited experience with the new legislation and expanded medical delegation. It seems important, nonetheless, that such judgments be made. Present decisions will help determine and perhaps limit future patterns of expanded delegation because political inertia and the development of vested interests in existing regulatory patterns may hinder rule changes in the future. If current decisions remain unexamined on the grounds that additional empirical data is needed before passing judgment, maximum benefits from expanded medical delegation may not be realized.<sup>202</sup>

Finally, note that a number of the issues discussed below are closely related to each other. These relationships will be noted as appropriate, but the analysis of issues seriatim may unduly obscure them. For example, a fundamental choice facing legislatures has been whether to adopt a Regulatory or Simple Authorization Statute. But this choice affects and is affected by several other legislative issues that may and indeed should influence it. The choice of a Simple Authorization Statute will largely determine who qualifies as a PA or NP and what a PA or NP may do because these statutes appear to authorize any person or any RN to perform any delegated medical act if the supervising physician determines he or she is qualified to perform that act.<sup>203</sup> On the other hand, the difficulty of establishing rules about PA and NP qualifications and their scope of practice may influence legislatures to adopt a Regulatory Statute in order to delegate these decisions to administrative agencies believed to have the necessary expertise. A second example is the relationship between PA and NP qualifications and their scopes of practice. If extensive training is required for qualification, relatively liberal rules on scope of practice seem more easily justified.<sup>204</sup> Conversely, if extensive training requirements are not established,

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<sup>202</sup> For a similar caution about waiting for the "white knight of empiricism" before passing judgment on legislation, see Ackerman, *Regulating Slum Housing Markets On Behalf of the Poor: Of Housing Codes, Housing Subsidies, and Income Redistribution Policy*, 80 YALE L.J. 1093, 1100-01 (1971).

<sup>203</sup> See text at notes 160, 187 *supra*.

<sup>204</sup> For example, the PA Regulatory Statutes of Colorado, New York, and South Dakota establish some of the higher training requirements for PA qualification. See note 255 and accompanying text *infra*. At the same time, these statutes appear to be relatively liberal in authorizing PAs to make diagnostic and treatment judgments and to prescribe drugs. See text at notes 320-21, 343-47 *infra*.

one may believe that more restrictive rules on scope of practice are necessary.<sup>205</sup>

### A. Regulatory or Simple Authorization Statutes

The great majority of PA and NP statutes are Regulatory Statutes that authorize professional licensing boards to regulate expanded delegation through one or more forms of prior control.<sup>206</sup> Three factors appear to explain this pattern: the ostensible concern of legislators with the quality of care to be provided by physicians and nonphysicians participating in expanded medical delegation,<sup>207</sup> the interests of organized medicine in controlling expanded delegation through the use of state medical licensing boards,<sup>208</sup> and the interests of organized nursing in limiting expanded delegation to RNs and in controlling the process through state nurse licensing boards.<sup>209</sup>

The official position of the AMA on this issue has been clear, significant, and interesting. In December 1970, when political interest in the use of PAs was just beginning,<sup>210</sup> the AMA's House of Delegates recommended that state medical practice acts be amended "to remove any barriers to increased delegation of tasks to allied health personnel by physicians."<sup>211</sup> This recommendation defined allied health personnel to include unlicensed but "trained" PAs, RNs, and licensed practical nurses, and, importantly, it suggested that the amendment "might be" in the form of a Simple Authorization Statute.<sup>212</sup> At that time, Colorado, Florida, Kansas, and Oklahoma had PA Simple Authorization Statutes.<sup>213</sup> In 1971 and 1972, five other states adopted PA Simple Authorization Statutes, three of them using the language recommended by the AMA.<sup>214</sup> In these same two years, however, 15 states adopted PA Regulatory Statutes,

<sup>205</sup> This phenomenon may be seen by a comparison of the statutory language of NP Regulatory Statutes with corresponding language in NP Simple Authorization Statutes. Many NP Regulatory Statutes, which provide for administrative determination of NP qualifications, expressly authorize the performance of "acts of medical diagnosis" and "prescription of treatment." On the other hand, NP Simple Authorization Statutes, which do not provide for administrative determination of NP qualifications, typically authorize only the performance of "services" or "medical regimens prescribed by the physician," language that appears to be more limiting. See text at notes 311-14 *infra*.

<sup>206</sup> See text at notes 144-77 *supra*. Prior controls may be any of three types: (1) a requirement that PAs or NPs must graduate from a training program approved by an administrative agency; (2) a requirement that a PA's or NP's competency must be certified by an administrative agency; or (3) a requirement that PA or NP job descriptions must be approved by an administrative agency.

<sup>207</sup> This concern is evidenced in many purposes clauses of PA statutes. See, e.g., CAL. BUS. & PROF. CODE § 2510 (West 1974).

<sup>208</sup> See section I.D. *supra*.

<sup>209</sup> See text at notes 119-20, 129-30 *supra*.

<sup>210</sup> December 1970 was before President Nixon's statement promising a 50% expansion in Federal funding of allied health personnel training programs, with 50% of the total to be devoted to training PAs. President Nixon, Message, *supra* note 1, at 3122. Relatively few PA statutes and no NP statutes had been enacted at that time. See note 2 and accompanying text *supra*.

<sup>211</sup> Licensure of Health Occupations, recommendation (a) (prepared by the AMA Council on Health Manpower; adopted by the AMA House of Delegates, Dec., 1970), reprinted in SADLER & BLISS, *supra* note 9, app. I.

<sup>212</sup> *Id.*

<sup>213</sup> See note 2 and accompanying text *supra*.

<sup>214</sup> Ch. 5, § 1 [1972], Sess. Laws of Alaska (amended in part and repealed in part 1974); ARK. STAT. ANN. § 72-604(2)(p) (Supp. 1973); CONN. GEN. STAT. ANN. § 20-9 (Supp. 1975); Law of July 5, 1971, ch. 212 [1971], 58 Del. Laws 651 (repealed 1973); MICH. COMP. LAWS ANN. § 338.371 (Supp. 1975). The PA statutes of Arkansas, Connecticut, and Delaware copied the AMA's recommended language.

including Florida and Oklahoma, which thereby amended their earlier Simple Authorization Statutes.<sup>215</sup> Nonetheless, 1972, which ended with seven of 24 PA statutes in Simple Authorization form, represented the high point for state adoption of PA Simple Authorization Statutes.

In June 1972 the AMA's House of Delegates recommended that PA legislation empower state medical licensing boards to approve "on an individual basis" the supervising physician, the PA, and a job description of the "proposed functions" for the PA.<sup>216</sup> The Delegates endorsed this form of PA Regulatory Statute because prior controls were deemed necessary to ensure the quality of PA services and thereby to assure third-party payors, insurance companies and government health service programs, that reimbursements could appropriately be made to physicians for PA services rendered under physician supervision.<sup>217</sup> Although the AMA's resolution indicated that such reimbursement questions had arisen only as to PAs working in "a location physically remote from [an] employing physician,"<sup>218</sup> the AMA recommended that all proposed PA functions be given individual approval by a state medical licensing board, no matter where the PA might be located.<sup>219</sup> The resolution also recommended that third-party reimbursement for PA services be limited to services that had individual licensing board approval,<sup>220</sup> thereby inviting the cooperation of third-party payors in implementing the AMA's recommended form of legislation. One may ask whether the AMA's June 1972 recommendation was not prompted more by an interest in establishing organized medicine's control over expanded medical delegation than in solving a particular reimbursement problem caused by conservative bureaucracies.

Since 1972 only Tennessee has adopted a PA Simple Authorization Statute,<sup>221</sup> Delaware has repealed its statute,<sup>222</sup> and Alaska and Kansas have replaced their PA Simple Authorization Statutes with Regulatory Statutes.<sup>223</sup>

<sup>215</sup> ALA. CODE tit. 46, §§ 297(22j)-(22nn) (Supp. 1973) (enacted 1971); ARIZ. REV. STAT. ANN. §§ 32-1421(9) (Supp. 1974) (amended 1972), 32-2501 (Supp. 1974) (enacted 1972); FLA. STAT. ANN. § 458.135 (Supp. 1975) (enacted 1971); GA. CODE ANN. §§ 84-6201 to -6209 (Supp. 1974) (enacted 1972); IDAHO CODE § 54-1806(d) (Supp. 1974) (amended 1972); IOWA CODE ANN. §§ 148B.1-.10 (1972) (enacted 1971); MD. ANN. CODE art. 43, § 122(b)(6) (Supp. 1974) (amended 1972); NEB. REV. STAT. §§ 85-179.01-.18 (Supp. 1974) (enacted 1972); N.H. REV. STAT. ANN. §§ 329:21(XII)-(XIII) (Supp. 1973) (enacted 1971); N.Y. EDUC. LAW §§ 6530-36 (McKinney 1972) (enacted 1971) and N.Y. PUB. HEALTH LAW §§ 3700-02 (McKinney Supp. 1973) (enacted 1971); N.C. GEN. STAT. § 90-18 (13) (Supp. 1974) (amended 1971); OKLA. STAT. ANN. tit. 59, §§ 519-23 (Supp. 1974) (enacted 1972); ORE. REV. STAT. §§ 677.012, 055, 090, 232, 255, 510 (1973) (enacted 1971); UTAH CODE ANN. § 58-12-40 (1973) (enacted 1971); VT. STAT. ANN. tit. 26, §§ 1313(d),(e), tit. 31, §§ 1725-29 (1975) (enacted 1971); WASH. REV. CODE ANN. §§ 18.71A.010 to -.060 (Supp. 1974) (enacted 1971); W. VA. CODE ANN. §§ 30-3A-1 to -4 (1971) (enacted 1971).

<sup>216</sup> AMA BOARD OF TRUSTEES, REPORT Z, GUIDELINES FOR COMPENSATING PHYSICIANS FOR SERVICES OF PHYSICIANS' ASSISTANTS 2, Recommendation 1 (Approved by AMA House of Delegates, June, 1972).

<sup>217</sup> *Id.* at 1.

<sup>218</sup> *Id.*

<sup>219</sup> *Id.* at 2, Recommendation 2.

<sup>220</sup> *Id.* at 2, Recommendation 4.

<sup>221</sup> TENN. CODE ANN. § 63-608 (Supp. 1974).

<sup>222</sup> Ch. 55 § 5 [1973] 59 Del. Laws, *amending* DEL. CODE tit. 24, § 1731(d)(6).

<sup>223</sup> ALASKA STAT. §§ 08.64.107, 170 (Supp. 1974); KAN. STAT. ANN. § 65-2896 (Supp. 1975).



In addition, 12 other states have enacted PA Regulatory Statutes,<sup>224</sup> and the majority of NP statutes enacted have been Regulatory Statutes.<sup>225</sup>

Two related social welfare arguments have been made to justify adoption of Regulatory Statutes instead of Simple Authorization Statutes. The first is that some form of prior legal control over expanded medical delegation is necessary to protect the public from incompetent performance by unqualified nonphysicians.<sup>226</sup> The second is that prior controls are necessary to promote expanded delegation by helping assure consumers, physicians, and other potential employers that PAs and NPs are competent to perform particular medical acts.<sup>227</sup> Analysis of these claims suggests that these arguments are not persuasive and that the choice of a Regulatory Statute instead of a Simple Authorization Statute may diminish social gains from expanded medical delegation.

The claim that prior controls over expanded delegation are necessary to protect the public will be persuasive only if potential benefits to society from preventing harm caused by unqualified PAs and NPs seem likely to outweigh potential costs to society from using prior controls.<sup>228</sup> These future benefits and costs cannot be measured and weighed against each other in a precise way, but analysis of several underlying factors suggests that the likelihood of substantial harm from unqualified PAs and NPs is not great and that the potential costs of a prior control system may be significant. The social benefits from a prior control system will consist of the harm prevented by excluding from expanded delegation those nonphysicians for whom a reasonable showing of competency could not be made before a panel of disinterested medical experts. Claims that the amount of such harm would be substantial seem to rest upon an implicit analogy between the practice of medicine by physicians and expanded medical delegation.<sup>229</sup> Licensure of physicians may be justified on social welfare grounds since without licensure the relatively high incomes and social status of physicians might attract many unqualified persons into the occupation and

<sup>224</sup> HAWAII REV. STAT. § 453-2 (Supp. 1974) (amended 1973); ME. REV. STAT. ANN. tit. 32, §§ 2594-A (Supp. 1974) (enacted 1973), 3270-A (Supp. 1973) (enacted 1973); MASS. GEN. LAWS ANN. ch. 112, §§ 9C-H (Supp. 1975) (enacted 1973); MINN. STAT. ANN. §§ 145.861-.866 (Supp. 1975) (enacted 1973); NEV. REV. STAT. §§ 630.015, .025, .271, .273, .275 (1973) (enacted 1973); N.M. STAT. ANN. § 67-5-3.1 to -3.6, 10.G (1974) (enacted 1973); N.D. CENT. CODE § 43-17-02(10) (House Bill No. 1484, approved April 8, 1975); S.C. CODE ANN. § 56-1355(4) (Supp. 1974) (enacted 1974); S.D. COMPILED LAWS ANN. §§ 36-4A-1 to -42 (Supp. 1974) (enacted 1973); VA. CODE ANN. §§ 54-281.4 to .9 (1974) (enacted 1973); WIS. STAT. ANN. §§ 15.407(2) (Supp. 1975), 445.01(3), 448.51 (1974) (enacted 1973); WYO. STAT. ANN. §§ 33-338.1 to .8 (Supp. 1975) (enacted 1973).

<sup>225</sup> Since 1972, 17 NP Regulatory Statutes have been enacted, *see* note 168 and accompanying text *supra*, and five NP Simple Authorization Statutes have been enacted, *see* note 177 and accompanying text *supra*.

<sup>226</sup> DUKE PROJECT, *supra* note 10, at 23-24; Dean, *supra* note 10, at 6-7; *Problem of Statutory Authorization*, *supra* note 10, at 421.

<sup>227</sup> Forgotson, *supra* note 10, at 295; DUKE PROJECT, *supra* note 10, at 23-24.

<sup>228</sup> This manner of analyzing the public protection argument for Regulatory Statutes has been suggested by the analysis of "non-profit rationales for licensing." Moore, *The Purpose of Licensing*, 4 J. LAW & ECON. 93, 103-12 (1961) [hereinafter cited as Moore].

<sup>229</sup> One searches in vain among writings that propose prior controls over expanded medical delegation for justifications beyond the assertion that protection of the public requires them. *See, e.g.*, note 226 and accompanying text *supra*. The analogy between expanded delegation and the practice of medicine by physicians is a natural one, however, and would seem to provide the best arguments for prior controls.

the variability in the quality of physicians' services, the importance of that variability to the success of patients' treatments, and the relative inability of consumers to evaluate the quality of physicians' services suggest that substantial harm may be caused to consumers by the practice of unqualified physicians.<sup>280</sup> It does not follow, however, that prior controls over expanded medical delegation are similarly justified. Nonphysicians will be attracted into PA and NP occupations only to the extent that physicians choose to employ them. Expanded medical delegation will consist of simpler, more routine medical acts, indicating that variability in quality of nonphysicians' services and the importance of that variability in the outcome of patients' treatments will be much less than in the case of physicians' services, although admittedly much feasible delegation may involve decisions that are important to a patient's welfare.<sup>281</sup> Most significantly, expanded delegation, with the exception of limited independent practice,<sup>282</sup> will interpose a licensed physician between the individual consumer and nonphysician. The physician will be legally responsible for his or her negligence in selecting the nonphysician, in selecting the acts to be delegated, and in supervising the nonphysician's performance.<sup>283</sup> The physician also will be responsible under the master-servant doctrine for negligent performance by PA and NP employees<sup>284</sup> and arguably should be similarly responsible for PAs and NPs supervised by the physician but employed by another person.<sup>285</sup> In effect, physicians will be buying PA and NP services for consumers, thereby substituting physicians' abilities to evaluate the quality of nonphysicians' services for consumers' relative inability to do so.<sup>286</sup> These characteristics of expanded medical delegation all suggest that the frequency with which unqualified PAs and NPs will be employed is likely to be low and that relatively little harm will result from their performing medical acts absent a system of prior controls.

A prior control system over expanded medical delegation will result in social costs because the imposition of quality standards will tend to diminish the amount of expanded medical delegation and the price of medical services will be higher than without such controls. In this situation it is likely that some consumers will forego necessary medical services, thereby suffering harm, and that other consumers will be forced to pay higher prices for higher quality medical services than they desire to purchase.<sup>287</sup>

<sup>280</sup> See Moore, *supra* note 228, in particular at 106.

<sup>281</sup> See text at notes 25-27 *supra*.

<sup>282</sup> Limited, independent practice by PAs and NPs is generally outside the scope of this Article. Regulatory Statutes would appear to be the appropriate statutory form for authorization and regulation of such practice. See text at notes 440-41 *infra*.

<sup>283</sup> Leff, *supra* note 76, at 363.

<sup>284</sup> *Id.* at 366.

<sup>285</sup> See text at notes 384-88 *infra*.

<sup>286</sup> Of course, the ability of individual physicians to evaluate and supervise the quality of nonphysicians' services may vary substantially. One may ask, however, whether the significance of this variability with respect to patient harm is likely to be greater than the significance of physician variability respecting many other types of medical acts that are not subject to prior legal controls, e.g., intricate surgical operations, combining drugs to treat a specific patient for a specific disease, or the use of medical equipment as a physician-substitute in various diagnostic and treatment procedures.

<sup>287</sup> Kessel, *Supply of Physicians*, *supra* note 90, at 272; Moore, *supra* note 228, at 104.

It has been argued above that the inherent nature of expanded delegation and malpractice law constraints upon physicians make it unlikely that many unqualified PAs and NPs would be employed absent prior controls. One might conclude that prior controls will not diminish substantially the amount of expanded medical delegation and that the entire issue is *de minimis*. This assumption, however, would ignore an important distinction between the theory and practice of administrative regulation over medicine in general and expanded delegation in particular. In theory, an administrative agency operating under a Regulatory Statute would preclude by prior controls only those medical delegations for which a reasonable showing of competent performance cannot be made. In practice, administrative agencies with the power to preclude are likely to preclude too much. These agencies are likely to make overly conservative or restrictive judgments about competence because of a lack of techniques and resources to determine competence and because of the vested interests of organized medicine and nursing in limiting the supply and types of nonphysicians participating in expanded medical delegation. Much discussion in the following sections of this part is devoted to demonstrating how this gap between theory and practice can develop and that in fact such a gap does exist under PA and NP Regulatory Statutes.

The foregoing analysis of potential social benefits and costs of prior controls over expanded medical delegation suggests that the harm from allowing unqualified PAs and NPs to practice without prior controls seems likely neither to be substantial nor to outweigh the benefits from allowing individual physicians to make initial decisions about what to delegate to whom. At the very least, the analysis suggests that distinctions might be made among different types of expanded medical delegation, imposing prior controls only over delegations that have characteristics closely analogous to the characteristics of medical practice that appear to justify prior controls over physicians. For example, prior controls might be limited to expanded delegation involving (1) limited, independent practice by nonphysicians; (2) nonphysician practice in locations physically remote from the supervising physician; or (3) issuance of drug prescriptions by nonphysicians. Similar distinctions have been recognized to a limited extent under some PA and NP Regulatory Statutes. Under a few PA Regulatory Statutes, an administrative agency's approval of a specific job description is required only for acts to be performed in a setting physically remote from the supervising physician.<sup>288</sup> The NP Regulatory Statutes of Alaska and New Hampshire have been interpreted by the nurse licensing boards of those states to authorize expanded medical delegation to two distinct categories of RNs, those working under the relatively close supervision of a physician in a hospital setting, upon whom no prior controls have been imposed, and those working with greater scope for the exercise of medical judgment who are subject to prior controls.<sup>289</sup>

<sup>288</sup> See, e.g., Ala. PA Regs, *supra* note 146, Rule VII § 2; Iowa PA Regs, *supra* note 146, § 136.5(3).

<sup>289</sup> Position Paper of the Alaska Bd. of Nursing 2 (May 15, 1974); Letter from New Hampshire Nursing Board to Philip Kissam, Jan. 3, 1975.

The second social welfare claim for Regulatory Statutes is that prior controls are necessary to promote expanded medical delegation in several ways. It has been argued that such controls will reassure both consumers and potential employers about the competence of PAs and NPs, thereby promoting their acceptance and effective use by physicians.<sup>240</sup> A closely related argument is that detailed administrative regulation of expanded delegation will help resolve physicians' uncertainties about the legality of particular medical delegations. Such inquietude might be a significant obstacle to expanded medical delegation in view of the generally broad but ambiguous statutory provisions authorizing delegations and resulting physician concern about disciplinary, civil, and criminal liability.<sup>241</sup> Regulatory Statutes have also been supported on the ground that they will ensure a better flow of information to health planners and funding agencies about the employment of PAs and NPs, thereby facilitating the evaluation and expansion of medical delegation.<sup>242</sup>

These secondary claims for Regulatory Statutes seem largely misplaced since there are less restrictive alternatives that would accomplish the same purposes.<sup>243</sup> First, voluntary certification of PA and NP qualifications by state or professional agencies<sup>244</sup> and a legislative or judicial requirement of patients' informed consent before performance of service by a PA or NP<sup>245</sup> would provide the same information to consumers and physicians about PA and NP qualifications as prior controls without excluding from practice noncertified PAs and NPs that physicians are willing to use.<sup>246</sup> Consumers desiring to purchase only "qualified" PA and NP services might pay higher prices for services of certified PAs and NPs, but other consumers would be free to pay lower prices for services of noncertified PAs and NPs.<sup>247</sup> Secondly, voluntary certification also would provide a procedure by which uncertain physicians

<sup>240</sup> DUKE PROJECT, *supra* note 10, at 23-24; Forgotson, *supra* note 10, at 295.

<sup>241</sup> See text at notes 311-14 *infra*; Forgotson, *supra* note 10, at 295.

<sup>242</sup> Dean, *supra* note 10, at 7.

<sup>243</sup> The following analysis is suggested by Moore, *supra* note 228, at 104-06.

<sup>244</sup> National certification programs for different categories of PAs and NPs have already been established by professional organizations. See, e.g., NATIONAL BOARD OF MEDICAL EXAMINERS, ANNOUNCEMENT OF THE 1974 CERTIFYING EXAMINATION FOR PRIMARY CARE PHYSICIAN'S ASSISTANTS (1974) [hereinafter cited as PA CERTIFYING EXAMINATION ANNOUNCEMENT]. Massachusetts' PA Regulatory Statute provides for a limited kind of nonmandatory certification by a state agency; the Massachusetts Board of Approval of Physician's Assistants Programs is only authorized to issue "advisory guidelines" as to medical acts that any particular PA may perform. MASS. GEN. LAWS ANN. ch. 112 § 9G (Supp. 1975); Mass. PA Regs, *supra* note 146, § 4. Kansas also provided for state nonmandatory certification of PAs' credentials under its former PA Simple Authorization Statute, first by the state board of regents and subsequently by the medical licensing board. Law of July 1, 1972, ch. 294, § 1 [1972] Kan. Laws 1101, as amended, Law of July 1, 1973, ch. 315, § 1 [1973] Kan. Laws 1049 (subsequently amended to become a PA Regulatory Statute, 1975).

<sup>245</sup> Such informed consent should require that a patient be clearly informed that a PA or NP will serve them and that the PA's or NP's qualifications or lack thereof be available to the patient if requested. Under many PA Regulatory Statutes, PAs must identify themselves and their roles to patients. See, e.g., Ala. PA Regs, *supra* note 146, Rule VII § 1; GA. CODE ANN. § 84-6210 (Supp. 1974). These rules make no mention of the availability of the PAs' qualifications, but under these statutes all PAs will have been qualified by the state. In any event, the theory underlying the informed consent doctrine of malpractice law, that patients be reasonably informed of risks of treatment, would seem to require notification. See generally 61 AM. JUR. 2d *Physicians and Surgeons* § 154 (1972).

<sup>246</sup> See Moore, *supra* note 228, at 104.

<sup>247</sup> See Moore, *supra* note 228, at 106. The social welfare benefits of this consumer option are discussed in the text at note 237 *supra*.

and other employers could establish a presumption of legality for delegation of specific acts without binding more confident employers to decisions by administrative agencies.<sup>248</sup> Thirdly, simple registration of all PAs and NPs, without qualifying conditions, would provide accurate information for the evaluation, planning, and policing of expanded medical delegation.<sup>249</sup> All this could be done without incurring the potential losses to social welfare that seem likely to accompany imposition of prior controls.

The author concludes that PA and NP Simple Authorization Statutes are more likely to promote social welfare than comparable Regulatory Statutes.<sup>250</sup> One would be better assured of this conclusion's validity if two relatively simple provisions were added to the typical Simple Authorization Statute. First, a Simple Authorization Statute might include a provision similar to the one in California's NP Simple Authorization Statute that requires physicians to specify the procedures and protocols to be followed in the course of any expanded medical delegation.<sup>251</sup> This proviso would help ensure that both physicians and nonphysicians think carefully about their respective responsibilities before engaging in them. These procedures and protocols, if reduced to writing, also might make malpractice litigation and physician disciplinary proceedings more effective mechanisms for preventing incompetent delegations. Secondly, voluntary certification by a state agency of PA or NP qualifications to perform any particular medical acts might promote expanded medical delegation in the face of potential consumer and physician uncertainty. Consumers and physicians who will not accept or employ effectively merely any PA or NP then would have the opportunity to use nonphysicians whose qualifications have been state approved.<sup>252</sup>

### B. PA and NP Qualification

The legal standards and procedures that define who may qualify as a PA or NP differ substantially in Regulatory and Simple Authorization Statutes. Regulatory Statutes contain legislative rules of some specificity. They reflect a marked tendency to limit PAs and NPs to persons who possess a relatively broad range of medical skills as shown by the successful completion of a formal training program. Such rule-making seems likely to preclude much useful

<sup>248</sup> To ensure that voluntary certification does not have a dampening effect upon physicians who desire to use noncertified PAs and NPs, a statute recognizing such a system might provide explicitly that the failure to obtain voluntary certification shall not be used as evidence in any subsequent legal proceeding. Otherwise courts and medical licensing boards in subsequent civil, criminal, and administrative proceedings involving use of noncertified PAs or NPs might employ the traditional presumptions against the unlicensed practice of medicine described in the text at notes 73-78 *supra*.

<sup>249</sup> Alaska's former PA Simple Authorization Statute required simple registration of PAs with the state medical board. Ch. 5, § 1(6) [1972] Sess. Laws of Alaska (subsequently repealed).

<sup>250</sup> Federal and state drug control laws in certain instances may require the licensure of physicians' agents who exercise discretion in the prescription and dispensing of drugs. See text at notes 333-39 *infra*. If any such requirements were to be established, the conclusion that Simple Authorization Statutes are preferable to Regulatory Statutes would have to be qualified by the observation that prior controls over PAs and NPs authorized to exercise discretion in the prescription and dispensing of drugs are legally necessary.

<sup>251</sup> CAL. BUS. & PROF. CODE § 2725(d)(1),(2) (West Supp. 1974).

<sup>252</sup> See text at note 237 *supra*.

expanded delegation to persons with medical skills limited to particular medical acts or to persons who acquire their medical skills through informal, on-the-job training and experience. Under Simple Authorization Statutes, on the other hand, supervising physicians appear to have been granted a great deal of discretion in selecting nonphysicians to whom they may delegate medical acts.

### 1. *Regulatory Statutes*

Under a Regulatory Statute, the first and most important qualification issue is whether any nonphysician or RN who can demonstrate the skill to perform a particular medical act may qualify as a PA or NP to perform that act or whether only nonphysicians or RNs with relatively comprehensive skills may qualify. PAs and NPs may be limited to persons with comprehensive skills by two related rules, (1) a requirement that the PA or NP have successfully completed a training program approved by the administrative agency, or have demonstrated training and experience equivalent to such a program, and (2) a requirement that approved training programs provide relatively comprehensive training.

The first requirement is in effect under most PA Regulatory Statutes<sup>253</sup> and most NP Regulatory Statutes for which regulations are available.<sup>254</sup> The second requirement, that training be relatively comprehensive, is specified under at least nine PA Regulatory Statutes,<sup>255</sup> and four NP Regulatory Statutes.<sup>256</sup> In addition, standards for PA and NP training programs developed by the AMA and other professional organizations are at least the minimum training requirements for qualification under eight other PA Regulatory Statutes<sup>257</sup> and

<sup>253</sup> PAs must complete an approved training program or demonstrate equivalent training and experience under at least 26 PA Regulatory Statutes. Maryland and Wisconsin are the only apparent exceptions to date. Maryland provides for registration of "non-certified applicants . . . who, by reason of their training, skill, experience or background may be qualified to perform certain delegated duties" without establishing completion of an approved program as the standard of competence for qualification. Md. PA Regs, *supra* note 146, §§ .01(F),.03(C). Wisconsin does not require state certification for PA practice. Wis. STAT. ANN. § 448.51(1) (1974). The PA Regulatory Statutes of five other states, for which regulations were unavailable, do not establish completion of an approved training program as the standard of competence for qualification. ALASKA STAT. §§ 08.64.107, .170(a)(1) (Supp. 1974); IDAHO CODE § 54-1806(d) (Supp. 1975); MINN. STAT. ANN. §§ 145.861-.866 (Supp. 1975); N.D. CENT. CODE § 43-17-02(10) (Supp. 1975); S.C. CODE ANN. § 56-1355(4) (Supp. 1974).

<sup>254</sup> NPs must complete an approved training program or demonstrate equivalent training and experience under all nine of the NP regulations cited in note 171 *supra*, except that New Hampshire does not apply this standard or any other prior control to RNs working under relatively close physician supervision in institutional settings. See text at note 239 *supra*.

<sup>255</sup> Ala. PA Regs, *supra* note 146, Rule V, § 6 (two-year minimum); Cal. PA Regs, *supra* note 146, § 1379.25,41,.64,.74 (specified curricula); COLO. REV. STAT. ANN. § 12-31-106(1)(d) (1973) (specified curriculum); Fla. PA Regs, *supra* note 146, Rule V, § 6 (two-year minimum); Ga. PA Regs, *supra* note 146, § 360-5.03(b)(2)(i) (two-year minimum); Me. PA Regs, *supra* note 146 (programs listed in HEW-AMA directory); N.Y. EDUC. LAW § 6531(d) (McKinney 1972) (two-year minimum for primary care PA training programs) and N.Y. Health PA Regs, *supra* note 146, § 94.2(g) (broad training or experience required for specialist PAs); S.D. COMPILED LAWS ANN. §§ 36-4A-13,-15 (Supp. 1974) (specified curricula); Vt. PA Regs, *supra* note 146, Rule III(c) (comprehensive skills required).

<sup>256</sup> Me. NP Regs, *supra* note 171, § III(c)(7)(c) (specified curricula); N.H. NP Regs, *supra* note 171, Part B., §§ 3.1(A),2(A),3(A),4(A) (requiring professionally approved courses or masters degrees in nursing with two or three years supervised experience for different categories of NPs); Va. NP Regs, *supra* note 171, § VI(E)(2) (specified curricula); Wash. NP Regs, *supra* note 171, §§ 308-120-190,-200 (comprehensive skills required).

<sup>257</sup> Ariz. PA Regs, *supra* note 146, *Qualifications* (1)(b); HAWAII REV. STAT. § 453-2 (Supp. 1974); Iowa PA Regs, *supra* note 146, § 136.4(2); Mass. PA Regs, *supra* note 146, § 9.1; Neb. PA Regs, *supra* note 146, § 2.2; Nev. PA Regs, *supra* note 146, § C(3); N.M. PA Regs, *supra* note 146, § (1); N.C. PA Regs, *supra* note 146, Rule V.

one other NP Regulatory Statute.<sup>258</sup> These standards seem to require relatively comprehensive training of PAs and NPs within given medical specialties.<sup>259</sup> In view of this pattern and the traditional emphasis in medical licensure on formal, institutional education,<sup>260</sup> it would be surprising if medical and nurse licensing boards that have not established formal requirements for comprehensive training of PAs or NPs do not follow such standards in making individual determinations of competency. Two factors appear to explain the decision to limit PAs and NPs to persons with comprehensive medical training. The first is medical licensors' tradition of assessing a person's competence to practice by evaluating the quality of the candidate's formal education rather than the quality of his or her patient care.<sup>261</sup> Medical and nurse licensing boards will certainly find it administratively easier and less expensive to measure PA and NP qualifications by traditional methods that rely on accreditation of formal educational programs, which will tend to be relatively comprehensive for economic reasons if no other. The support for the new legislation from operators of formal training programs<sup>262</sup> and the national standards and accrediting mechanism for formal PA training programs already established by organized medicine<sup>263</sup> also encourage use of comprehensive qualification standards. A second reason for requiring broad training of PAs and NPs may be the argument that the quality of performance of a given medical act will be better to the extent that the actor has relatively comprehensive training to perform related medical acts. For example, the quality of diagnostic procedures may be better if the person performing the procedure also is trained in treatment. This argument overlooks two features of expanded medical delegation—that medical studies already have shown that narrowly limited medical acts may be performed competently by persons with training limited to those acts<sup>264</sup> and that expanded delegation, with the exception of limited independent practice, involves a supervising physician who can supply the comprehensive medical knowledge that the nonphysician lacks.

The limitation of PAs and NPs to those with comprehensive training may have substantial social costs. Formal PA training programs require 12 months to two academic years at a minimum,<sup>265</sup> and formal NP programs range from 3 to 12 months of full-time training away from nursing practice.<sup>266</sup> In states with Regulatory Statutes, potentially substantial opportunities for expanded delegation to nonphysicians with less formal, more limited, and less expensive

<sup>258</sup> Vt. NP Regs, *supra* note 171, § II(B).

<sup>259</sup> See, e.g., AMA ESSENTIALS, *supra* note 12, § VIII.

<sup>260</sup> See text at notes 94-98 *supra*.

<sup>261</sup> See Carlson, *supra* note 10, at 859-61; Kessel, *Supply of Physicians*, *supra* note 90, at 268-69.

<sup>262</sup> See text at note 124 *supra*.

<sup>263</sup> See, e.g., AMA ESSENTIALS, *supra* note 12.

<sup>264</sup> See studies cited in note 27 *supra*.

<sup>265</sup> AMERICAN MEDICAL ASSOCIATION & BUREAU OF HEALTH RESOURCES DEVELOPMENT, DEP'T OF HEALTH, EDUCATION AND WELFARE, PHYSICIAN SUPPORT PERSONNEL 1973-74, DHEW Pub. No. NIH 74-318 (1974).

<sup>266</sup> AMERICAN NURSES ASSOCIATION & BUREAU OF HEALTH RESOURCES DEVELOPMENT, DEP'T OF HEALTH, EDUCATION AND WELFARE, PREPARING REGISTERED NURSES FOR EXPANDED ROLES 1973-74, Part I DHEW Pub. No. NIH 74-31 (1974).

training are likely to be precluded or at least restricted. In legal proceedings testing the legality of expanded delegation to a nonphysician who has not qualified under a Regulatory Statute, tribunals are likely to be even less disposed to finding the delegation valid than they have been traditionally because the Regulatory Statute represents a clear declaration of legislative policy that expanded delegation be performed only by persons qualifying under the Statute.

A second qualification issue under Regulatory Statutes is whether only graduates of training programs approved by the administrative agency may qualify or whether persons also may qualify with less formal training and experience that may be deemed equivalent to formal training programs (equivalency training). The statutory or regulatory definition of PA appears to preclude recognition of equivalency training under at least 12 PA Regulatory Statutes,<sup>267</sup> and available NP regulations generally do not recognize equivalency training as a basis for qualification.<sup>268</sup> On the other hand, equivalency training is recognized under at least 16 PA Regulatory Statutes<sup>269</sup> and one NP Regulatory Statute.<sup>270</sup> The failure to recognize equivalency training, even though it consists of relatively comprehensive training, thus will prevent many former medical corpsmen, nurses with specialized medical experience, and other informally trained nonphysicians from participating in expanded medical delegation.<sup>271</sup>

A person may qualify as a PA on the basis of equivalency training under many PA Regulatory Statutes, but recognition of equivalency training raises some conceptual and practical problems that may limit its actual availability. Existing statutes and regulations generally are silent on the question of what informal training and experience will be deemed equivalent to training offered by a formal program,<sup>272</sup> simply designating an evaluating agent and procedures.

<sup>267</sup> COLO. REV. STAT. ANN. § 12-31-106(1)(d) (1974); HAWAII REV. STAT. § 453-2 (Supp. 1974); KAN. STAT. ANN. § 65-2896(2)(b) (Supp. 1975); ME. REV. STAT. ANN. tit. 32, § 3270-A (Supp. 1973); MASS. GEN. LAWS ANN. ch. 112, § 9C (Supp. 1975); N.H. REV. STAT. ANN. § 329:21(XII) (Supp. 1973); N.M. STAT. ANN. § 67-5-3.1(C) (1974); ORE. REV. STAT. § 677.065(1) (1973); S.D. COMPILED LAWS ANN. §§ 36-4A-1(3),(4) (Supp. 1974); UTAH CODE ANN. § 58-12-40 (Supp. 1973); Va. PA Regs, *supra* note 146, *Qualifications* (2); WASH. REV. CODE ANN. § 18.71A.010 (Supp. 1974). Notwithstanding statutory provisions that define PAs as persons having completed "approved training programs," the medical licensing boards in two of these states have interpreted this language broadly and will qualify PAs on the basis of training deemed equivalent to approved training programs, Me. PA Regs, *supra* note 146; Ore. PA Regs, *supra* note 146, § 50-020(2).

<sup>268</sup> Among nine states with available NP Regulations, *see* note 171 and accompanying text *supra*, only North Carolina has recognized equivalency training as a basis for qualification. N.C. NP Regs, *supra* note 171, Rule III, § 1(c).

<sup>269</sup> Ala. PA Regs, *supra* note 146, Rule III, § 1(2)(b); Ariz. PA Regs, *supra* note 146, *Qualifications* (2); CAL. BUS. & PROF. CODE § 2515(b) (West 1974); Letter from Florida Board of Medical Examiners to Philip Kissam, June 27, 1974; GA. CODE ANN. § 84-6204(b)(1) (Supp. 1974); IOWA CODE ANN. § 148B.1(6) (1972); Me. PA Regs, *supra* note 146; Neb. PA Regs, *supra* note 146, § 2.4; Nev. PA Regs, *supra* note 146, § C(3); N.Y. EDUC. LAW § 6531(d) (McKinney 1972); Okla. PA Regs, *supra* note 146, § E(3); Ore. PA Regs, *supra* note 146, § 50-020(2); Vt. PA Regs, *supra* note 146, § III(a)(2),(3); W. Va. PA Regs, *supra* note 146, § 8.05(c); Wis. PA Regs, *supra* note 146, § 50.10(b) (until 1980); Wyo. STAT. ANN. § 33-338.2(ii) (Supp. 1975).

<sup>270</sup> N.C. NP Regs, *supra* note 171, Rule III, § 1(c).

<sup>271</sup> See Chappell and Drogos, *supra* note 27, for a favorable evaluation of relatively comprehensive pediatric care provided by a RN with informal training.

<sup>272</sup> Exceptions are Georgia's regulation, which provides that completion of a "formal course of study in the health field" together with related work experience adding up to four years may be substituted for completion of an approved training program, Ga. PA Regs, *supra* note 146, § 360-5-.03(b)(2), and



These vary among four options: equivalency examinations administered by medical licensing boards;<sup>278</sup> equivalency examinations administered by approved PA training programs within the state;<sup>274</sup> national certification examinations established by organized medicine;<sup>275</sup> and individual determinations by licensing boards based on a candidate's experience and recommendations.<sup>276</sup> In theory, an effective equivalency examination would test directly a person's proficiency in performing medical acts without attempting to determine competence indirectly by testing for formal kinds of knowledge acquired in academic programs.<sup>277</sup> Proficiency testing techniques in medicine are not generally available, however, although interest in developing such techniques seems to be growing.<sup>278</sup> Even if such techniques are feasible for PA equivalency examinations, their development will require a more substantial commitment of new resources than can realistically be expected. Given these factors, there is a danger that equivalency examinations will place too much emphasis upon acquisition of academic knowledge and too little on proficiency in patient care. This type of examination is not likely to allow many PA candidates to qualify on the basis of equivalency training. Reliance on national certification examinations to measure equivalency training appears to be subject to the same criticism.<sup>279</sup> More importantly, the present national certification examination for primary care PAs does not recognize equivalency training at all, because it limits examination candidates to graduates of approved training programs or PAs and NPs with at least four years experience "as a PA or NP."<sup>280</sup> Ad hoc determinations of equivalency training by administrative agencies would seem to be a more flexible and potentially more effective procedure than equivalency or national certification examinations that are oriented towards academic training. This procedure is not without its problems since the very absence of standards may allow medical licensing boards to make conservative decisions.

A third qualification issue is whether to require all PA and NP candidates to pass an examination or obtain certification from a professional organization. At least 12 states require all PA candidates to pass an examination, either a state-administered one or a national certification examination.<sup>281</sup> At least four

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Vermont's regulation, which provides that two years of training and experience under a physician covering a relatively comprehensive set of medical tasks may be substituted for completion of an approved training program, Vt. PA Regs, *supra* note 146, § III(a)(3).

<sup>278</sup> See, e.g., Ala. PA Regs, *supra* note 146, Rule III, § 1(2)(c).

<sup>274</sup> See, e.g., Ala. PA Regs, *supra* note 146, Rule III, § 1(2)(b).

<sup>275</sup> See, e.g., Neb. PA Regs, *supra* note 146, Rule 2.4.

<sup>276</sup> See, e.g., N.Y. Educ. PA Regs, *supra* note 146, § 60.8(c).

<sup>277</sup> See Carlson, *supra* note 10, at 859-60.

<sup>278</sup> *Id.*

<sup>279</sup> For example, the 1974 Certifying Examination for Primary Care Physician's Assistants consisted of a one day written examination covering a broad variety of medical acts and a separate assessment of each candidate's skill in performing a physical examination. See PA CERTIFYING EXAMINATION ANNOUNCEMENT, *supra* note 244, Examination Schedule and Summary of Health Care Functions.

<sup>280</sup> *Id.* Eligibility Requirements.

<sup>281</sup> Ala. PA Regs, *supra* note 146, Rule III, § 1(2)(c); Ariz. PA Regs, *supra* note 146, Examination; Cal. PA Regs, *supra* note 146, §§ 1379.12, 13, 40; COLO. REV. STAT. ANN. § 12-31-106(1)(f) (1973); GA. CODE ANN. § 84-6204(b)(2); Iowa PA Regs, *supra* note 146, §§ 136.4(1)(d), (5); KAN. STAT. ANN. § 65-2896(2)(c) (Supp. 1975); N.M. PA Regs, *supra* note 146, Rule 17(2); Ore. PA Regs, *supra* note 146, § 50-025; S.D. COMP. LAWS ANN. § 36-4A-1(3), (4) (Supp. 1974); Va. PA Regs, *supra* note 146,

states require national certification for NPs in certain instances.<sup>282</sup> The recent interest displayed by organized medicine and nursing in developing national certification examinations for PAs and NPs<sup>283</sup> makes it likely that an increasing number of licensing boards will require passage of a national certification examination as a condition of PA or NP qualification under a Regulatory Statute. Should this occur, organized medicine will have established control over the quality and supply of PAs and NPs in a manner similar to its control over physicians.<sup>284</sup> The possible advantage of such a development would be higher quality PA and NP services. The possible disadvantages are a reduced supply of PAs and NPs because of imposition of costly quality standards, more limited use of expanded medical delegation, and more expensive medical services generally.

National certification examinations to assess the competency of PAs or NPs can help promote maximum feasible medical delegation if they are not made a condition of PA qualification to practice under state laws. First, national certification can help provide consumers and physicians with information about the quality of those PAs or NPs who obtain certification.<sup>285</sup> Secondly, nationally certified PAs and NPs will have greater job mobility across state lines, particularly if national certification entitles them to automatic qualification under Regulatory Statutes. Such mobility may serve both private and public interests as it increases career attractiveness and allows PAs and NPs to be employed where they are most needed. If passage of a national certification examination is made a condition of qualification, however, the quality control imposed thereby may be unduly restrictive in several ways. For example, the most recent national certifying examination for primary care PAs appeared to test only for comprehensive training and arguably was oriented largely towards an assessment of formal academic knowledge.<sup>286</sup> The disadvantages of requiring comprehensive skills and testing for formal academic knowledge have been discussed above.<sup>287</sup> In addition, the eligibility criteria for this examination indicate an excessively limited concept of equivalency training. Those who could sit for the examination must have graduated from a formal training program or have spent at least "four years of medical clinical experience in

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*Qualifications* (3); Wis. PA Regs, *supra* note 146, § 50.10(3). California, Iowa, New Mexico, and Virginia explicitly require national certification of all PAs, but in several other states administrative agencies may administer examinations or prescribe equivalent ones.

<sup>282</sup> Idaho NP Regs, *supra* note 171, at 8 (nurse anesthetists must pass national certification examination); N.H. NP Regs, *supra* note 171, § 3.1(A)(b) (nurse midwives must pass national certification examination); Vt. NP Regs, *supra* note 171, § II.B (nurse midwives must pass national certification examination); Wash. NP Regs, *supra* note 171, § 308-120-190(5).

<sup>283</sup> See NATIONAL JOINT PRACTICE COMMISSION, STATEMENT ON CERTIFICATION OF NURSES AND PHYSICIANS (1974); Todd, *National Certification of Physicians' Assistants by Uniform Examinations*, 222 J.A.M.A. 563 (1972).

<sup>284</sup> Organized medicine's control over the supply of physicians is discussed in the text at notes 94-98 *supra*.

<sup>285</sup> The advantages of providing this information to consumers and physicians are discussed in the text at notes 243-48 *supra*.

<sup>286</sup> See PA CERTIFYING EXAMINATION ANNOUNCEMENT, *supra* note 244, in particular *Summary of Health Care Functions*.

<sup>287</sup> See text at notes 265-66, 271 *supra*.

primary care as a physician's assistant or nurse practitioner."<sup>288</sup> Any state that makes passage of this examination a condition of PA qualification will preclude all persons except NPs, who may not be interested in qualifying as PAs anyway, from qualifying on the basis of equivalency training obtained in that state, because four years of prior practice as a PA in that state will be illegal. If most states require passage of this examination, the opportunity to qualify as a PA on the basis of equivalency training will be limited to NPs or medical corpsmen with at least four years experience in the military.

## 2. *Simple Authorization Statutes*

Under Simple Authorization Statutes, the statutory language designating who may perform delegated medical acts coupled with the decisions of supervising physicians will determine in the first instance who may qualify as PAs or NPs. Three PA Simple Authorization Statutes refer to "a physician's trained assistant, a registered professional nurse or licensed practical nurse"; one refers to "a person qualified by education, training and experience"; and one simply refers to any nonphysician.<sup>289</sup> Six NP Simple Authorization Statutes refer merely to RNs; three to both RNs and licensed practical nurses; and one to RNs with "appropriate training" to perform "special acts . . . delegated by a physician."<sup>290</sup> Under these statutes, a qualified PA or NP would appear to be any nonphysician or nurse, usually a professional nurse, whom a physician selects to perform a delegated medical act.<sup>291</sup> The one possible statutory limitation on physicians' discretion to choose PAs and NPs is the reference in some statutes to "trained assistant" or "training," which might be interpreted narrowly to mean medical training in a formal educational program. To support this interpretation, it might be argued that a particular legislature enacting a Simple Authorization Statute intended to restrict qualified PAs or NPs to graduates of formal training programs in view of the importance such programs have played in the development of expanded medical delegation.<sup>292</sup> This interpretation, like many of the qualification requirements under Regulatory Statutes, would have the unfortunate effect of precluding expanded delegation to persons trained in particular medical acts and to persons who have obtained medical skills on an informal basis.<sup>293</sup> A broader interpretation of "trained" and "training" seems preferable as a matter of policy, an interpretation that finds support in the argument that legislative use of these terms equally might have been intended as a mere limitation of authorized expanded delegations to those made to nonphysicians who meet the malpractice law standard of competency.<sup>294</sup>

<sup>288</sup> PA CERTIFYING EXAMINATION ANNOUNCEMENT, *supra* note 244, *Eligibility Requirements*.

<sup>289</sup> See text at notes 155-57 *supra*.

<sup>290</sup> See text at notes 179-81 *supra*.

<sup>291</sup> Of course, under malpractice law, the physician will be liable for any damages caused by negligence in selecting a nonphysician who is incompetent to perform the delegated medical act. See Leff, *supra* note 76, at 360-63.

<sup>292</sup> See text at note 39 *supra*.

<sup>293</sup> See text at notes 265-66, 271 *supra*.

<sup>294</sup> This standard is discussed in Leff, *supra* note 76, at 363.

### C. Scope of Practice Rules

Scope of practice rules are those that define medical acts that may or may not be delegated to PAs and NPs, as well as the nature of physician supervision over delegated acts. With certain major exceptions noted below, the new legislation generally leaves scope of practice questions to a case-by-case resolution. On the whole such resolution seems desirable, but an analysis of the major exceptions together with legislative silence on certain important issues suggests that legislatures and administrative agencies may be implementing an overly conservative policy toward PA and NP scope of practice.

All Simple Authorization Statutes and some Regulatory Statutes provide that scope of practice questions are to be resolved initially by supervising physicians.<sup>296</sup> Under some other Regulatory Statutes, administrative agencies have chosen to leave scope of practice questions largely to physicians.<sup>296</sup> Under approximately half of the Regulatory Statutes for which regulations are available, scope of practice questions are to be resolved initially by administrative agency approval of job descriptions on a case-by-case basis.<sup>297</sup> Such job descriptions are not likely to answer all questions and should leave some discretion to supervising physicians. Ultimately, of course, particular scope of practice questions may be decided by disciplinary, civil, and criminal proceedings. The general absence of scope of practice rules seems desirable because the diversity of potential delegations makes it difficult to legislate effectively as to PAs and NPs with widely varying skills who might work under quite different degrees of physician supervision.<sup>298</sup> The absence of rules or standards governing the "outer boundaries" of expanded medical delegation, however, may create certain problems for the full realization of benefits from expanded delegation.

Three related scope of practice questions help define the outer boundaries of expanded medical delegation: (1) whether PAs and NPs may make diagnostic and treatment judgments; (2) whether PAs and NPs may practice in locations remote from their supervising physician; and (3) whether PAs and NPs may prescribe or dispense drugs. The medical studies noted above suggest that under certain conditions PAs and NPs may competently perform any of

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<sup>296</sup> The broad discretion of physicians to determine scope of practice questions under Simple Authorization Statutes is discussed at notes 152-59, 177-87 and accompanying text *supra*. PA Regulatory Statutes that limit administrative control to PA qualification and leave scope of practice questions to supervising physicians are HAWAII REV. STAT. § 453-2 (Supp. 1973); ME. REV. STAT. ANN. tit. 32, § 3270-A (Supp. 1974); MASS. GEN. LAWS ANN. ch. 112, §§ 9C-H (Supp. 1975); UTAH CODE ANN. § 58-12-40 (1973). Maine's NP Regulatory Statute also limits administrative control to NP qualification. ME. REV. STAT. ANN. tit. 32, § 2102(2)(e) (Supp. 1973).

<sup>297</sup> Colorado's Child Health Associate Law authorizes child health associate-PAs to "practice pediatrics" with few restrictions other than on drugs they may prescribe. COLO. REV. STAT. ANN. §§ 12-31-101 to -115 (1973). Colorado's medical licensing board has not issued regulations that further define or limit the scope of practice for child health associate-PAs. Letter from Loretta Arduser, Secretary, Colorado State Board of Medical Examiners, to Philip Kissam, June 17, 1975. Similarly, New Mexico's and New York's PA regulations do not require approved job descriptions and place relatively few limits on NP or PA scope of practice. N.M. PA Regs, *supra* note 146; N.Y. Health PA Regs, *supra* note 146.

<sup>298</sup> See note 149 and accompanying text *supra*.

<sup>299</sup> Cohen and Dean, *To Practice or Not to Practice*, *supra* note 7, at 359-60.

these tasks.<sup>299</sup> The following discussion analyzes the problems created by the legislative silence on these questions and the legislative choices that have been made to date.

The absence of statutory standards governing these scope of practice questions may create substantial legal uncertainty that will retard the development of maximum feasible medical delegation. First, under Regulatory Statutes, administrative agencies may prohibit or at least hesitate to authorize outer boundary delegations. Secondly, without explicit authorization for these delegations by statute or regulatory action, physicians may hesitate to make the most effective use of PAs and NPs because of the possibility of subsequent unfavorable legal proceedings.<sup>300</sup> Finally, with legislative silence on outer boundary delegations, the seemingly conservative policies of organized medicine about PA and NP scope of practice are likely to carry greater weight than otherwise with administrative agencies, physicians, and tribunals involved in legal proceedings concerning expanded delegation.<sup>301</sup>

In December 1971, the AMA's House of Delegates approved the *Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician*, a set of standards for training primary care PAs and NPs.<sup>302</sup> To establish such standards, it was necessary to define the scope of practice for which primary care assistants should be trained. The AMA Essentials begin by noting that the primary care assistant "will not supplant the doctor in the sphere of decision-making required to establish a diagnosis and plan therapy."<sup>303</sup> No justification was given for this recommendation, either in the Essentials or in a task force report that preceded it.<sup>304</sup> A mere assertion by organized medicine that licensed physicians must "make diagnoses" and "plan therapy" is apparently enough. If established by law, this prohibition would help ensure that PAs and NPs merely supplement rather than substitute for physicians' services. A possible explanation for the AMA's position is that "supplemental" services by PAs and NPs are likely to generate new demand for medical services, thereby protecting physicians' fees and incomes.<sup>305</sup>

The AMA Essentials do recognize that PAs and NPs may carry out a broad variety of medical procedures, certain kinds of treatment modifications, and "emergency" diagnostic and treatment judgments. PA and NP services are

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<sup>299</sup> See notes 26-27 and accompanying text *supra*.

<sup>300</sup> The absence of explicit authorization for outer boundary delegations will create legal uncertainties similar to those for all expanded delegations under traditional forms of state medical practice and allied health professional acts. The latter type of uncertainty is described and explained in section I.C. *supra*.

<sup>301</sup> The written policies of organized medicine on PA and NP scope of practice described below would seem to constitute some evidence of "customary practice." The importance of medical custom in both malpractice cases and interpreting medical practice acts has been well documented. See, e.g., Forgotson, *supra* note 10, at 291-92; Leff, *supra* note 76, at 339-44.

<sup>302</sup> AMA ESSENTIALS, *supra* note 12.

<sup>303</sup> *Id.* at 1.

<sup>304</sup> *Id.*; AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN COLLEGE OF PHYSICIANS AND AMERICAN SOCIETY OF INTERNAL MEDICINE, OCCUPATIONAL GUIDELINES FOR THE ASSISTANT TO THE PRIMARY CARE PHYSICIAN 1-2 (1971).

<sup>305</sup> See text at notes 116-18 *supra*.

defined to include "executing [a physician's] standing orders."<sup>806</sup> Although this term is not defined further, its customary use by health professionals indicates that its meaning includes treatment modifications by nonphysicians working under a physician's written directions.<sup>807</sup> In other words, a nonphysician working under standing orders may determine the severity of symptoms of an already diagnosed disease or other abnormal condition and choose to modify treatment, perhaps by the dispensation of drugs.<sup>808</sup> PA and NP services are also defined to include the "independent performance of evaluative and treatment procedures essential to provide an appropriate response to life-threatening, emergency situations."<sup>809</sup> This provision establishes that in case of dire need a PA or NP may make a diagnosis and initiate treatment until a physician is contacted. The AMA Essentials do not mention remote practice or drug prescriptions by PAs and NPs, although a general reference is made to the variations in practice that may result from "geographic, economic and sociologic factors,"<sup>810</sup> and the recognition of the execution of standing orders as a legitimate function for PAs and NPs seems to imply authority to engage in limited, independent decision-making with respect to drugs.

In sum the AMA Essentials seem to be conservative on the question of diagnostic and treatment judgments, and they are unclear on the other two outer boundary questions. If any generalization can be made about scope of practice rules on these questions under the new legislation, it is that they tend to be at least as conservative as the AMA Essentials.

The typical provisions in PA statutes that allow PAs to perform "medical services," "patient's services," or "services"<sup>811</sup> under a physician's supervision do not resolve the outer boundary questions. These terms are not further defined by statute, and their ambiguous nature easily could allow interpretations that prohibit PA practice along the outer boundaries of expanded medical delegation.<sup>812</sup> The language of NP Simple Authorization Statutes is similar, authorizing "delegated medical acts," "standardized procedures," "services," or merely the "execution of medical regimens."<sup>813</sup> In contrast, approximately half of the NP Regulatory Statutes authorize NPs to perform "acts of medical diagnosis" and "prescription of medical therapeutic or corrective measures" to the extent authorized by regulation.<sup>814</sup> This language provides clearly that

<sup>806</sup> AMA ESSENTIALS, *supra* note 12, at 2, ¶ 5.

<sup>807</sup> See *Acts of Diagnosis by Nurses*, *supra* note 12, at 467-68, 474-75.

<sup>808</sup> *Id.* at 467-68.

<sup>809</sup> AMA ESSENTIALS, *supra* note 12, at 2, ¶ 7.

<sup>810</sup> *Id.* at 1.

<sup>811</sup> See text at notes 141, 158-59 *supra*.

<sup>812</sup> Three PA Regulatory Statutes are less ambiguous in authorizing the scope of practice for PAs. Alaska's statute provides that a PA "may examine, diagnose or treat" under a physician's supervision. ALASKA STAT. § 08.64.170(a)(1) (1974). Colorado's Child Health Associate Law authorizes child health associate-PAs to "practice pediatrics" and to prescribe certain drugs under a physician's supervision. COLO. REV. STAT. ANN. §§ 12-31-102(2),-103(2) (1973). South Dakota's statute authorizes PAs to "make a tentative medical diagnosis and institute therapy or referral" and "to prescribe medication for symptoms and temporary pain relief." S.D. COMPILED LAWS ANN. § 36-4A-22(3) (Supp. 1974).

<sup>813</sup> See text at notes 182-84 *supra*.

<sup>814</sup> See text at note 169 *supra*.

administrative agencies may authorize NPs to make diagnostic and treatment judgments and to prescribe or dispense drugs.

PAs and NPs have been prohibited from making diagnostic and treatment judgments under at least ten PA Regulatory Statutes,<sup>315</sup> one NP Regulatory Statute<sup>316</sup> and four NP Simple Authorization Statutes.<sup>317</sup> Furthermore, in five cases the rules prohibiting the exercise of discretion by PAs are so broad that treatment modifications by PAs also seem proscribed.<sup>318</sup> Under all of these statutes, PAs and NPs at best are limited to patient work-ups (*i.e.*, taking medical histories, performing physical examinations, and related diagnostic procedures), presenting the patient to the physician, and carrying out treatments prescribed by the physician.<sup>319</sup>

Rules under a few PA and NP Regulatory Statutes provide or imply that PAs and NPs may make diagnostic and treatment judgments that they are competent to perform. The Colorado Child Health Associate Law authorizes child health associate-PAs to "practice pediatrics" under physician supervision,<sup>320</sup> and the South Dakota PA statute authorizes PAs to "[m]ake tentative medical diagnosis and institute therapy or referral . . . [and] to treat common childhood diseases."<sup>321</sup> By administrative opinion, Nebraska has authorized PAs to prescribe certain drugs, without limiting this authority to followup treatment after an initial diagnosis by a physician.<sup>322</sup> The absence of such a limitation suggests that the Nebraska medical licensing board is willing to recognize diagnostic and treatment judgments by PAs through individual approval of job descriptions. Nevada and Washington by regulation recognize remote practice by PAs.<sup>323</sup> Because this authority would be ineffectual without

<sup>315</sup> The prohibitions against PAs making diagnostic and treatment judgments are found in Ala. PA Regs, *supra* note 146, Rule IX (although PAs who are physicians not licensed in Alabama may be given broader authority); Ariz. PA Regs, *supra* note 146, "Method of Performance" (2); Cal. PA Regs, *supra* note 146, §§ 1379.22,.62,.72; Md. PA Regs, *supra* note 146, § .05(A); N.H. PA Regs, *supra* note 146, § I.C.; ORE. REV. STAT. § 677.065(3) (1973); VA. CODE ANN. § 54-281(4)(a) (1974); Wash. PA Regs, *supra* note 146, §§ (2)(a),(b); W. Va. PA Regs, *supra* note 146, § 8.01; Wis. PA Regs, *supra* note 146, § 50.02(7); Wyo. PA Regs, *supra* note 146, §§ 5(c),(f).

<sup>316</sup> Va. NP Regs, *supra* note 171, § I.A. In addition, New Hampshire's NP regulations specifically limit the types of diagnostic judgments that may be made by certain categories of NPs. See text at note 328 *infra*.

<sup>317</sup> COLO. REV. STAT. ANN. §§ 12-38-202(7),(9)(c) (1973); N.J. STAT. ANN. § 45:11-23(1)(b) (Supp. 1975); N.Y. EDUC. LAW § 6902(1) (McKinney Supp. 1973); TENN. CODE ANN. § 63-740 (Supp. 1974). These statutes authorize RNs to perform treatment modifications but not diagnostic and treatment judgments. See text at note 186 *supra*.

<sup>318</sup> See Ala. PA Regs, *supra* note 146, Rule IX; Ariz. PA Regs, *supra* note 146, "Method of Performance" (1),(2); Cal. PA Regs, *supra* note 146, §§ 1379.22,.62,.72; N.H. PA Regs, *supra* note 146, § I.C.; ORE. REV. STAT. § 677.065(3) (1973) and Ore. PA Regs, *supra* note 146, §§ 50-040(1),(2). Alabama's Rule IX appears to limit PAs to performing specified medical procedures that do not include treatment modifications, although PAs who are physicians but not licensed in Alabama may be given broader authority by the state medical board. The rules of the other four states require PAs to report the results obtained from any diagnostic procedure to a physician before initiating therapeutic procedure, an apparent prohibition of treatment modifications as well as diagnostic and treatment judgments.

<sup>319</sup> The four NP Simple Authorization Statutes that authorize RNs to perform treatment modifications do not appear to authorize RNs to perform diagnostic procedures such as physical examinations and medical histories. See text at note 186 *supra*.

<sup>320</sup> COLO. REV. STAT. ANN. § 12-31-102(2) (1973).

<sup>321</sup> S.D. COMPILED LAWS ANN. § 36-4A-22(3) (Supp. 1974).

<sup>322</sup> Memorandum from Rex Higley, Director of the Bureau of Examining Boards, Nebraska Department of Health, Aug. 12, 1974.

<sup>323</sup> Nev. PA Regs, *supra* note 146, § I.(4); Wash. PA Regs, *supra* note 146, § 5(b)(i).

concomitant authority for PAs to make diagnostic and treatment judgments about more common medical disorders, these regulations also suggest that the medical boards in these states are authorizing such judgments on the basis of approved job descriptions.

As noted, many NP Regulatory Statutes appear to allow diagnostic and treatment judgments by NPs to the extent authorized by regulatory agencies.<sup>324</sup> Among the few available regulations that address this issue, Nevada and Washington have authorized NPs to perform diagnostic and treatment judgments.<sup>325</sup> In addition, New Hampshire and Vermont have authorized nurse-midwives to "manage" or "assume responsibility" for normal or low-risk obstetrical patients, authorization that includes the initial judgment that the patient is low-risk,<sup>326</sup> and New Hampshire has authorized psychiatric NPs to "identif[y] and interpret problems related to the mental health of the patient . . . and provid[e] appropriate therapy or referral."<sup>327</sup> In contrast, New Hampshire has limited NPs other than nurse-midwives and psychiatric NPs to making an initial judgment of normal or abnormal condition, with referral of abnormal conditions to physicians required,<sup>328</sup> and Virginia has limited NPs to recommending diagnoses and treatment plans to physicians, except in emergency situations.<sup>329</sup>

PAs and NPs are precluded from practicing in remote locations, that is outside of the supervising physician's office, a hospital in which the physician has patients, or patients' homes, under at least ten PA Regulatory Statutes and one NP Regulatory Statute.<sup>330</sup> To the contrary, Nevada, South Dakota, Washington, and Wisconsin have authorized remote practice by PAs,<sup>331</sup> and Alaska, Nevada, and New Hampshire have recognized self-employed NPs who may work "in collaboration with" or "upon referrals" from physicians, an apparent authorization of remote practice by NPs.<sup>332</sup>

The authority of PAs and NPs to make independent decisions regarding the use of drugs, either by prescribing retail sales of drugs to patients or by dispensing drugs directly to patients in hospitals, nursing homes, and physicians' offices, depends not only on the relevant PA or NP statute and regulations but also on federal and state drug control laws that place certain limitations on who may prescribe and dispense drugs. Federal law relies generally on state

<sup>324</sup> See text at note 314 *supra*.

<sup>325</sup> Nev. NP Regs, *supra* note 171, § III.C; Wash. NP Regs, *supra* note 171, § 308-120-200(3).

<sup>326</sup> N.H. NP Regs, *supra* note 171, Part B, §§ 3.1(B)(d),(e); Vt. NP Regs, *supra* note 171, § III.

<sup>327</sup> N.H. NP Regs, *supra* note 171, Part B, § 3.4(B)(c).

<sup>328</sup> *Id.*, Part B, §§ 3.2(B)(c), 3.3(B)(d).

<sup>329</sup> Va. NP Regs, *supra* note 171, § I(A).

<sup>330</sup> The prohibitions against PAs practicing in remote locations are found in Ala. PA Regs, *supra* note 146, Rule VII, § 2; COLO. REV. STAT. ANN. § 12-31-103(1) (1973); FLA. STAT. ANN. § 458.135(3) (Supp. 1975); GA. CODE ANN. § 84-6204(e); Iowa PA Regs, *supra* note 146, § 136.5(3); NEB. REV. STAT. § 85-179.06 (1974); N.C. PA Regs, *supra* note 146, Rule VII, § 2; Va. PA Regs, *supra* note 146, "Method of Performance" (2); W. Va. PA Regs, *supra* note 146, § 8.10(a); Wyo. PA Regs, *supra* note 146, § 4(b). Virginia has prohibited remote practice by NPs. Va. NP Regs, *supra* note 171, § II.

<sup>331</sup> Nev. PA Regs, *supra* note 146, § I.(4); S.D. PA Regs, *supra* note 146, § 20:50:01:04; Wash. PA Regs, *supra* note 146, § (5)(b)(i); Wis. PA Regs, *supra* note 146, § 50.06.

<sup>332</sup> ALASKA BOARD OF NURSING POSITION PAPER, 2 (May 15, 1974); Nev. NP Regs, *supra* note 171, § C; N.H. NP Regs, *supra* note 171, Part A, § 1.1.



law to determine practitioners' qualifications to prescribe or dispense drugs, but it does establish two significant conditions. The Food, Drug, and Cosmetic Act requires that retail sales of prescription drugs be made only upon the written or oral "prescription of a practitioner licensed by law to administer such a drug."<sup>333</sup> It seems clear that a PA or NP whose qualifications have been individually approved by an administrative agency and who has been granted explicit authority to administer drugs by legislative rule or approved job description would satisfy this requirement because the determination of those licensed by law to administer drugs is a matter of state law.<sup>334</sup> Clear answers are not similarly available for two other cases, (1) prescriptions by PAs and NPs whose qualifications have received state approval by a form of license but who have been neither granted nor denied explicit authority to administer drugs, and (2) prescriptions by PAs and NPs who have not been licensed to administer drugs but who complete prescription order forms previously signed in blank by their supervising physician. Resolution of the first case will depend on whether the nonphysician's general authority to perform medical acts is interpreted to include the authority to administer drugs. An interpretation recognizing such authority seems reasonable in view of the general lack of statutory limitations on PAs' and NPs' authority to perform medical acts and the obvious importance of drug prescriptions to modern medicine, but such an approach is uncertain because of the typically ambiguous scope of practice provisions mentioned above.<sup>335</sup> Determination of the second issue will depend on whether PAs and NPs who prescribe drugs on forms signed in blank by their supervising physicians are recognized as agents who are merely carrying out a "physician's prescription" or whether they are considered independent practitioners.<sup>336</sup> The former view is supported by the policy underlying the Food, Drug, and Cosmetic Act, which is to rely on state law to govern the medical aspect of drug prescriptions, and by the authority of physicians under the new state laws to employ PAs and NPs generally as agents who perform medical acts. The ambiguous nature of statutory scope of practice provisions, however, renders uncertain the resolution of this issue.

The second condition imposed by federal law is that narcotics, barbiturates, amphetamines, and other dangerous drugs that are deemed "controlled substances" under the Drug Abuse Prevention and Control Act may be prescribed or dispensed only by a person "licensed . . . or otherwise permitted by . . . the jurisdiction in which he practices . . . to distribute [or] dispense . . . a controlled substance in the course of professional practice. . . ."<sup>337</sup> Regulations make it clear that physicians' agents who prescribe the retail sale of controlled substances must be "licensed . . . or otherwise permitted" by the jurisdiction in

<sup>333</sup> 21 U.S.C. § 353(b)(1) (1970).

<sup>334</sup> *Schlessing v. United States*, 239 F.2d 885, 886-87 (1956); *United States v. 22 Devices, More or Less, Halux Therapeutic Generator*, 98 F. Supp. 914, 917-19 (1951).

<sup>335</sup> See text at notes 311-14 *supra*.

<sup>336</sup> Neither Federal regulations nor case law appears to address this agency question, which is not surprising in view of the fact that physicians traditionally have not delegated the act of prescribing drugs.

<sup>337</sup> 21 U.S.C. §§ 802(20), 829(a),(b) (1970).

which they practice to so prescribe and must be registered with the federal government.<sup>338</sup> Agents who merely dispense controlled substances to patients directly need not be registered but must be "licensed . . . or otherwise permitted" by state law to dispense controlled substances.<sup>339</sup> Under these provisions, state licensure is not necessary to grant permission to PAs and NPs to prescribe or dispense controlled substances, but the exact nature of the alternative required permission is unclear. Thus questions may arise that are similar to the scope of practice issues under the Food, Drug, and Cosmetic Act.

State pharmacy and narcotics control acts regulate the flow of drugs in the same manner as the federal drug control laws, relying mainly on state licensure laws to determine practitioners' qualifications to prescribe or dispense drugs.<sup>340</sup> A survey of these laws is beyond the scope of this Article, but it should be noted that these laws may add additional restrictions to those imposed by federal law. For example, a state pharmacy act may provide that only "licensed practitioners" can prescribe drugs, rather than "authorized persons,"<sup>341</sup> and it may regulate the dispensing of all prescription drugs, not merely controlled substances.<sup>342</sup> To the extent that additional restrictions are imposed by these laws, they create added uncertainties about the legal authority of PAs and NPs to prescribe or dispense drugs.

Explicit authority for PAs to prescribe or dispense drugs has been granted under at least four PA Regulatory Statutes. Colorado's statute provides that child health associate-PAs may prescribe specified prescription drugs that have been approved by the state medical board.<sup>343</sup> South Dakota's statute is less clear in providing authority for PAs to "prescribe medication for symptoms and temporary pain relief"<sup>344</sup> and in authorizing the medical board to approve "such other tasks" for PAs "for which adequate training and proficiency can be demonstrated."<sup>345</sup> By administrative opinion, Nebraska has recognized a physician's right to delegate his "prescribing authority" to PAs for drugs other than controlled substances.<sup>346</sup> New York by regulation has authorized PAs to dispense drugs including controlled substances to hospital inpatients if the order is countersigned by the supervising physician within 24 hours.<sup>347</sup> To the contrary, PAs appear to be precluded from prescribing or dispensing prescription drugs under at least ten PA Regulatory Statutes, explicitly in four cases<sup>348</sup>

<sup>338</sup> 21 C.F.R. § 1306.03(a) (1975).

<sup>339</sup> 21 C.F.R. § 1301.24(b) (1975).

<sup>340</sup> See, e.g., KAN. STAT. ANN. §§ 65-1626(h), 65-1637 (Supp. 1975) (requiring that a prescription be by "a duly licensed practitioner"); N.Y. EDUC. LAW § 6810(1) (McKinney Supp. 1973) (requiring that a prescription be by "a person legally authorized to issue such prescription").

<sup>341</sup> Compare the Kansas and New York provisions cited in the preceding footnote.

<sup>342</sup> See, e.g., KAN. STAT. ANN. § 65-1635 (Supp. 1975); N.Y. EDUC. LAW § 6807(b) (McKinney Supp. 1973).

<sup>343</sup> COLO. REV. STAT. § 12-31-103(2)(b) (1973).

<sup>344</sup> S.D. COMPILED LAWS ANN. § 36-4A-22(3) (Supp. 1974).

<sup>345</sup> *Id.* § 36-4A-23.

<sup>346</sup> Memorandum from Rex Higley, Director of the Bureau of Examining Boards, Nebraska Department of Health, Aug. 12, 1974.

<sup>347</sup> N.Y. PA Health Regs, *supra* note 146, § 94.2(e).

<sup>348</sup> Md. PA Regs, *supra* note 146, § .05B; VA. CODE ANN. § 54-281.4(a) (1974); W. VA. CODE ANN. § 30-3A-4 (1971); W. Va. PA Regs, *supra* note 146, § 8.01; Wis. PA Regs, *supra* note 146, § 50.11.

and implicitly in the others by prohibitions against the exercise of diagnostic and treatment judgments and treatment modifications.<sup>349</sup>

Only a few available regulations under NP Regulatory Statutes address the drug prescription issue. Washington has authorized NPs to use drug therapy "pursuant to protocols jointly recognized by the medical and nursing professions."<sup>350</sup> New Hampshire and Vermont have authorized nurse-midwives to dispense "medications" to normal or low-risk obstetrical patients.<sup>351</sup> New Hampshire's regulations, however, limit NPs other than nurse-midwives to "recommending non-prescription drugs," to "regulating and adjusting" physician-prescribed medications, and to dispensing certain prescription medications in emergency situations only.<sup>352</sup>

In summary, outer boundary delegation most effectively allows PAs and NPs to substitute their services for those of physicians, rather than merely to supplement physicians' ministrations. Not coincidentally, such expanded delegation most threatens physicians' fees and incomes. Most PA and NP statutes and available regulations thereunder do not clearly resolve by legislative rule the three important scope of practice issues that define the outer boundaries of expanded medical delegation: diagnostic and treatment judgments, remote practice, and prescription of drugs. When legislative rules have been promulgated, they have tended to preclude PAs from making diagnostic and treatment judgments or prescribing drugs. Too few NP regulations are available to indicate a trend one way or the other on these issues. Under a majority of Regulatory Statutes, it is possible for authority for outer boundary delegations to be awarded on a case-by-case basis through administrative approval of job descriptions. In view, however, of the general absence of statutory standards on these questions, organized medicine's conservative position, and the control of the confirmation process by state medical boards and state medical societies, authorization for outer boundary delegations through approved job descriptions may be quite limited.<sup>353</sup> The consequence of this legal structure will be uncertainty about or denial of the rights of PAs and NPs to make diagnostic and treatment judgments for more common medical disorders, to prescribe drugs for such disorders, and to practice in locations remote from their supervising physician, despite the fact that such practices seem medically feasible in many instances. In scope of practice regulation, as with other issues under the new legislation, organized medicine seems to be protecting successfully the economic interests of physicians.

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<sup>349</sup> Ala. PA Regs, *supra* note 146, Rule IX (although PAs who are physicians not licensed in Alabama may be given broader authority); Ariz. PA Regs, *supra* note 146, "Method of Performance" (1),(2); Cal. PA Regs, *supra* note 146, §§ 1379.22,62,72; N.H. PA Regs, *supra* note 146, § 1.C.; Ore. PA Regs, *supra* note 146, § 50-040(1),(2); Wyo. PA Regs, *supra* note 146, § 5(e).

<sup>350</sup> Wash. NP Regs, *supra* note 171, § 308-120-200(3).

<sup>351</sup> N.H. NP Regs, *supra* note 171, Part B, §§ 3.1(B)(e)(2),(4); Vt. NP Regs, *supra* note 171, § III(D).

<sup>352</sup> N.H. NP Regs, *supra* note 171, Part B, §§ 3.2(B)(g),(h), 3.3(B)(j),(k), Part C.

<sup>353</sup> Empirical studies of what is happening under the mechanism of approved job descriptions is clearly a next step in the study of PA and NP statutes. See Cohen and Dean, *To Practice or Not to Practice*, *supra* note 7, at 350.

#### D. *Issues Specific to Regulatory Statutes*

Legislatures that have adopted PA or NP Regulatory Statutes also have been compelled to choose a state agency or agencies to administer the statute and promulgate regulations to further define allowable medical delegations. In addition, legislatures that have enacted PA Regulatory Statutes and administrative agencies acting under these statutes have chosen in many cases to prohibit or restrict hospital employment of PAs and to limit the number of PAs that a physician may supervise. Analysis of these issues reveals a pattern of conservative regulation that may limit possible benefits from expanded medical delegation.

##### 1. *Which Administrative Agency?*

Professional licensing boards and, in a few cases, professional societies have been delegated all administrative authority under 45 of the 51 PA and NP Regulatory Statutes, and they have been assigned significant authority under three of the other six statutes.<sup>354</sup> Alternatively, all or partial administrative authority has been allotted to state Health Departments or Boards.<sup>355</sup> Analysis of this choice indicates that state health agencies may be the preferable regulatory body, at least with respect to expanded delegation occurring in health care institutions.

The explanation for the prevailing pattern of delegation of administrative authority to professional licensing boards seems clear. These agencies already have primary governmental responsibility for controlling the quality of medical and nursing practices, and the principle of efficient administration seems to dictate that these agencies control the quality of any new aspect of such practices. Furthermore, organized medicine and nursing wield substantial political power on this issue, and it is in their interest to see administrative authority lodged in agencies that they control.<sup>356</sup> The social welfare benefits from delegating administrative authority to professional licensing boards are not so clear. Unified regulation of medical and nursing practices may yield some social benefits because of efficient use of existing administrative expertise and more efficient communication between the regulators and the regulated. Sev-

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<sup>354</sup> Administrative authority is shared between professional licensing boards and state health agencies under two PA Regulatory Statutes, NEB. REV. STAT. § 85-179.13 (Supp. 1974) (authorizing the medical board to promulgate regulations "only with the approval" of the State Department of Health); N.Y. EDUC. LAW §§ 6530-36 (McKinney 1972) and N.Y. PUB. HEALTH LAW §§ 3700-02 (McKinney Supp. 1973) (authorizing the State Commissioner of Education, who delegates his authority on medical matters to the state medical board, to qualify PAs and authorizing the State Commissioner of Health to regulate PA scope of practice); and one NP Regulatory Statute, ch. 354, § 1, [1974] Miss. Gen. Laws 405, *amending* MISS. CODE ANN. § 73-15-5(2) (1972) (authorizing the nurse licensing board and state health board to promulgate joint regulations). All administrative authority has been delegated to state health agencies by three PA Regulatory Statutes, MASS. GEN. LAWS ANN. ch. 112, § 9F (Supp. 1975) (establishing a Board of Approval and Certification of Physician Assistant Programs in the Department of Public Health); MINN. STAT. ANN. § 145.864 (Supp. 1975) (allowing the State Board of Health to authorize new categories of health manpower); VT. STAT. ANN. tit. 26, § 1726 (1975) (authorizing the Secretary of the State Human Services Agency, upon "consultation" with the medical licensing board, to regulate PA practice).

<sup>355</sup> See statutes cited in previous footnote.

<sup>356</sup> See section I.D. *supra*.

eral considerations suggest, however, that this argument is not very persuasive and that substantial social costs may be incurred by allotting control over expanded delegation to professional licensing boards. These agencies traditionally have demonstrated little concern with controlling the quality of medical and nursing practice by licensed practitioners,<sup>367</sup> and they seem to have had insufficient administrative resources to carry out this function.<sup>368</sup> One may infer from this that professional licensing boards have not accumulated vast reserves of administrative resources that would make regulation of expanded delegation by them any more efficient than regulation by another agency. On the other hand, these agencies may have particular interests in restricting the amount of expanded delegation that occurs,<sup>369</sup> and much of the analysis of this part suggests that regulatory action by these boards has been overly conservative.<sup>360</sup>

State health agencies appear to be an attractive alternative agency to which authority over expanded medical delegation might be given, at least with respect to delegations that occur in an institutional setting.<sup>361</sup> The Hill-Burton Hospital Construction Act of 1946 required states to license hospitals in order to qualify for federal hospital construction grant allotments.<sup>362</sup> Since 1946, almost every state has adopted hospital and nursing home licensure laws administered by state health agencies,<sup>363</sup> some of which appear to apply even to ambulatory medical clinics.<sup>364</sup> These laws generally give broad authority to state health agencies to supervise the quality of care rendered by health institutions, including medical care,<sup>365</sup> although a general criticism of state hospital licensure has been that only a few state health agencies have adequately superintended institutional medical care.<sup>366</sup> Three considerations make

<sup>367</sup> See, e.g., Forgotson, *supra* note 10, at 312-15; Kessel, *Supply of Physicians*, *supra* note 90, at 268-69, 272-73.

<sup>368</sup> See, e.g., *Contemporary Studies Project: Regulation of Health Personnel in Iowa—A Distortion of the Public Interest*, 57 IOWA L. REV. 1006, 1050 (1972).

<sup>369</sup> See section I.D. *supra*.

<sup>360</sup> See sections III.B., C. *supra* and subsections III.D.2., 3. *infra*.

<sup>361</sup> Three states have authorized professional licensing boards to regulate expanded delegation occurring only or primarily in physicians' and nurses' private practices, while implicitly authorizing state health agencies to regulate expanded delegation in institutional settings. California's NP Simple Authorization Statute, CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1974), only authorizes the state medical and nurse licensing boards to regulate expanded delegation that occurs outside licensed health care institutions, apparently leaving any state regulation of expanded delegation within institutions to the general licensing power of the State Health Department. See text at notes 362-65 *infra*. In a similar fashion, Alaska's and New Hampshire's nurse licensing boards have taken the position that RNs performing additional medical acts under close physician supervision in institutional settings need not be certified under the NP Regulatory Statutes of those states. See text at note 239 *supra*.

<sup>362</sup> Act of Aug. 13, 1946, ch. 958, § 2, 60 Stat. 1040.

<sup>363</sup> Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305, 308 (1970).

<sup>364</sup> See, e.g., N.Y. PUB. HEALTH LAW § 2801(1) (McKinney 1972) (defining a hospital for which a license must be obtained to mean "a facility or institution engaged principally in providing services by or under the supervision of a physician . . . including, but not limited to, a . . . diagnostic center [and] treatment center . . ."); cf. KAN. STAT. ANN. §§ 65-425(f), (h) (Supp. 1975) (defining a medical care facility for which a license must be obtained to include "ambulatory surgical centers").

<sup>365</sup> Worthington and Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305, 309 (1970).

<sup>366</sup> *Id.* at 309-10, 317-19; A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 108-15 (1969). These authors mention New York and Michigan as examples of effective state regulation of medical care in hospitals.

state health agencies an attractive alternative to professional licensing boards. First, the natural constituency of a state health agency is licensed health care institutions rather than physicians and nurses.<sup>867</sup> Although medical and nursing staffs can influence decision-making by health care institutions,<sup>868</sup> these institutions respond to different incentives than individual professionals.<sup>869</sup> Hospitals, clinics, and nursing homes are likely to be less interested than organized medicine in restricting the supply of physicians' services and more interested in being able to provide innovative, less expensive medical services.<sup>870</sup> Secondly, state health agencies that have already assumed responsibility for supervising institutional medical care arguably would be more efficient than professional licensing boards in regulating expanded delegation in an institutional setting. Thirdly, assigning authority over expanded delegation to other state health agencies might encourage them to assume greater responsibility for supervising the overall quality of institutional medical care.

New York's Health Department has been relatively active in supervising institutional medical care.<sup>871</sup> New York's PA Regulatory Statute delegates authority to the State Health Commissioner to regulate the practice of qualified PAs,<sup>872</sup> and the Commissioner's regulations indicate some advantages from regulation by state health agencies. The regulations do not restrict expanded medical delegation to PAs beyond what is set forth in the statute: the PA must perform "under the supervision" of a physician and acts delegated must be "within the scope of practice of such supervising physician."<sup>873</sup> The regulations also appear to be designed specifically to promote effective expanded delegation in health care institutions. Any physician may supervise a maximum of six PAs who are employed by a health care institution,<sup>874</sup> allowing hospital-based physicians to make much more effective use of PAs than in most states where they are limited to supervising one or two PAs.<sup>875</sup> The regulations also permit PAs that are employed by health care institutions or extended privileges therein to dispense drugs to inpatients, if the medical orders are countersigned by the supervising physician within 24 hours.<sup>876</sup> In contrast, medical licensing boards in several states preclude all drug prescriptions by PAs, and many others are silent on the issue.<sup>877</sup>

A few PA Regulatory Statutes have established special committees or

<sup>867</sup> For a discussion of the potential influence of hospitals upon state health agencies in another area of health regulation, the issuance of certificates-of-need that are required for hospital expansion or construction, see Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143, 1172-88 (1973).

<sup>868</sup> *Id.* at 1162-63.

<sup>869</sup> *Id.* at 1160-62.

<sup>870</sup> For example, nonprofit hospitals may have particular incentives to serve the community by providing low-cost ambulatory services that could be implemented with effective use of PAs and NPs.

<sup>871</sup> See note 366 *supra*.

<sup>872</sup> N.Y. PUB. HEALTH LAW §§ 3700-02 (McKinney Supp. 1973).

<sup>873</sup> N.Y. EDUC. LAW § 6532(1) (McKinney 1972); N.Y. Health PA Regs, *supra* note 146, §§ 94.2(a),(b).

<sup>874</sup> N.Y. Health PA Regs, *supra* note 146, § 94.2(d).

<sup>875</sup> See text at notes 394-410 *infra*.

<sup>876</sup> N.Y. Health PA Regs, *supra* note 146, § 94.2(e).

<sup>877</sup> See text at notes 343-49 *supra*.

councils to advise state administrative agencies on PA regulation,<sup>378</sup> in an apparent attempt to provide professional licensing boards with additional resources and expertise and to ameliorate any interest of these boards in restricting the supply of physician services. These committees typically are composed of a substantial number of physicians, including representatives of the medical board and a medical school that trains PAs, a smaller number of RNs, one or two PAs, and occasionally a layman. With this composition and merely advisory authority, it seems unlikely that these new agencies will exercise a liberalizing influence. In any event, their additional expertise and perspective could be provided to state health agencies as easily as to professional licensing boards.

## 2. *May Hospitals Employ PAs?*

PAs must be employed by physicians or physician owned corporations under at least 13 PA Regulatory Statutes,<sup>379</sup> and regulations under three other statutes suggest that licensing board approval of PA job descriptions is contemplated only for physician employed PAs.<sup>380</sup> This prohibition against hospital-employed PAs does not seem justified, and it may diminish social benefits from expanded delegation. The prohibition appears to be based on a largely unexamined quality of care argument, one that has been advanced by the AMA and probably by the nursing profession as well.<sup>381</sup> The AMA's House of Delegates stated, "[D]irect responsibility to and supervision by a physician is a critical element in the safe and effective performance of a physician's assistant. . . . [Therefore] a physician's assistant [should] not function in that capacity when an employee of and paid by a hospital or by a full-time salaried hospital based physician."<sup>382</sup>

It is difficult to see how hospital employment would diminish a PA's responsibility to a physician or undermine a physician's supervisory authority. The AMA argument apparently is based on the theory that the hiring, general supervision, and firing of PAs by a hospital administration rather than by

<sup>378</sup> CAL. BUS. & PROF. CODE §§ 2519-20 (West 1974); IOWA CODE ANN. § 148B.5 (1972); N.Y. PUB. HEALTH LAW § 3702 (McKinney Supp. 1973); WIS. STAT. ANN. § 15.407(2) (Supp. 1975).

<sup>379</sup> Ala. PA Regs, *supra* note 146, Rule VIII; COLO. REV. STAT. ANN. § 12-31-102(2) (1973) (an exception is provided for PA employment by governmental agencies, but any PA so employed must be supervised by an individual physician, § 12-31-114(1)(c)); Fla. PA Regs, *supra* note 146, Rule II, § 1 (as interpreted, letter from George S. Palmer, Executive Director, Florida Board of Medical Examiners, to Philip Kissam, June 27, 1974); IDAHO CODE § 54-1806(d) (Supp. 1975); NEV. REV. STAT. § 630.273 (1973); Okla. PA Regs, *supra* note 146, Rule 10(B),(D); Ore. PA Regs, *supra* note 146, § 50-015(1); S.D. COMPILED LAWS ANN. § 36-4A-20 (Supp. 1974); VT. STAT. ANN. tit. 26, § 1727(c) (1975); VA. CODE ANN. § 54-281.4(a) (1974); WASH. REV. CODE ANN. § 18.71A.050 (Supp. 1974); W. Va. PA Regs, *supra* note 146, §§ 8.01,.08; Wyo. PA Regs, *supra* note 146, § 4(a).

<sup>380</sup> ARIZ. PA Regs, *supra* note 146, *Preamble, Professional Corporation or Partnership, PA Application Form*; Iowa PA Regs, *supra* note 146, § 136.3(1), *PA Application Form*; N.C. PA Regs, *supra* note 146, Rule II(1), *PA Application Form*.

<sup>381</sup> Prohibition of PA employment by hospitals would serve the economic interests of nurses by discouraging competition from PAs in the institutions where most nurses work. In 1966, approximately 66⅔% of all active professional nurses were hospital-employed. Jones, Struve, & Stefani, *Health Manpower in 1975—Demand, Supply, and Price*, App. V, II REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER, 229, 244-45 (1967).

<sup>382</sup> AMA HOUSE OF DELEGATES, EMPLOYMENT OF PHYSICIANS' ASSISTANTS (June, 1972). This document refers to a similar position taken by the American Hospital Association (AHA) in November 1970, although a new statement on PAs in hospitals is presently "under consideration" by the AHA. Letter from Jay Hedgepath, General Counsel, AHA, to Philip Kissam, March 4, 1975.

physicians would encourage employment of unqualified PAs and their inappropriate use. Such employment and use decisions, however, appear to be quintessentially medical decisions that are similar to decisions to grant hospital admitting privileges to physicians. Effective control over the latter is lodged with hospitals' medical staffs,<sup>383</sup> and there is little reason to doubt that medical staffs cannot exercise similar control over hospital employment and use of PAs. In any event, this power could be given to hospital medical staffs by legislative rule. This would be a less restrictive alternative than outright prohibition of hospital employment and would resolve the concerns of the AMA.

Another argument against hospital employment of a PA might be the reduction or elimination of malpractice liability of the supervising physician for injuries caused by the PA's negligence, and the consequent decrease in the physician's responsibility for selection and supervision of the PA. Hospital-employed PAs working under the supervision of physicians, however, would seem to constitute "borrowed servants," that is, hospital employees for whose negligence the supervising physician is liable just as if he were an employer.<sup>384</sup> Private physicians and physicians employed by hospitals are equally liable for negligence of hospital employees working under their supervision.<sup>385</sup> Admittedly, the borrowed servant doctrine in some cases has been limited to "medical" as opposed to "administrative" acts<sup>386</sup> or to acts performed only under the observation and direct control of physicians,<sup>387</sup> limitations that recognize a hospital's responsibility for selection and general supervision of traditional kinds of hospital employees acting outside the physical presence or effective control of physicians. Such confines, however, would not seem appropriate for cases involving negligence of PAs, who are authorized only to provide patient care under a physician's supervision.<sup>388</sup> In any event, doubt about unlimited application of the borrowed servant doctrine to hospital-employed PAs could be resolved by a statute providing that, for purposes of tort liability, any supervising physician should be conclusively presumed to be an employer of a PA providing services to the physician's patients.<sup>389</sup> This provision obviously would be a less restrictive alternative than prohibition of hospital employment.

The potential benefits from hospital employment of PAs and their super-

<sup>383</sup> See Ludlam, *Physician—Hospital Relations: The Role of Staff Privileges*, 35 LAW & CONTEMP. PROB. 879, 887-88, 897 (1970).

<sup>384</sup> See generally 61 AM. JUR. 2d *Physicians and Surgeons* § 164 (1972).

<sup>385</sup> Compare *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944) (private physicians liable for negligence of hospital employees) with *Yorston v. Pennell*, 397 Pa. 28, 153 A.2d 255 (1959) and *McConnell v. Williams*, 361 Pa. 355, 65 A.2d 243 (1949) (physicians salaried by hospital liable for negligence of other hospital employees).

<sup>386</sup> *Swigerd v. City of Ortonville*, 246 Minn. 339, 75 N.W.2d 217 (1956); *Moeller v. Hauser*, 237 Minn. 368, 54 N.W.2d 639 (1952); *Benedict v. Bondi*, 384 Pa. 574, 122 A.2d 209 (1956).

<sup>387</sup> *Bernardi v. Community Hospital Ass'n*, 166 Colo. 280, 443 P.2d 708 (1968).

<sup>388</sup> See text at notes 141, 152 *supra*.

<sup>389</sup> A number of states by statute or regulation have established such a rule. See, e.g., ALA. CODE tit. 46, § 297(2211)(b) (Supp. 1973) ("In the performance of any medical service contemplated by this article, an assistant to a physician shall be conclusively presumed to be the agent, servant or employee solely of the licensed physician or physicians under whose supervision he performs such service . . .").



vision by a number of physicians should be weighed against the potential losses from such use of PAs. Hospitals would seem to be institutions in which a great deal of cost effective expanded delegation might take place. For example, a hospital could open or expand out-patient or emergency services at lower cost if a relatively few physicians were able to supervise PAs employed by the hospital.<sup>390</sup> As another example, surgeons and other hospital based specialists might not find it economically feasible to employ a full-time PA, but a hospital well might employ the PA to work on a part-time basis for each of several physicians. The effective consequence of restricting hospital employment of PAs is not to protect the public but rather to limit the use of PAs in areas of medical practice where their use may be the greatest competitive threat to physicians' and nurses' incomes and practices. Expansion of relatively low-cost hospital based ambulatory services using PAs may draw patients away from primary care physicians practicing in the community served by the hospital. Hospital employment of surgical and other specialist PAs to work for several physicians may increase the opportunities for price competition by particular physicians who make substantial use of the PAs, thereby threatening price discrimination by specialist physicians.<sup>391</sup> Finally, the majority of all practicing RNs are employed by hospitals,<sup>392</sup> and, as noted above, RNs feel that non-nurse PAs threaten nursing incomes and status.<sup>393</sup>

### 3. *How Many PAs May A Physician Supervise?*

Physicians apparently will be limited by legislative rule to supervising no more than one or two PAs under a substantial majority of PA Regulatory Statutes. At this writing, rules that generally limit physicians to supervising one or two PAs have been established under 21 statutes, although waivers to this rule are explicitly available in three cases.<sup>394</sup> Rules authorizing physicians to supervise a larger number of PAs have been established under two other

<sup>390</sup> Teams of hospital employed PAs might be supervised by salaried physicians or, in the case of emergency services, by rotating on-call private physicians as well.

<sup>391</sup> The benefits to physicians of price discrimination and its likelihood of occurrence among hospital based physicians have been described at notes 109-35 and accompanying text *supra*.

<sup>392</sup> Jones, Struve, & Stefani, *Health Manpower in 1975—Demand, Supply, and Price*, App. V, II REPORT OF THE NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER, 229, 244-45 (1967).

<sup>393</sup> See text at note 119 *supra*.

<sup>394</sup> At least five states have limited physicians to supervising one PA at a time. Ala. PA Regs, *supra* note 146, Rule VIII(b); Ariz. PA Regs, *supra* note 146, *Application* (2); COLO. REV. STAT. ANN. § 12-31-103(5) (1973); Nev. PA Regs, *supra* note 146, § D.6; Ore. PA Regs, *supra* note 146, § 50-015(2). Sixteen other states have limited physicians to supervising no more than two PAs, although Maryland's, New Mexico's, and Wisconsin's rules recognize the possibility of waivers in specified cases. CAL. BUS. & PROF. CODE § 2516 (West 1974); FLA. STAT. ANN. § 458.135(6)(d) (Supp. 1975); GA. CODE ANN. § 84-6204(e) (Supp. 1974); IOWA CODE ANN. § 148B.3 (1972); Me. PA Regs, *supra* note 146; Md. PA Regs, *supra* note 146, §§ 04.C,D (limiting physicians to two PAs in non-institutional practices and providing for individual medical board approval of facility guidelines for use of PAs); MASS. GEN. LAWS ANN. § 9E (Supp. 1975); NEB. REV. STAT. § 85-170.09(3) (Supp. 1974); N.H. PA Regs, *supra* note 146, Rule II; N.M. STAT. ANN. § 67-5-3.6 (Supp. 1973) (medical board may waive limit for physicians and PAs providing health services on a "free or reduced fee" basis); N.C. GEN. STAT. § 90-18(13)(a) (Supp. 1974); Okla. PA Regs, *supra* note 146, Rule 10(H); VA. CODE ANN. § 54-281.5 (1974); W. Va. PA Regs, *supra* note 146, § 8.07; Wis. PA Regs, *supra* note 146, § 50.08 (but exceptions may be recognized if a written plan for supervision of a larger number of PAs is approved): WYO. STAT. ANN. § 33-338.3(b) (Supp. 1975).

PA Regulatory Statutes.<sup>395</sup> The remaining ten PA Regulatory Statutes do not contain specific numerical limitations, but regulations were unavailable under eight of these statutes,<sup>396</sup> and administrative agencies under the other two can control the number of PAs supervised by a physician through their power to approve employment of PAs by physicians.<sup>397</sup>

Exceptions to the prevailing pattern are found in the legislation of five states. New York authorizes physicians in private practice to employ a maximum of four PAs,<sup>398</sup> and physicians may supervise up to six hospital employed PAs.<sup>399</sup> Washington limits physicians to supervising only one PA with relatively comprehensive training and responsibility, but a waiver of this rule may be obtained from the medical licensing board, and the board may allow physicians to supervise larger numbers of PAs with more limited duties.<sup>400</sup> The rules of three other states provide for waiver of the numerical limitation in certain instances. Maryland limits physicians to employing two PAs in their "non-institutional practice," but health care institutions apparently may propose guidelines for licensing board approval of physician supervision of a larger number of PAs in institutional settings.<sup>401</sup> New Mexico limits physicians to two PAs, except that the medical board may authorize a greater number of PAs for physicians "working in a health facility providing health service to the public primarily on a free or reduced fee bases."<sup>402</sup> Finally, Wisconsin limits physicians to two PAs, but the medical board is empowered to grant waivers.<sup>403</sup>

The apparent purpose of the prevailing low numerical limitation on PAs is to ensure effective supervision of their performance. An absolute restriction of this sort, however, can be justified on social welfare grounds only if the economic benefits from physicians supervising a larger number of PAs are not likely to outweigh the harm that would result from such supervision.<sup>404</sup> The economic benefits from allowing physicians to supervise "PA teams"<sup>405</sup> might be substantial. Furthermore, the relatively large number of PAs practicing in New York<sup>406</sup> coupled with the decision of New York's regulators to

<sup>395</sup> N.Y. EDUC. LAW § 6532(4) (McKinney 1972); N.Y. Health PA Regs, *supra* note 146, § 74.2(d); Wash. PA Regs, *supra* note 146, § 5(a).

<sup>396</sup> At this writing, regulations were unavailable for the PA Regulatory Statutes of Alaska, Hawaii, Idaho, Kansas, Minnesota, North Dakota, South Carolina, and Utah.

<sup>397</sup> S.D. COMPILED LAWS ANN. § 36-4A-19 (Supp. 1974); Vt. PA Regs, *supra* note 146, § II(b).

<sup>398</sup> N.Y. EDUC. LAW § 6532(4) (McKinney 1972).

<sup>399</sup> N.Y. EDUC. LAW § 6532(5) (McKinney 1972) and N.Y. Health PA Regs, *supra* note 146, § 94.2(d).

<sup>400</sup> Wash. PA Regs, *supra* note 146, § 5(a).

<sup>401</sup> Md. PA Regs, *supra* note 146, §§ 04.C.D.

<sup>402</sup> N.M. STAT. ANN. § 67-5-3.6 (1973).

<sup>403</sup> Wis. PA Regs, *supra* note 146, § 50.08.

<sup>404</sup> See Moore, *supra* note 228, at 104, 110.

<sup>405</sup> Supervision of "PA teams" may take one of two different forms—a physician's full-time supervision of several PAs or a physician's supervision of several PAs at different times during his practice. Opportunities for the latter form of supervision will arise in institutional or large group practices.

<sup>406</sup> As of March 1, 1974, 128 of the 655 reported PAs practicing under PA statutes were in New York. Cohen and Dean, *To Practice or Not to Practice*, *supra* note 7, at 353. Nine months later there were approximately 200 PAs practicing in New York. Letter from Julia Freitag, M.D., Director, Office of Medical Manpower, N.Y. Dep't of Health, to Philip Kissam, Nov. 18, 1974.

maintain liberal rules on PA numbers suggests that expanded delegation to PA teams need not sacrifice competence.<sup>407</sup> Further, physicians have not been limited in the number of NPs they may supervise under NP Regulatory Statutes, despite the similar functions of NPs and PAs. Even if one concedes that the possibility of harm from use of PA teams is also substantial, restricting a physician to supervising one or two PAs without exception seems unjustifiably harsh. Without experimentation, the medical profession will never discover whether supervision of PA teams is feasible or not. Thus, at the very least, the Washington, Maryland, and Wisconsin regulations that recognize the possibility for waiver of low numerical restrictions<sup>408</sup> seem preferable to absolute limitations.

New Mexico's statute, which authorizes supervision of PA teams with medical board approval but only for free health services,<sup>409</sup> crystallizes nicely the basic problem with numerical restrictions and with much else about the new legislation. Allowing supervision of PA teams for free health services but not fee-producing services certainly cannot be justified as a quality control in the public interest. This provision can serve only to protect physicians' incomes by limiting the supply of medical services generally and by reducing the possibility that PAs will be used to increase economic competition in the fee-producing sector.<sup>410</sup> As in other issues discussed in this Article, legislative rules that arguably are better designed to promote the public interest have been overcome by an effort to protect physicians' economic interest, a motive that appears to go to the heart of much that is incomplete and unduly restrictive in the new legislation.

#### IV. SOME RECOMMENDATIONS

This part offers recommendations for legislative rules to improve the prospects for maximum feasible expanded delegation. These rules are presented in summary form in order to pull together the various analyses in preceding parts of this Article. The rules are presented in the form of a "Model Simple Authorization Statute" and a "Model Regulatory Statute"<sup>411</sup> because statutory change is necessary to authorize expanded delegation in some states and may be necessary in others to improve statutes and regulations that are incomplete or unduly restrictive. Nonetheless, many of these recommendations may be implemented under existing Regulatory Statutes by administrative action in view of the broad authority generally delegated to administrative agencies by these statutes.<sup>412</sup>

<sup>407</sup> See notes 295-96 and accompanying text *supra*.

<sup>408</sup> Md. PA Regs, *supra* note 146, §§ 04.C,D; Wash. PA Regs, *supra* note 146, § 5(a); Wis. PA Regs, *supra* note 146, § 50.08.

<sup>409</sup> N.M. STAT. ANN. § 67-5-3.6 (Supp. 1973).

<sup>410</sup> See text at notes 113-15 *supra*.

<sup>411</sup> The model statutes are presented as PA statutes because these authorize expanded delegation to a broader range of nonphysicians than NP statutes. Nonetheless, the recommendations in these models apply equally to NP statutes.

<sup>412</sup> See note 146 and accompanying text *supra*.

The author recommends the Model Simple Authorization Statute. The arguments for regulatory alternatives seem insupportable on social welfare grounds. Prior legal controls over the independent practice of medicine by physicians may be justified, but the analogy between such practice and expanded medical delegation seems weak if for no other reason than the ethical and legal responsibility of physicians for acts performed under their supervision. Prior controls over expanded delegation may well limit the social benefits from expanded delegation if administrative agencies implement prior controls in an unduly conservative manner, as seems likely.<sup>413</sup> This prediction is strengthened by the observation that administrative agencies under Regulatory Statutes in fact seem to be implementing unnecessarily conservative policies.<sup>414</sup>

There are nonetheless several reasons why a Simple Authorization Statute might be rejected and some form of Regulatory Statute adopted. First, a great number of Regulatory Statutes are in effect, and reform possibilities may be limited to improving the existing legal structure. Secondly, legislators reasonably may disagree with the conclusion that social costs of a prior control system over expanded delegation are likely to outweigh social benefits; this conclusion, after all, is no more than a prediction of future probabilities. Thirdly, imposition of prior controls over nonphysicians authorized to prescribe or dispense prescription drugs is justified if uncertainty about the authority of unlicensed physicians' agents to prescribe or dispense drugs under the federal drug control laws<sup>415</sup> effectively prohibits such practice. Unlike legal uncertainty about other forms of expanded delegation, this uncertainty is created by federal law and cannot be resolved by state legislation alone.<sup>416</sup>

#### A. *Alternative A: A Model Simple Authorization Statute*

A Simple Authorization Statute designed to promote expanded medical delegation in the public interest would contain the following provisions:

- (1) An exemption from the medical practice act for any act of medical diagnosis or prescription of therapeutic or corrective measures performed by any person under a physician's supervision; provided that such performance is in accordance with written policies and protocols established by the physician and nonphysician;
- (2) Explicit recognition that the authority to prescribe therapeutic measures includes authority for the nonphysician to prescribe and dispense prescription drugs to the extent authorized by the supervising physician;
- (3) Explicit recognition that the nonphysician may practice in locations remote from his supervising physician to the extent authorized by the physician;
- (4) A voluntary certification system administered by a state agency<sup>417</sup> to deter-

<sup>413</sup> See section III.A. *supra*.

<sup>414</sup> See sections III.B.-D. *supra*.

<sup>415</sup> The nature of this uncertainty is discussed in the text at notes 333-39 *supra*.

<sup>416</sup> Of course, if any federal drug control law is established or interpreted to require licensure of physicians' agents who prescribe drugs, prior controls to effect licensure of these nonphysicians will be necessary to authorize such prescriptions, and these controls will be justified as a necessary means of promoting expanded delegation.

<sup>417</sup> This agency might be the state health agency, at least for expanded delegation that is part of a licensed health care institution's services. See text at notes 354-77 *supra*.

mine the competence of nonphysicians to perform any medical act or acts, with failure to obtain or denial of voluntary certification excluded from evidence in any subsequent legal proceeding,<sup>418</sup>

- (5) Express provisions that patients shall be informed clearly that direct care services are to be provided by a nonphysician; that evidence of the nonphysician's training, formal or informal, shall be readily available to patients; and that, for purposes of malpractice liability, any supervising physician shall be presumed conclusively to be a principal, master, or employer of any nonphysician performing medical acts under the physician's supervision.

This Model Simple Authorization Statute has four basic advantages over the typical Simple Authorization Statute enacted to date. First, the voluntary certification system and the explicit authorization for diagnostic and treatment judgments, drug prescriptions, and remote practice would promote maximum feasible delegations by establishing standards and procedures to provide presumptive legal validity for more innovative delegation, delegation that physicians otherwise may avoid because of uncertainty about potential liability.<sup>419</sup> Secondly, the requirement of Provision (1) that written policies and protocols be established, which follows California's NP Simple Authorization Statute,<sup>420</sup> would help ensure that physicians and nonphysicians alike focus scrupulously on the quality of care to be provided by the nonphysician. Thirdly, the voluntary certification system, together with the notice requirements, would help provide information to consumers about the relative competencies of nonphysicians, allowing patients the choice of obtaining services from physicians only, state-certified PAs, or uncertified PAs.<sup>421</sup> Finally, the conclusive presumption of a master-servant relationship between any supervising physician and supervised nonphysician performing medical acts would remove any doubt about the full application of the borrowed servant doctrine to hospital employed nonphysicians.<sup>422</sup>

In lieu of a state administered voluntary certification program, whose costs would be borne by the state, decision makers might choose to rely on national PA and NP certification programs operated by professional groups for the dual purposes of promoting expanded delegation and providing consumers with information about relative competencies of nonphysicians. This reliance would seem unwise, however, since these programs apply only to nonphysicians trained to perform a relatively comprehensive set of medical functions and are controlled by organizations with an apparent interest in restricting expanded delegation.<sup>423</sup>

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<sup>418</sup> This provision would help ensure that the voluntary certification system is truly voluntary. See note 248 and accompanying text *supra*.

<sup>419</sup> See text at notes 252, 299-314 *supra*.

<sup>420</sup> CAL. BUS. & PROF. CODE § 2725(d) (West Supp. 1975).

<sup>421</sup> See text at note 237 *supra* for a discussion of the welfare benefits from allowing consumers to choose lower-priced services of uncertified PAs.

<sup>422</sup> See text at notes 384-89 *supra*.

<sup>423</sup> See text at notes 284-88 *supra*.

B. *Alternative B: A Model Regulatory Statute*

A Regulatory Statute best designed to promote expanded medical delegation would contain the following provisions:

- (1) Delegation of regulatory authority to the state health agency or, in the alternative, division of regulatory authority between the state health agency for services that are offered within a licensed health care institution and the state medical licensing board for other delegations;
- (2) An express provision that nonphysicians may qualify to perform any particular medical act and that qualification need not be based on completion of a formal, approved training program; prior administrative determination of PAs' qualifications should be limited to those PAs granted authority to prescribe or dispense drugs if the only justification for a Regulatory Statute is the need to authorize and control drug prescriptions by PAs;<sup>424</sup>
- (3) Explicit authorization of outer boundary medical delegations to qualified PAs or NPs in the same manner as provisions (1), (2), and (3) of Alternative A;
- (4) Explicit recognition that hospitals and other licensed health care institutions may employ PAs and that PAs may be supervised at different times by different physicians;
- (5) A provision that any general limitation on the number of PAs that may be supervised by a physician shall be waived by the regulatory agency on a showing that supervision of a larger number is reasonable.

The purpose of these recommendations is to implement prior controls in a manner that would avoid the significantly restrictive aspects of the new legislation noted in sections B, C, and D of part III of this Article.

Delegation of regulatory authority to the state health agency, or division of such authority between the state health agency and professional licensing boards, would avoid the negative aspects of organized medicine's effective control over expanded delegation through regulation by medical licensing boards. If permitted by law, hospitals and other licensed health care institutions probably will be the centers of much useful expanded medical delegation.<sup>425</sup> State health agencies appear more likely than medical boards to be free from influence of medical professionals who have interests that are threatened by expanded medical delegation, and thus health agencies seem more apt to recognize innovative delegations and maximize benefits from the new legislation.<sup>426</sup> It may be argued that a division of regulatory responsibility would cause jurisdictional confusion and an increase in administrative costs. California's NP Simple Authorization Statute, which appears to provide for a similar division of responsibility,<sup>427</sup> and New York's PA Statute, which divides responsibility along different lines,<sup>428</sup> are precedents that indicate these factors present no insurmountable problem. Moreover, the state health agency might choose

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<sup>424</sup> See text at notes 415-16 *supra*.

<sup>425</sup> See text at note 390 *supra*.

<sup>426</sup> See text at notes 354-77 *supra*.

<sup>427</sup> See note 361 and accompanying text *supra*.

<sup>428</sup> See note 354 and accompanying text *supra*.

to regulate expanded medical delegation largely as part of its overall institutional review,<sup>429</sup> thus modifying any burden of increased cost.

Provision (2), that nonphysicians may qualify to perform any particular medical act or acts based on limited and informal training, is designed to avoid the traditional, restrictive practice of relying on comprehensive training in formal academic programs as the standard for competence to perform medical acts.<sup>430</sup> This provision would require use of approved job descriptions to take account of the many different types of possible authorizations.<sup>431</sup> It may be argued that alternative means of determining competency are not available<sup>432</sup> or that the provision would be administratively unworkable,<sup>433</sup> but competency assessments and administrative burdens have not been deemed insurmountable problems by the large number of states that already approve job descriptions for PAs or NPs.<sup>434</sup> Moreover, as state health agencies gain experience, they will develop categories of approvable job descriptions, thereby easing the administrative burden.<sup>435</sup> This provision also would limit prior legal controls over nonphysicians' qualifications to nonphysicians authorized to prescribe or dispense drugs when licensure of drug-prescribing agents of physicians is deemed to be the only justification for prior controls.<sup>436</sup> Because drug prescription is such an important part of medical practice, this requirement would effectively establish prior controls over most or all nonphysicians who engage in diagnostic and treatment judgments and remote practice. Such a limitation would be similar to the regulation of NPs under the NP Regulatory Statutes of Alaska and New Hampshire, which provide for certification only of those NPs who engage in outer boundary delegations.<sup>437</sup>

Provision (3) authorizes outer boundary delegations in order to provide clear statutory authority for administrative agencies to recognize such delegations by regulation or approved job descriptions. This section would help promote expanded delegation in the same manner as the corresponding provisions of *Alternative A*. Provisions (4) and (5) are designed to preclude administrative agencies from prohibiting hospital employment of PAs, limiting such employment by requiring that only one physician may supervise a PA, or

<sup>429</sup> Such regulation in effect would delegate most or all prior controls over expanded delegation to the governing bodies of licensed health care institutions. This form of regulation has been labelled "institutional licensure," and it is most closely associated with proposals made by Professor Nathan Hershey of the University of Pittsburgh School of Public Health. See Carlson, *supra* note 10, 872-74; Hershey, *New Directions in Licensure of Health Personnel*, 24 *ECON. BUS. BULL.* 22, 31-34 (1971). The practical effect of the Model Simple Authorization Statute proposed herein probably would be quite similar to institutional licensure. Under Simple Authorization Statutes, health care institutions presumably will establish internal regulations for governing expanded medical delegations. See, e.g., *AMA HOUSE OF DELEGATES, STATUS AND UTILIZATION OF NEW OR EXPANDING HEALTH PROFESSIONALS IN HOSPITALS 2* (June, 1973) (recommending that procedures governing expanded delegations in hospitals be established in medical staff bylaws).

<sup>430</sup> See text at notes 253-66 *supra*.

<sup>431</sup> See Hershey, *New Directions in Licensure of Health Personnel*, 24 *ECON. BUS. BULL.* 22, 31-34 (1971).

<sup>432</sup> See text at note 278 *supra*.

<sup>433</sup> See DUKE PROJECT, *supra* note 10, at 42-43.

<sup>434</sup> See text at notes 149, 174 *supra*.

<sup>435</sup> DUKE PROJECT, *supra* note 10, at 43.

<sup>436</sup> See text at notes 415-16 *supra*.

<sup>437</sup> See text at note 239 *supra*.

restricting the number of PAs or NPs that a physician may supervise without exception. These kinds of restrictions seem designed particularly to accomplish nothing more than protection of physicians' and nurses' economic interests.<sup>438</sup>

### C. *A Final Option: Limited Independent Practice*

States suffering from substantial physician shortages in certain locales may discover that maximum feasible medical delegation by physicians will not provide sufficient expansion of medical services if too few physicians in these areas are willing to employ PAs and NPs to remedy the shortage. These states should have a particular interest in authorizing special categories of PAs or NPs to practice independently, referring more difficult medical problems to appropriate physicians or specialists. A Canadian study suggests that such practice by NPs is medically feasible.<sup>439</sup>

Regulation of independent practice by nonphysicians is generally beyond the scope of this Article, but it may be noted that effective authorization and regulation of such practice might best be achieved by a modified form of the Model Regulatory Statute discussed above. First, individual state approval of these nonphysicians' qualifications would be necessary because authority to prescribe retail sales of drugs would be essential to this practice, and Federal law requires that such prescriptions be made by practitioners "licensed" by the state to administer such drugs.<sup>440</sup> Secondly, authorization in broad terms for these nonphysicians to practice medicine, together with an administrative procedure for defining scope of practice limits on a case-by-case basis, would seem preferable to the traditional approach of attempting to define statutorily the scope of limited independent medical practice. As previously discussed, the latter approach creates substantial uncertainty about the legality of particular medical acts.<sup>441</sup>

Alaska, Nevada, and New Hampshire have authorized certain forms of limited, independent medical practice by NPs under their NP Regulatory Statutes. New Hampshire's statute provides that NPs may practice "either in private practice or in a collaborative relationship with physicians."<sup>442</sup> By regulatory action, Alaska and Nevada have recognized "private" or "independent" practice by NPs.<sup>443</sup> Available regulations, however, provide little further guidance or information as to the scope of practice authorized for independent NPs. Nevada and New Hampshire both require some evidence of a "collaborative relationship" between the NP and a physician or physicians,<sup>444</sup> an apparent attempt to ensure that medical problems beyond the NP's competence are appropriately referred. Nevada's regulations do not authorize clearly

<sup>438</sup> See text at notes 379-410 *supra*.

<sup>439</sup> Spitzer, *supra* note 27.

<sup>440</sup> 21 U.S.C. § 353(b)(1) (1970).

<sup>441</sup> See section I.C. *supra*.

<sup>442</sup> N.H. REV. STAT. ANN. § 326-A:5-a(I) (Supp. 1973).

<sup>443</sup> ALASKA BOARD OF NURSING, POSITION PAPER 1 (May 15, 1974); Nev. NP Regs, *supra* note 171, § III C.

<sup>444</sup> Nev. NP Regs, *supra* note 171, § C; N.H. NP Regs, *supra* note 171, part A, § 1.1.



either diagnostic and treatment judgments or drug prescriptions by independent NPs.<sup>445</sup> Finally, New Hampshire's regulations limit most categories of NPs to making an initial judgment of normal or abnormal condition, while requiring referral of abnormal conditions to physicians,<sup>446</sup> and to modifying drug treatments prescribed by physicians.<sup>447</sup> These regulations do not appear to have been designed to obtain maximum social benefits from limited, independent practice by NPs.<sup>448</sup>

#### V. SUMMARY OF MAJOR CONCLUSIONS

The foregoing analysis has suggested that much of the new state legislation governing expanded medical delegation is unduly restrictive and incomplete in several respects. First, a substantial majority of the statutes have established a regulatory structure that seems wholly or largely unnecessary. These statutes also have delegated most administrative authority to state medical licensing boards, which appear to have a significant interest in restricting the performance of medical acts by nonphysicians. Secondly, nonphysicians performing medical acts have been limited in many cases to persons trained in formal educational programs to perform a relatively comprehensive set of medical functions. This limitation precludes from expanded delegation persons with less formal training or with training to perform only specific medical acts, an exclusion that seems unjustified and costly. Thirdly, the scope of practice of qualified nonphysicians has in many cases been unduly restricted and has not been defined in the manner that seems necessary to promote maximum feasible expanded delegation.

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<sup>445</sup> See Nev. NP Regs, *supra* note 171.

<sup>446</sup> See text at notes 326-28 *supra*.

<sup>447</sup> See text at notes 351-52 *supra*.

<sup>448</sup> It is interesting to compare Nevada's and New Hampshire's NP regulations with NP regulations proposed by Alaska's nursing board in November, 1974, Proposed Regulations for Advanced Registered Nurse Practitioners (Alaska Board of Nursing, proposed Nov. 1974). Under Alaska's proposed regulations, individual NPs would have been able to obtain clear authorization to prescribe drugs. *Id.* § 44.321(g). These regulations were never approved by Alaska's state medical board, and they were rejected by the State Attorney General for this and other "technical" reasons in April 1975. Phone interview with Joyce Hazelbaker, Executive Officer, Alaska Board of Nursing, Sept. 9, 1975.